Congress of the United States
Washington, DC 20515

March 2, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius and Administrator Tavenner:

We write to provide formal comments on the "Advance Notice of Methodological Changes for Calendar Year 2013 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2013 Call Letter," released by the Centers for Medicare and Medicaid Services (CMS) on February 17, 2012. Our comments relate to the impact of these proposed policies on MA beneficiaries in Puerto Rico. A number of us have written to you (or your predecessors) on prior occasions regarding this topic.[1] We respectfully ask that CMS address the points we raise—or reiterate—below in the agency's 2013 Rate Announcement, to be published on April 2, 2012.

At 69.3 percent, Puerto Rico's MA penetration rate is the highest in the nation by a substantial margin. Nearly 480,000 of Puerto Rico's approximately 690,000 Medicare beneficiaries are enrolled in an MA plan. To place this in context, the MA penetration rate nationwide is 27 percent. The jurisdiction with the second-highest penetration rate is Minnesota at 46.2 percent, over 20 percentage points below Puerto Rico.

Historically, MA plans in Puerto Rico have provided a number of benefits that are not available to beneficiaries on the Island under traditional Fee-for-Service (FFS) Medicare. These benefits are generally provided to members with no additional premium charged. Furthermore, MA plans in Puerto Rico often cover a significant portion (or all) of their members' deductibles, co-payments, Part B premiums, and Part B late enrollment penalties. Such financial support is particularly critical in Puerto Rico, since the territory—unlike the 50 states—is not eligible to receive federal matching funds under Medicaid to provide premium and other cost-sharing assistance to low-income beneficiaries who are enrolled in FFS Medicare.

In light of the exceptionally high MA penetration rate in Puerto Rico, as well as the quality and affordability of care these plans provide to their members, changes in the federal government's MA payment policies have the potential to uniquely impact the Island's elderly and disabled population.

[1] On October 21, 2010, Reps. Pierluisi, Serrano, Velázquez and Gutierrez and Senator Menendez wrote to Secretary Sebelius and CMS Administrator Berwick, and received a response from Secretary Sebelius dated December 23, 2010. On March 30, 2011, Reps. Pierluisi and Rangel wrote to Secretary Sebelius and CMS Administrator Berwick, and received a response from Secretary Sebelius dated July 11, 2011.

Proposed Benchmarks for 2013

In prior correspondence in October 2010 and March 2011, a number of the undersigned urged CMS to exercise its authority to make adjustments to the calculation method utilized to determine per capita FFS spending in Puerto Rico, which is used as the basis for setting payment rates for MA plans under the 2010 *Affordable Care Act*.

It is important to recognize CMS's actions to date. In its response to the March 2011 letter, CMS expressly acknowledged that "Medicare enrollment, cost, and use patterns in Puerto Rico are different than in the States." For example, in every state and territory except Puerto Rico, Medicare-eligible beneficiaries are automatically enrolled in Part B unless they opt out. Pursuant to a 1972 provision in the Social Security Act, beneficiaries in Puerto Rico are not automatically enrolled in Part B, but rather must affirmatively opt in. See 42 U.S.C. § 1395p(f)(3). As a result, the percentage of FFS beneficiaries enrolled in Part B in Puerto Rico is far below what it is in the 50 states. Therefore, the amount that the federal government pays per FFS enrollee is significantly lower on the Island relative to the national average. In recognition of this fact, CMS—in its 2012 Rate Announcement—refined the methodology used to calculate per capita FFS spending in Puerto Rico, so that it will be based exclusively on beneficiaries who are enrolled in both Part A and Part B. This will result in fairer payments to Island MA plans.

We are grateful for the action already taken by CMS, but strongly believe that additional action is warranted.

First, given the importance of the aforementioned correction—to account for the lack of automatic Part B enrollment in Puerto Rico—we urge CMS to implement this correction immediately, rather than to phase it in gradually over the five-year period between 2012 and 2016, as is currently envisioned. Simply put, we see no principled basis to delay full implementation of this much-needed correction. At a minimum, we respectfully submit that the balance of the equities militates in favor of immediate implementation.

Further, as has been noted in previous correspondence, there are at least two factors in addition to the Part B issue that serve to artificially depress per capita FFS spending in Puerto Rico. First, although Puerto Rico hospitals are reimbursed under the Inpatient Prospective Payment System, they do not receive the same base rate as hospitals in the 50 states for treating FFS Medicare patients. As you know, the base rate is intended to cover a hospital's operating and capital costs. Every hospital in the states receives the same base rate, regardless of where the hospital is located—about $5,630 per discharge. But Puerto Rico hospitals receive a base rate that is based on 75 percent of the federal base payment amount and 25 percent of a Puerto Rico-specific rate, for both operating and capital payments. See 42 U.S.C. § 1395ww(d)(9)(E). As a result, the base rate for Puerto Rico hospitals is $4,899—13 percent less than the base rate for hospitals in the states.

In addition, Puerto Rico hospitals serving large numbers of low-income patients do not receive fair disproportionate share hospital (DSH) payments because Supplemental Security Income (SSI), a major factor in calculating such payments, has not been extended to the Island. See 42 U.S.C. § 1301(a)(1). Despite efforts, Congress has not authorized use of an alternative formula for Puerto Rico hospitals that would mitigate the current payment disparity notwithstanding the fact that Island residents are not eligible for SSI. These two factors, each of which is unique to

Puerto Rico, result in the FFS Medicare program paying less per enrollee in Puerto Rico that it would pay per (similarly-situated) enrollee in the states.

Therefore, we respectfully ask CMS to adjust the calculation method used to determine per capita FFS spending in Puerto Rico to account for the fact that (a) Puerto Rico hospitals receive a lower base rate than hospitals in the states under the IPPS system and (b) Puerto Rico hospitals do not receive fair DSH payments because SSI has not been extended to the Island and no alternative formula to account for this factor has been enacted.

We firmly believe that CMS has the authority to modify the calculation method as requested, even if we stipulate that the agency does *not* have the authority to set aside or modify the statutory provisions that give rise to the disparity in base rates or DSH payments for Puerto Rico hospitals. After all, the lack of Part B automatic enrollment in Puerto Rico is also the result of a federal statute that CMS cannot override, and the agency appropriately exercised its authority to adjust for this factor in its 2012 Rate Announcement. We note that 42 U.S.C. § 1853(n) gives the Secretary the authority—during the process of setting the "adjusted average per capita cost" in any given MA contract year—to make adjustments to ensure actuarial equivalence, and believe an adjustment based on these two factors would fall well within that authority.

Quality Bonus Demonstration Project

Beyond the Puerto Rico-specific issues raised above, we also want to raise several issues that are of national scope but that are particularly relevant to MA beneficiaries in Puerto Rico. As you know, for a number of years CMS has used a star-based rating system for MA plans. These ratings are designed to enable beneficiaries to compare plans available in their area so they can select the plan that is most appropriate for them. Under this system, MA plans are ranked on a scale from 1 star to 5 stars. However, Congress did not provide guidance to CMS as to which criteria the agency should utilize to determine a plan's star rating. CMS, in its discretion, has elected to base a plan's rating upon numerous performance measures, with relevant data gleaned from three surveys and CMS administrative data on plan quality and member satisfaction.

Starting this year, pursuant to CMS's Quality Bonus Demonstration Project, MA plans that have a quality rating of three stars and above will receive bonus payments.

We support bonus payments for plans that have a rating of three stars and above, because we believe these payments will provide plans with an incentive to maintain or improve their star ratings, which will ultimately result in better services for beneficiaries. However, we are concerned that a number of superb MA plans might not obtain a three-star rating under the current system because they operate in disadvantaged jurisdictions and cover a large proportion of low-income beneficiaries—whose health outcomes tend, on average, to be worse. This makes it harder for the MA plan to score as high as it might otherwise score on many of the performance criteria that CMS is utilizing.

Accordingly, we urge CMS to consider implementing the following three recommendations:

- First, we support CMS's current proposal to add a measure of quality improvement to the 2013 Plan Ratings methodology. The current system—which rewards plans based on outcomes per se rather than improvement in outcomes—would seem to disadvantage

plans in high-need jurisdictions, where the "baseline" may well be lower. Context matters and plans should not be rated in a vacuum.

- Second, we believe the performance measures should be supplemented—again, so as to ensure that the star rating system accurately reflects plan quality to the greatest extent feasible and does not inadvertently penalize plans in low-income jurisdictions. Specifically, we believe it would be appropriate for CMS to consider as a relevant factor whether a plan has been accredited by the National Committee on Quality Assurance (NCQA), a rigorous, comprehensive and transparent accreditation program. We believe this would be particularly appropriate because CMS has already granted NCQA "deeming authority" for the MA program, which enables NCQA to review MA organizations on behalf of CMS in many key categories, including access to services and quality assurance.
- Finally, we have been advised that one or more of the surveys that plan members are asked to complete—and that are then used by CMS to gauge plan performance—are only made available in English. Because we believe this could place MA plans in Puerto Rico (and other U.S. jurisdictions) at a distinct disadvantage, we urge CMS to make these surveys available in Spanish.

Thank you for your attention to these matters.

Sincerely,

Pedro R. Pierluisi
Member of Congress

Charles B. Rangel
Member of Congress

José E. Serrano
Member of Congress

Luis V. Gutierrez
Member of Congress

Nydia M. Velázquez
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cc. Jonathan D. Blum, Deputy Administrator and Director for the Center of Medicare, Centers for Medicare and Medicaid Services
Paul Spitalnic, Director, Medicare Part C & D, Office of the Actuary, Centers for Medicare and Medicaid Services