

Addressing Puerto Rico's Medicare Crisis **And Implementing an Urgent Path to Recovery**

Working Paper
As of November 30, 2015 (v8).

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This is the result of research and work performed with the help of the members of the Medicaid and Medicare Advantage Products Association of Puerto Rico, the Puerto Rico Institute of Statistics, Mr. William Toby, Jr., and the Puerto Rico Healthcare Crisis Coalition. - Roberto Pando, MS, JD, Chair of MMAPA Policy Committee and PR Chamber of Commerce Health Committee. November 2015.

1. The Problem

There are two essential things Federal policy-makers must understand about Puerto Rico if they are to achieve their goal of addressing Puerto Rico's Medicare crises and implement an urgent path to recovery. In the first place, it is essential to understand that the Medicare and Medicaid statutes, that is, the "law," by design, treat Puerto Rico and our other US Territories differently. In the second place, it is vital to understand that this differential treatment over the past forty-eight years has resulted in unintended effects on the 1.6 million Medicare and Medicaid beneficiaries residing in the Commonwealth of Puerto Rico, and those effects are measurable and pernicious.

This history involving a statutorily imposed different and fragmented implementation of Medicare and Medicaid for US citizens residing in Puerto Rico has created a disparate and unstable healthcare system. Adding to the problem at this critical stage for the Commonwealth of Puerto Rico, our health care system is in the midst of an economic crisis, and without further action from the Federal agencies, the situation on the island could become a humanitarian crisis for the Obama Administration.

As explained in subsequent sections, we can define distinct circumstances in three categories: statutory, programmatic, and socio-economic, which have now been exacerbated by the negative unintended consequences of the Affordable Care Act (ACA) for Medicare beneficiaries residing in Puerto Rico. Unless Federal action is taken, the ACA net result for Puerto Rico would be billions of dollars in cuts to a Medicare program that is already the cheapest in the nation.

In parallel, it is logical to conclude that Federal programs cannot reverse decades of statutory and programmatic disparities by simply continuing to implement the standard program rules and regulations that are based on a consistent program structure across the states. Consequently, Administrative action to reasonably adjust Medicare programs is urgent, and is also possible without Congressional action.

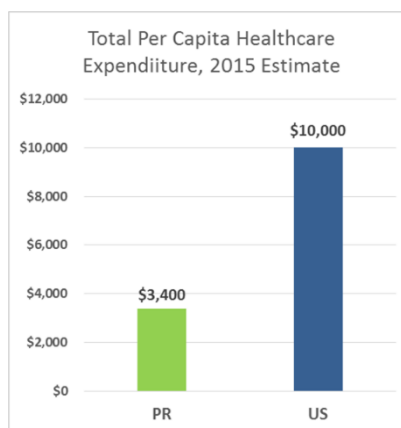
Administrative overall action is needed now in Medicare Advantage, as well as in Medicare Part A, Part B, and Part D to make all feasible corrections effective in 2017, without further delay. This will provide needed health security for 3.5 million Americans in Puerto Rico, including over 740,000 Medicare beneficiaries and over 300,000 dual eligible.

2. Basic Background

Puerto Rico ranks 26th among states in total Medicare beneficiary population. And when compared to the largest territories, the Commonwealth population of 3.4 million accounts for 90% of the total population in the territories.

Since the passage of the Social Security Act in 1965, Congress has played the dominant role in shaping the financing of health services in Puerto Rico. In 1966, Puerto Rico embraced both Medicare and Medicaid after a long-standing tradition of free health care to the indigents that dates back to our Spanish heritage prior to 1898.

Today, at the very macro level, total healthcare expenses per capita are approximately \$3,400 in Puerto Rico, compared to the national average projection of \$10,000 or more for 2015.¹ Not only Puerto Rico is very distant from US average funding levels for healthcare, but also has significantly less resources for healthcare than many countries with diverse healthcare systems like Canada, France, Germany, and the UK, which are also known to spend significantly less than the US average.² Many of these well studied and recognized healthcare systems spend \$5,000-\$6,000 per capita, placing Puerto Rico's expenditure levels at a distinct disadvantage for many perspectives, especially considering that core inputs like prescription drugs, equipment, electric power and others are acquired within the US market, and mostly at above average prices. Moreover, the partial and uneven implementation of the Medicare and Medicaid programs for 5 decades has been a core element impacting the resulting imbalances that we see today. The situation of relative underfunding and increasing disparities within the same US healthcare economy, and the same Federal programs, has sustained itself only by inevitably depressing professional compensation, stalling capital and information technology investments, and by increasing barriers to appropriate access to care for the low income population.



The economic position of the system in Puerto Rico is such an outlier that, even after executing on all the proposed adjustments presented by health care stakeholders, the Medicare program, and the Medicare + Medicaid services for duals, will still have the most cost-effective platform in the nation.

3. The Obama Administration's Plan Before Congress Recognizes Puerto Rico Cannot Save Itself

The Administration proposal to Congress from October 2015, summarizes the nature of the crisis in Puerto Rico and the urgency for action. The proposal acknowledges increasing issues of poverty, unemployment, and the largest wave of outmigration since the 1950s. In addition, the proposal emphasizes the need to strengthen fiscal discipline, while it recognizes that Puerto Rico and austerity cannot do it alone. The Administration also reiterates its commitment to work with Puerto Rico and exercise to the maximum its administrative authorities, noting that they will be not enough to resolve the crisis.

Clearly, Congressional action targeted to critical elements in the situation of Puerto Rico calls for imminent attention. Notwithstanding, Congressional action alone will not be enough either, and, most certainly, will not be urgent enough to mitigate and avoid further harm to the health system, especially to Medicare and dual eligible beneficiaries on the island. Efforts to support proposals in Congress should not delay or substitute for needed fixes that are undeniably within the scope of

¹ <http://www.forbes.com/sites/danmunro/2015/01/04/u-s-healthcare-spending-on-track-to-hit-10000-per-person-thi-year/>
 Estimates for Puerto Rico are based on the financial statements of health plans in the island reported to the National Association of Insurance Commissioners (NAIC). CMS reports for Medicare FFS, and reports of the Government of Puerto Rico Office of Management and Budget.

² World Health Organization (WHO) <http://apps.who.int/gho/data/node.main.78?lang=en>

authority of HHS and related executive agencies (*See Appendix A*). It is only by exhausting administrative alternatives, and executing rapidly on corresponding adjustments, that the Administration can legitimately and forcefully demand Congressional support for proposals that clearly require legislation. Given pre-existing statutory and programmatic differences in the Medicare program for Puerto Rico, legitimate, fair and no-bailout type adjustments are executable by HHS/CMS in the immediate term. The needed adjustments in Medicare would mitigate recent funding reductions to impact benefits, beneficiary disposable income, provider payments, and local government tax collections.

4. Traditional Medicare FFS has Not worked in Puerto Rico (As it does everywhere else)

US citizens residing in Puerto Rico were made part of the Medicare FFS program at its inception in 1965. At that point, health care services in Puerto Rico for Medicare eligible beneficiaries were mainly provided publicly, through a system of primary care centers and hospitals operated by the government. The parallel system in itself created a distinct situation compared to the rest of the jurisdictions where service provision was mainly a private market development, which the Medicare program used under a FFS model. In the 1980s, significant statutory changes established particularly lower Part A payments to Puerto Rico. Meanwhile, other important statutory distinctions included no auto-enrollment to Part B, and exclusion of Supplemental Security Income (SSI) from Medicare Savings Programs.³ In parallel, the population profile in Puerto Rico's population was also distinct, with an income per capita less than half of the national average, and close to 50% of the population living below the Federal Poverty Level (FPL).

As explained in more detail below, the situation of Medicare in Puerto Rico has a structural imbalance rooted in the differential treatment Congress defined at the foundation of traditional Medicare and Medicaid programs. We can describe this structural imbalance under 3 areas: statutory differences, resulting in programmatic uniqueness, and aggravating socio-economic circumstances. As a result, over the last 5 decades the evolution of the programs has generated a healthcare economy with increasing disparities compared to any other US jurisdiction.

Traditional Medicare FFS has never worked in Puerto Rico like elsewhere. Statutory differences, 3 decades of coexistence with public provision of "Medicaid" benefits, and a lack of balance between the high cost-sharing levels and no-help for the disposable income of the poor, never allowed this program to operate on an economic basis that could resemble a situation comparable to its place and evolution for the rest of the nation.

4.1. A Different Medicare FFS Program and Medicare FFS Context defined in Statute

Congress included US citizens residing in Puerto Rico to form part of the national Medicare and Medicaid programs when created in 1965. However, statutory amendments also defined a differential treatment, which mostly lowered funding, lowered provider payments, and limited

³ References to Medicare and Medicaid history in Puerto Rico are based on a review of the statute, Congressional Research Service reports, and special contribution of the Federal Programs Timeline by Mr. William Toby, Jr., former national HCFA Administrator and Regional Office Administrator for the New York Region, in charge of Medicare and Medicaid operations in New York, New Jersey, Puerto Rico and the US Virgin Islands.

benefits *Vis a Vis* the regular programs implemented everywhere else. Some of the major distinctions we can enumerate are:

- (A) Medicaid Cap, 1967** – Different from states, the law defined a fixed dollar limit (cap) for Federal funds assigned to the implementation of the Medicaid program in Puerto Rico. [SSA § 1108(f)] This was \$20 million in 1967, and close to \$400 million in 2015 (Non ACA). For many decades, the effective Federal matching for the Puerto Rico version of Medicaid was less than 20%, while the formula based on its income per capita would have assigned about 80%. This core distinction occurred in the context of the unique existence of a developing public healthcare program operated by the government of Puerto Rico. Most importantly, this system also served most of the Medicare FFS beneficiaries between the 1960s and 1990s.
- (B) Supplemental Security Income (SSI), Created in 1972** – No person shall be eligible for supplemental security income while they are outside of the United States. [SSA § 1614(f)(1)] For the purposes of supplemental security income, “United States” shall mean the 50 states and DC. [SSA § 1614(e)]. The average SSI annual payment is \$8,800, and if it was applicable in Puerto Rico, basically all the dual eligible beneficiaries would get this support.⁴ This exclusion naturally lowered the possibility of the poor Medicare FFS beneficiaries seeking care outside the public healthcare system, therefore having a suppressing effect in market based pricing of healthcare services.
- (C) A different Inpatient Prospective Payment System (IPPS) for Puerto Rico, 1983** [SSA § 1886(d)] – The enactment of the IPPS payment system excluded Puerto Rico initially in 1983, leaving Medicare payments under a cost-based reimbursement system for a system of hospitals that mostly operated under local government administration. Subsequently, Puerto Rico hospitals were included by Congress in the IPPS, but at a special, discounted rate, applying the national cost based formula to only 25% of the payment (this applied 100% everywhere else). For the other 75%, Congress enacted a special Puerto Rico-based IPPS, which essentially perpetuated the depressed local pricing levels within the Medicare FFS payment system. The national formula proportion was increased to 50% in 1997 and 75% in 2004. A recent analysis of 2013 FFS payments performed by Milliman, revealed that DRG payments in Puerto Rico average just 53% of the average payment in the US.
- (D) Disproportionate Share Hospital (DSH) Formula, 1984** – Even when Congress did not exclude or limit DSH payments to Puerto Rico, the use of SSI eligibility as an indicator of poverty has *de facto* excluded Puerto Rico hospitals from the DSH payments for decades. Rough estimates of the loss since the 1980s could amount to over \$1 billion in aggregate payments lost by participating Medicare hospitals in Puerto Rico. The implementation of the temporary uncompensated care formula after the ACA has provided a partial correction and increased payments. However, the lack of a legitimate proxy to the use of SSI as an indicator of poverty is still unfairly lowering payments to Puerto Rico hospitals in both the old DSH, and also in the new uncompensated care payment proportion. [SSA § 1886(d)(5)(F)(vi)(I)]

⁴ From - US Census Bureau, American Fact Finder, 2011-2013 American Community Survey 3-Year Estimates.

(E) Beneficiaries are deemed enrolled in Medicare Part B with the exception of residents of Puerto Rico [SSA § 1837(f)(3)] – The distinct exception of no auto-enrollment in part B has also influenced significantly Medicare program participation, access to care, and healthcare economics in Puerto Rico. In recent times, CMS data reveals that Part A only beneficiaries in the island are close to 20% of all the Medicare eligible, while the national average is less than 10%.⁵

This statutory difference has also impacted the profile of the population in FFS Medicare, after an unprecedented increase in the MA penetration in the 2000s. In the MIPPA Medicare Advantage Report released by MedPac on June 2009, the Commission describes how different the FFS population in Puerto Rico is, with only about 30% of FFS beneficiaries having Part B at the time. MedPac explained that “Part B AAPCC calculated on such a small population may be extremely volatile, with large changes from year to year [...]”.⁶ CMS subsequently made an assessment about this scenario, and implemented an adjustment in the AAPCC calculation for Puerto Rico by excluding the Part A only beneficiaries from the MA payment formula starting in 2012.

This is a clear example of the type of legitimate adjustments CMS has the authority to make administratively, specially to avoid continuing disproportionate cuts, and beneficiary impacts. In this particular case, we also understand that the large Part A only population has also influenced Traditional Medicare FFS access and payments differently in Puerto Rico, impeding the evolution of physician and hospital services market pricing in a manner similar to other jurisdictions.

(F) Medicare Beneficiaries in Puerto Rico are excluded from Medicare Savings Programs [SSA sec 1905(p), especially (p)(3 and 4)] – The Omnibus Reconciliation Act of 1986 required states to pay for Medicare Part B premiums for beneficiaries up to 100% FPL or to cover Part B benefits through other means. Subsequently, in 1990, the requirement was extended to beneficiaries up to 120% FPL. These programs excluded beneficiaries residing in Puerto Rico.

According to CMS reports, 8.7 million beneficiaries participated in buy-in programs in 2013. This is approximately 17% of the Medicare population, which basically reflects the participation of most of the duals.⁷ In Puerto Rico, about 50% of the Medicare beneficiaries are similarly poor. The non-existence of Part B buy-in in Puerto Rico lowers the disposable income of beneficiaries, impacting duals (up to 87% FPL) and also non-duals up to 135% FPL.

Economics of supply and demand for healthcare services that could influence market prices have been particularly unique for the Medicare program in Puerto Rico. Medicare and Medicaid statutes

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/index.html>

⁶ http://www.medpac.gov/documents/reports/Jun09_Ch07.pdf?sfvrsn=0

⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/BuyIns2013.pdf>

discounted healthcare prices in PR relative to elsewhere, while Federal law has also defined a low income population in Puerto Rico that has much less disposable income to pay for healthcare cost-sharing and basic needs. In parallel, there was not a meaningful private commercial healthcare market in Puerto Rico when these programs developed, which supported the market valuation of healthcare services in the case of the states. As enumerated above, there are clear statutory differences that have affected healthcare economics and have contributed to the exacerbated and increasing rate disparities in Medicare FFS and in MA that we see today.

4.2. A Different Program defined by Programmatic Differences given historic Structural Decisions

Evolving from Spanish colonialism, healthcare provision in Puerto Rico developed largely as a public, government-led, operation in the middle of the 20th century. While health insurance organizations and private healthcare grew significantly in the US in the 1930s, the development of private healthcare in the island was really not meaningful until after the creation of Triple-S in 1959. In parallel, by **1960** the island had already been moving forward in the development of a regionalized public healthcare system that envisioned a pyramidal system of primary care centers, regional hospitals, a medical center and the participation of the University of Puerto Rico. This system was available and used by all the population, not just the poor.⁸

In **1965**, Congress included US citizens residing in Puerto Rico as part of the Medicaid and Medicare programs. However, a distinct and fragmented version of the programs was implemented in the following years. The initial key unique situation in Puerto Rico was precisely related to the development of a public healthcare system around the island, operated directly by the government. In said context, Congress made an exception to Puerto Rico by establishing a cap on Medicaid funds, assigned to the Puerto Rico government as a block grant. This cap has significantly limited the Medicaid funding to Puerto Rico during the entire period of 50 years of the program. Moreover, **between the 1960s and mid-1990s** Medicaid funding was used to support the public system, and a “Medicaid Fee For Service” operation never existed as it did in the rest of the nation.

Accordingly, the Medicare FFS program evolved within a unique context. Significant statutory differences in Part A payments, and the coexistence with a fully government operated public system, influenced the nature of the Medicare FFS program in the island, in a way not experienced by any other jurisdiction. As documented in many sources, relative poverty in Puerto Rico meant that about 50% of the Medicare FFS population was also poor. Consequently, a significant part of the Medicare FFS beneficiaries in Puerto Rico used the regular public system for decades. It should be noted, that the public system was mainly financed by the local central government and municipalities, while it employed health professionals based on salaries and fixed compensation. For the patients, services were free of charge.

Traditional Medicare standing alone was never a real healthcare access option for the majority of Puerto Ricans, and the public health system were able to mask this reality for about 3 decades. Consequently, the existing healthcare market in Puerto Rico was heavily defined by a public system

⁸ Maldonado, N. (n.d.). Revista Galenus. Retrieved November 24, 2015, from <http://www.galenusrevista.com/Historia-de-los-servicios-de-salud.html> ; <http://www.galenusrevista.com/Historia-de-la-regionalizacion.html>; and <http://www.galenusrevista.com/historia-de-la-medicina-en-Puerto.html>

that never billed or reasonably monetized the value of its services in any way similar to the context from which the Traditional Medicare FFS program “purchased” services in the rest of the nation.

In the **1990s**, the public system transitioned directly to Medicaid managed care. Apart from adapting prices and benefits to the limited availability of funds, the reformed program also defined eligibility thresholds for the first time. To be covered by the government system, you needed to meet specific income level thresholds, which in the upper end were approximately 87% of the Federal Poverty Level (FPL).

This implementation created an uninsured population in Puerto Rico that did not have access to a public system any longer. Among the low income, but not eligible for Medicaid, were thousands of Medicare FFS beneficiaries. In general, approximately half of the Medicare FFS beneficiaries were eligible to the Medicaid “Reforma” program, while it is estimated that approximately 30% were in the middle with no Medicaid program and also no Medigap or supplemental coverage from an employer.⁹

It should also be noted that by this time (1990s), Medicare managed care programs had already been developing around the nation for a couple of decades. However, given the economic history of the programs on the island, the resulting reimbursement rates for Puerto Rico were not logical or realistic under a payment formula that was based on the estimated local costs of Medicare FFS. The **Balanced Budget Act (BBA) of 1997** and the **Benefit Improvements and Protection Act (BIPA) of 2000** under the Clinton Administration introduced for the first time a Medicare managed care rate structure that sought to incent the availability of coordinated care programs in low cost underserved areas. Under this policy, managed care rates for Puerto Rico significantly increased, while still having a differential treatment in statute to lower the minimum payment per beneficiary even below the rural and urban floors in the states. Subsequently, the first managed care option in Puerto Rico was offered in **2001**.¹⁰

As a particular detail in the coexistence of the local Medicaid program and Medicare FFS, it should be noted that the Medicaid program has never covered the Part A deductible for duals. In the creation of the program in the early 1990s, the Puerto Rico government reached several waiver agreements with HCFA (CMS), among them, the exclusion of the Part A cost-sharing from the coverage for dual eligible individuals. Hospitals were to submit these costs as uncompensated care. This is still part of the formal definition of the program as of today, but most of the dual beneficiaries are now served through the integrated Medicare Platino program, through which hospitals get first-dollar payments from MA plans.

⁹ Riga-Pérez, D. (2000). Historia de la Medicina: La Salud en Puerto Rico en el Siglo XX. Puerto Rico Health Sciences Journal, 19(4), 357-368.

Izquierdo-Mora, Luis. (2009) *Pasemos la Antorcha, Puerto Rico, Épocas, Hechos y Estampas en el Campo de la Salud*.

¹⁰ Apart from the legislation as a primary source, the statutory evolution of Medicare managed care as it applies to Puerto Rico has also recently been reviewed by the *Congressional Research Service*, June 2015.

4.3. A Different Program defined by a unique Socio-Economic Context

The socio-economic context of Puerto Rico has also been a key element in the behavior of the Medicare beneficiary as a consumer of healthcare services. Notably, there are very significant differences in regards to education and poverty levels, as well as the availability of disposable income exacerbated by the lack of SSI.

> 65 Low Income Population Financial Circumstances

From - US Census Bureau, American Fact Finder, 2011-2013 American Community Survey 3-Year Estimates

	US	PR	PR-US
Total Population	43,056,386	581,981	(42,474,405)
Hispanic or Latino Origin (Of any race)	7.3%	99.1%	91.8%
Less than high school graduate	20.1%	52.5%	32.4%
With earnings	35.20%	25.00%	-10.2%
Mean earnings (dollars)	49,467	26,981	(22,486)
Mean Social Security income (dollars)	18,815	12,140	(6,675)
With retirement income	48.30%	30.20%	-18.1%
Mean retirement income (dollars)	23,707	14,159	(9,548)
With Food Stamp/SNAP benefits	8.70%	40.30%	31.6%
POVERTY STATUS IN THE PAST 12 MONTHS			
Population for whom poverty status is determined	41,752,673	575,221	(41,177,452)
Below 100 percent of the poverty level	9.50%	39.80%	30.3%
100 to 149 percent of the poverty level	11.00%	21.80%	10.8%
At or above 150 percent of the poverty level	79.60%	38.40%	-41.2%

The beneficiary choice of Medicare programs is very revealing of the influence of the socio-economic conditions on the use of the program and the decisions about healthcare. Particularly, we should note that:

- **Stand Alone Part D enrollment:** 44% of all Medicare in US vs Only 2% of all Medicare in PR¹¹
- **Individual Medigap enrollment:** Over 20% of all Medicare in US vs 1% of all Medicare in PR¹²
- **Estimated Medigap + Employer Supplemental:** Over 40% in US vs less than 5% in PR
- **Dual Eligible Beneficiaries in MA:** Approximately 20% in US vs 97% of A&B duals in PR
- **Total MA Penetration:** approximately 31% in US vs 75% in PR (90% of Medicare A&B)

These figures are a reflection of how the unique (a) statutory, (b) programmatic, (c) and socio-economic differences in Puerto Rico have generated a distinct consumer behavior and market context. In this environment, the evolution of Medicare FFS pricing and geographic indexes has been notably different than anywhere else in the nation. To avoid undue harm, CMS has to use proxies and make adjustments that recognize these differences and protect the Medicare program in Puerto Rico from continuing to distance itself as an unreasonable outlier at the bottom of payment rates.

¹¹ Based on CMS enrollment reports data for 2015

¹² <http://www.ahip.org/epub/MedigapBeneficiaries/>; PR estimates based in data from Triple-S enrollment in Medigap policies and estimates of retiree supplemental coverage.

Conclusion – Increasing risks of the statutorily different Medicare FFS Program

Ratio of Premium to Medicare FFS Funding

	PR	USVI	Lowest (HI)	New York	National Avg	Florida	Texas	Highest (AK)
Paid by Beneficiary	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
Medicare Funding	\$3.81	\$5.61	\$6.06	\$6.53	\$7.23	\$7.80	\$8.19	\$9.35

The table above illustrates the funding per premium dollar paid for Medicare beneficiaries that reside in various jurisdictions. The low level of funding to pay for benefits for beneficiaries in Puerto Rico is evident, even when these beneficiaries pay the same Medicare Tax and the same Part B premium (\$104.90) as everyone else. Beneficiaries in Puerto Rico and the health care system, should not be penalized and fall into a perpetual level of relative underfunding because of a history of statutory limitations and of a healthcare market dominated by public provision and public programs.

As we elaborate in the next section, most of the inputs to provide health care in Puerto Rico are actually purchased from the general US market or at higher than average prices. This has in turn created no space for an adequate valuation and evolution of professional compensation.

5. An Evident Death Spiral

Why Medicare in Puerto Rico is winning the Race to the Bottom

Puerto Rico’s Medicare program is unfortunately becoming the icon of the “chicken-and-the-egg” relation of factors, in a spiral that is going in the wrong direction fueled by decreasing MA funding, historic FFS disparities, and resulting in unsustainable inequities within the US healthcare programs. There is an evident miss-conception created by abysmal differences in the labor and non-labor positioning of costs in Puerto Rico within the Medicare program as a whole. Non-labor costs are not less in Puerto Rico, but depressed wages, and potential technical issues with labor cost estimates, may be reflecting an erroneous perception that providing services in Puerto Rico is cheaper.

Cost of Living Relative to 296 Metropolitan Statistical Areas in the States

Cost of Living Index (San Juan MSA)

Category	Index Avg = 100
Grocery Items	121.4
Housing	101.8
Utilities	182.1
Transportation	122.4
Miscellaneous Goods and Services	108.9
Overall Cost of Living Index	115.4

As evidenced in the data from the Cost of Living Index (COLI) performed by the Council for Community and Economic Research, Puerto Rico is not cheaper.¹³ In fact, out of 296 MSAs, the data reported for

¹³ <http://www.estadisticas.gobierno.pr/iepr/LinkClick.aspx?fileticket=SEqx6Sl8Ugo%3d&tabid=384>

first quarter 2015 places Puerto Rico as the 35th costliest area, and averaging 15% higher prices than the US average.

In regards to key healthcare inputs, we should note the following for the case of Puerto Rico:

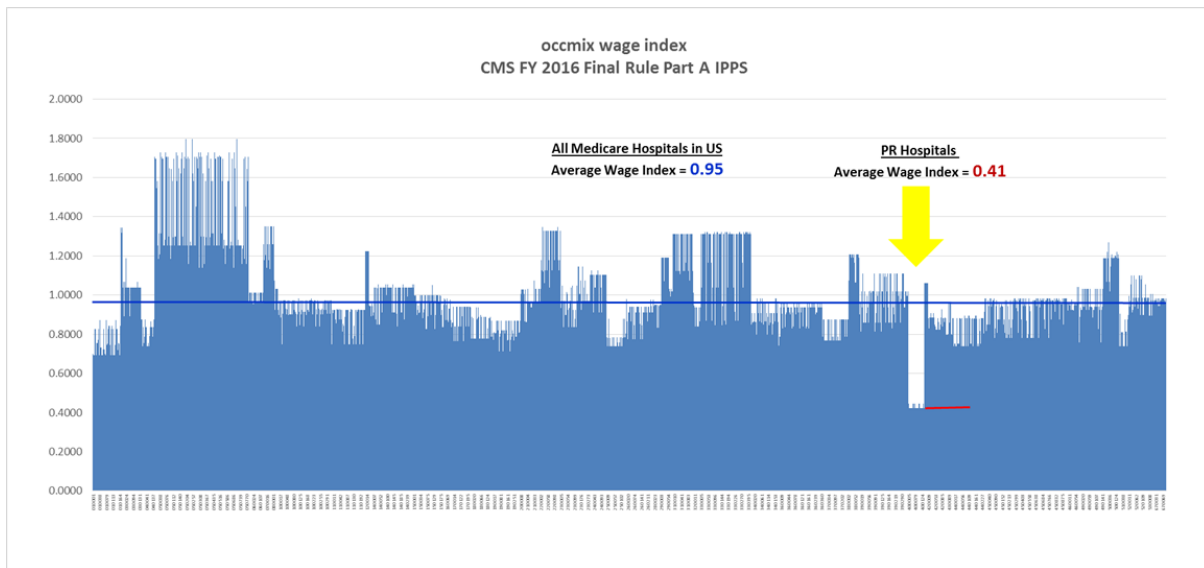
- Prescription drugs are purchased in the national market.
- Housing, office and construction costs are similar to US averages.
- Equipment and medical supplies are acquired in the national market.
- Diagnostic machines, computers and electronics are acquired from the US national market.
- For all the above materials, equipment, and goods, transportation costs have an effect that increases final purchasing price in Puerto Rico.

The only geographic factor that lowers costs in Puerto Rico is wages, which for health care have been significantly influenced by the statutory and programmatic uniqueness of the island, as detailed in previous sections. Moreover, if wage indexes or any geographic index in Medicare tends to be understated for Puerto Rico, the inevitable effect is to increase the pressures to decrease compensation or to avoid any increases for multiple years. With increasing Medicare cuts and non-labor costs increasing, our system is submerged in a race towards the bottom with regards to geographic cost indexes, and a death spiral is becoming evident in the funding of Medicare programs. How can the market generate wage increases when non-labor costs are increasing *via* national markets, while geographic indexes seem to perpetuate a depressed level of payment rates in the poorest areas of the US?

Since health professionals and physicians are US-educated and bilingual there is a natural escape valve for many. It is estimated that one physician leaves Puerto Rico every day, and most likely our highest quality professionals are the ones leaving. Inevitably, Puerto Rico is part of the US labor market of health professionals. Modern communications, transportation, 5 million Puerto Ricans, and over 50 million Hispanics in the US just makes the decision to move to the mainland much easier than ever. The magnitude of the funding differential in Medicare for Puerto Rico is almost a case of *unfair competition*, where the different version of the Medicare program existing in the mainland increasingly pulls the most qualified human resources out of the island.

Medicare Part A IPPS - Wage Index in Puerto Rico vs US

A critical increasing issue for the Medicare program in Puerto Rico is the evident disparity in the Part A wage index. For FY2016, Part A wage indices in the CMS Final Rule for hospitals in Puerto Rico were basically at the 0.4 floor. Moreover, this wage index is also applied to the outpatient ESRD payment formulas, extending the issue beyond the hospitals. There are several reasons why this disparity could exist; however, the extraordinary distance at the bottom is in itself cause for concern. At the more macro level, as explained in previous sections, the local health care market has evolved in a statutory and programmatic context that is unique within the US, and that has maintained health care compensation at increasingly lower and disparate levels of payment relative to the rest of the US. On the other hand, at the time it is not clear if Medicare Cost Reports for Puerto Rico hospitals could have information gaps or particular market-based issues which may be understating costs. The chart below illustrates how impressive the disparity is, for hospitals that have to meet the same contracting, credentialing and quality standards as those everywhere else in the states.



In order to understand how the PR Medicare (Part A) wage index could relate to the general situation of Puerto Rico, we reviewed the most recent data available in the Occupational Employment Statistics of the Federal Bureau of Labor Statistics.¹⁴ Not surprisingly, wages for Puerto Rico in general, are reported to be significantly lower than national averages. However, the revealing observation is that the average is approximately 59%, which is significantly higher than the relative position of the Medicare Part A wage index for Puerto Rico. As commented in the Final Rule for ESRD payments, CMS has the authority to consider all the factors described herein to maintain or establish a temporary floor that protects the reimbursements from falling further. A common sense, temporary rationale, could be that Puerto Rico wage indices in FFS should not be lower than the average ratio of Puerto Rico non-healthcare wages to US non-healthcare wages, using the data from the Occupational Employment Statistics (OES). It is evident that addressing and correcting this long-standing and aggravating issue will require further study. However, the fact that the wage index perpetuates a level of inequality in health care (vs mainland), to a significantly larger extent than the disparity of wages in the general economy according to the OES, is extremely concerning.

Comparison of Wages		
	Annual Compensation	PR % of US
PR Non-Health	\$27,131	59.01%
US Non-Health	\$45,980	

6. Medicare is so Different that Puerto Rico is excluded from Regular Analysis

Medicare FFS and MA rates for Puerto Rico have become such distant outliers that regulatory and research organizations like CMS, the Medicare-Medicaid Coordination Office (state profiles), MedPac, Kaiser Family Foundation, and others, frequently exclude the Puerto Rico data from analysis and reports. This exclusion and special disclaimers related to the numbers for Puerto Rico are becoming less about not having available data, and more about having data that is so different that it does not make sense, in regards to the operation of the Medicare program in the rest of the nation.

¹⁴ http://www.bls.gov/oes/current/oes_pr.htm

7. Medicare FFS and Medicare Advantage – Applied ACA Policy, Smart Spending

The Affordable Care Act (ACA) standpoint about MA is frequently defined in the context of an apparent “overpayment” to plans. MedPac and others described that pre-ACA MA plans were being paid 114% over the FFS per capita cost that CMS calculated for individual counties. In the case of Puerto Rico, the calculated ratio of MA benchmarks to CMS estimated FFS costs reached 180% (MedPac 2009).¹⁵ Unfortunately, the legislative process and related discussions about MA generated misconceptions and incomplete assessments about the situation in Puerto Rico. Using these percentages of FFS to make conclusions about the case of Puerto Rico is not simply unfair, but certainly incorrect, incomplete, harmful, and a blatant disregard of the very core healthcare policy principles that the Medicare program is trying to advance for the care of its beneficiaries. In 2011, the average MA benchmark in Puerto Rico (\$595) was -25% less than the US average (\$787), and -21% less than the state with the lowest average (HI = \$754). No matter the percentage that resulted from the comparison of the pre-ACA MA benchmark in Puerto Rico **vs** an *estimated FFS cost* in Puerto Rico, the absolute dollar numbers must be the focus when making a policy assessment about the cost of the Medicare program in Puerto Rico.

We are very concerned that percentages could create a harmful mask to the real scenario for over 740,000 Medicare beneficiaries in the island. These misinterpretations could hinder and delay the efforts to adapt the historically uneven statutory context by making legitimate corrections to the Medicare FFS and MA programs in Puerto Rico. Puerto Rico has the most cost-efficient MA program in the nation, and the most cost-efficient and integrated dual eligible Medicare + Medicaid program in the nation. CMS policy implementation can, and should, nurture the continuing progress in access and quality under the Medicare program (MA) that is giving the most value, for the least cost. Accordingly, CMS has the opportunity to avoid the use of national, “one-size-fits all”, policies and implementation methods that may generate unintended and harmful results when applied to Puerto Rico, in consideration of a unique statutory foundation defined by Congress, not by CMS.

Some key facts:

- The BBA (1997) and BIPA (2000), under the Clinton administration, defined minimum payments for Medicare managed care programs to protect low cost and rural areas in the nation. This policy purposely established payment rates above the estimated FFS costs of counties in favor of providing access and choice in the areas that were already the lowest cost areas for the Medicare program.
- Moreover, in both pieces of legislation, the case of Puerto Rico was – as in many previous instances under Medicare FFS – treated differently in the statute. The minimum Medicare managed care rates for Puerto Rico were explicitly and uniquely defined in the law, at much lower levels than the statutory minimum for the rest of the states. The resulting scenario was that: when BBA established a \$367 minimum payment, for Puerto Rico the minimum was \$302; when BIPA established a \$525 urban floor rate, for Puerto Rico it was \$395 (120% of the rate in 2000).¹⁶

¹⁵ [Report to Congress: Improving Incentives in the Medicare Program](#), June 2009, MedPac.

¹⁶ [Congressional Research Service Memorandum. Medicare Parts C & D in Puerto Rico](#). September 24, 2015.

- It should be noted that before minimum payments were established Medicare managed care was simply not financially feasible in Puerto Rico. The statutory distinctions and programmatic developments on the island, as described in previous sections, made it impossible to work with a rate based on the FFS cost estimates on the island. There was no Medicare plan offering in Puerto Rico before 2001.
- The MMA (2003) continued a similar policy and structure to protect low cost areas, maintaining Puerto Rico MA rates as an outlier at the bottom, but also providing an increased level of funding that gave the Medicare beneficiaries on the island the first opportunity to have accessible and appropriate care through Medicare.
- The Medicare Advantage program transformed healthcare in Puerto Rico in the 2000s, while being the absolute lower cost Medicare program in the entire nation. Some changes include:
 - Coverage of parts A & B gaps for low income population not eligible to Medicaid (>87%FPL), and not able to pay a Medigap policy in Puerto Rico.
 - Creation of a fully integrated Medicare+Medicaid program for duals (Platino, 2006).
 - Coverage of Part D premium and gaps for duals (Platino) and (partially) for non-dual beneficiaries excluded from the Part D LIS program.
 - For the first time providing some help to pay the Part B premiums to full benefit duals.
 - For the first time paying first-dollar Part A compensation to hospitals for duals (Platino).
 - Increased compensation and attention to critical services like primary care physicians, care management, hospital services, and outpatient dialysis.

The Affordable Care Act and Medicare in PR – Urgent Action Needed

The ACA returned to an MA rate setting based on local FFS cost estimates. Apart from the particularly dramatic change this meant to Puerto Rico, we should note the statute also confirmed the intent to protect the poorest, and to pay more than 100% FFS for certain areas.

- The ACA grouped all the counties in the nation in quartiles based on a couple of critical factors, mainly MA penetration, and relative costs compared to the nation.
- The law intended to protect poor areas and beneficiaries, by avoiding large rate cuts that would harm access to care and reduce benefits significantly.
- The law established an MA rate at 115% FFS for counties where (a) MA penetration rates over 25% (beneficiary choice) and (b) counties that had FFS costs below the national average. Puerto Rico counties surpassed the qualifying thresholds by enormous amounts with 75% MA penetration and FFS rates at 50% below the national average. Acknowledging the uniqueness of Puerto Rico, the ACA defined a process that defines the levels of FFS cost per quartile excluding the counties in Puerto Rico. Once the FFS spending that defines each quartile is determined, Puerto Rico counties are allocated to the appropriate quartile. This favored other counties in the mainland, and allowed a group of 78 counties among the states and DC to stay in the most protected (115%) quartile.

- The ACA established this explicit (quartile) policy to protect beneficiaries in the poorest areas, which defined a payment above the local FFS cost levels on purpose. In this manner, paying over local FFS costs, and covering benefits over traditional A & B were defined as the official policy for low cost areas, with the intention of protecting the frailest populations on the level of reductions to benefits and access potentially generated by a new FFS-based formula.

Unfortunately, unlike preceding Medicare managed care legislation, the ACA was not clear or prescriptive in the policy for MA rate setting in Puerto Rico. The BBA, BIPA and MMA defined unique lower rate floors for Puerto Rico to avoid a higher payment increase, but the ACA did not address the unique payment cliff that the un-adapted application of the ACA *FFS Estimate-based formula* could provoke for beneficiaries in Puerto Rico. The potential issues of going back to a formula based on FFS-cost estimates were anticipated in Congressional discussions and in MIPPA (2008). As mandated by Congress in MIPPA (2008), MedPac (2009) studied and identified the potential and unique issues that a new formula based on the average per capita FFS cost estimate could face in Puerto Rico.

Excerpt from MedPac Report, June 2009, Page 179

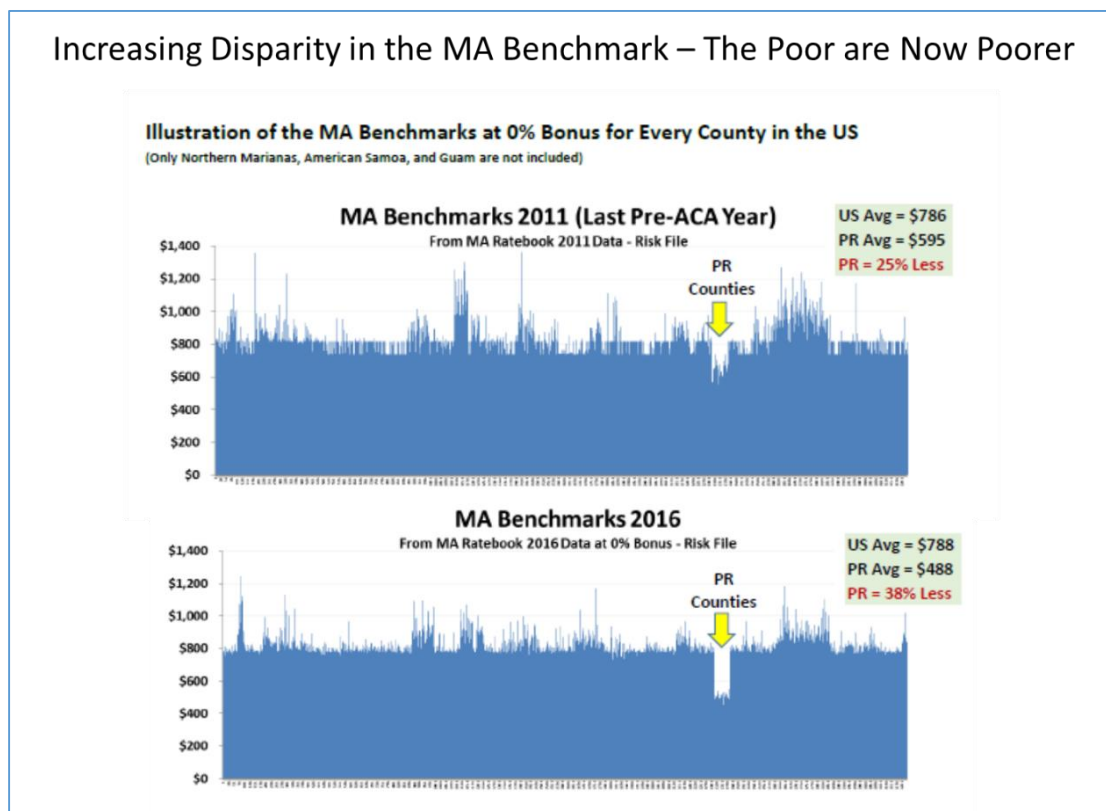
Should an adjustment be necessary in the future, the statute provides CMS with relatively broad authority to use actuarial methods to address situations in which the usual method of determining the AAPCC would yield an anomalous or potentially inaccurate result. In the case of Puerto Rico, CMS should expeditiously use its authority to employ an alternative calculation method to determine AAPCC rates if CMS finds that the current calculations are anomalous or potentially inaccurate, though we recognize that an alternative calculation may be difficult with the currently available data.

Since then, CMS has acknowledged the anomalous resulting cuts to the MA benchmarks for the island. In addition, the President’s Task Force Report from March 2011, also acknowledged the problem and stated that “the Administration is taking steps to address healthcare access issues for Puerto Rico’s Medicare beneficiaries by proposing to set Medicare Advantage rates in Puerto Rico in a more generous manner.” (March 2011, Page 50). This report also requested HHS to examine the potential limitations created by the exclusion of the Part D LIS program for Territories, which HHS confirmed in a subsequent report released on April 2013.

As of November 2015, we can identify two instances where CMS has made determinations that could help to mitigate the unique cuts to the MA program in Puerto Rico. One was the exclusion of the Part A only beneficiaries from the calculation of the FFS cost estimates. A second one was the adjustment of Part A costs based on the new uncompensated care payments for hospitals in the island starting in 2014 (also applied nationally). Notwithstanding, the reality has still been crisis-level cuts that could become even worse for beneficiaries in Puerto Rico. As of 2016, Puerto Rico has the largest cuts in MA benchmarks compared to 2016 Pre-ACA rates at **-23%**, which is also a **-18%** cut related to the 2011 MA benchmarks.

Consequently, there are several crucial facts that we can conclude based on this recent history and today’s status of the Medicare programs in Puerto Rico.

1. **CMS has the authority, and has been encouraged, to adjust the calculation of the average FFS per capita cost in Puerto Rico** given the potential for inaccuracies or if there is an anomalous result (MedPac 2009, Congressional Record 2010)¹⁷. CMS has already acted once based on the unique statutory context of the Medicare / MA programs in the island.
2. **The adjustments made so far are too far from being enough, certainly not close to “a more generous manner” (President’s Task Force 2011).** Puerto Rico has seen a net average benchmark decline of 18% since 2011, which will be worse in 2017 by 5%, or more, if action is not taken now. There is no other jurisdiction suffering a similar situation. Puerto Rico benchmarks in 2011 were **21% lower** than the average in the lowest state (**HI = \$754, PR = \$595**), and in 2016 will be **34% lower** than the lowest (**HI = \$741, PR = \$488**). The facts are that the results of rate setting so far for Puerto Rico are the extreme opposite of generous.
3. **The increasingly disparate scenario is getting worse in MA and Medicare FFS,** with issues borne out of differential statutory definition of Medicare and Medicaid, impacts to market and price dynamics, and incremental data issues in the current estimation of costs from the reduced FFS population.
4. **Beneficiaries need Administrative action now, to be effective in 2017.** There is a Federal healthcare program crisis in Puerto Rico, within a general fiscal and economic crisis. We have run out of time. It is estimated that cuts in MA are already equivalent to more than \$1 billion less per year (vs 2011 payment levels) loss that impacts over 570,000 Medicare beneficiaries, including 280,000 dual eligible.



¹⁷ 2010 Colloquy between Chairman Baucus and Senator Menendez, ACA Legislative Process – About the Medicare FFS Cost Calculation and the Medicare Advantage Program in PR.

Medicare Advantage in Puerto Rico has proven to Provide Better Care, at a Lower Cost

Physicians, hospitals and prescription drugs serving Medicare beneficiaries are paid with dollars, not with percentages of an estimated amount of FFS costs. When the scenario in Puerto Rico is reviewed independent of a percentage derived of a legally distinct, limited, incomplete and not fully understood Medicare FFS program costs, the reality is that Puerto Rico has excelled in doing more with too little.

- In the past 10 years, the Medicare Platino program has evolved as a fully integrated Medicare + Medicaid program that serves 97% of all the duals with Medicare A&B, who selected the program by choice. This program operates with a combined cost that is about **40%** of the average Medicare + Medicaid expense for duals in the nation. The total cost is still significantly lower even after excluding expenses for long term care services not included in Puerto Rico's Medicaid program.
- In addition, as CMS has increasingly noted, MA program operations in Puerto Rico have made enormous progress in measured quality ratings, frequently achieving 4 and 5 STAR ratings in improvement measures. Unfortunately, the progress made is being turned back by severe challenges arising from uniquely large reductions in MA funding. There is a point at the bottom of funding where the system will simply not work. We are encouraged by the commitment to take action by CMS and HHS for 2017 effective dates, and hope to never see what could be an inevitable collapse with humanitarian consequences.

There is no healthcare program in Puerto Rico that is as structured, monitored, quality driven and as integrated as the MAPD and MAPD-SNP plans that operate on the island today. The structure is set to channel spending in the smartest manner through the most developed delivery model that exists today in Puerto Rico, following HHS/CMS principles and requirements. Moreover, the additional ACA requirement of the **85% minimum MLR** assures the use of MA revenue for benefits, lowering cost-sharing, and provider compensation. A lot of care has been given, that would never have been given, if it was not for the implementation and development of Medicare Advantage in Puerto Rico during the past 14 years.

8. Legitimate Actionable Fixes for 2017 FFS and MA

CMS should take immediate administrative action to legitimately adjust payment formulas and methods for Medicare Parts A, B, C and D in Puerto Rico. Two main reasons: **(a)** confirmed issues and confirmed potential issues in the FFS data (**Appendix B**), and confirmed **(b)** statutory differences which created a distinct Medicare context, at risk of generating anomalous scenarios in rate setting and program economics.

In relation to the FFS data, recent studies performed by The Moran Corporation have confirmed critical issues in the data currently used by CMS to estimate the FFS costs and set the MA rates for Puerto Rico. It is our conclusion that the findings confirm the data for the remaining traditional FFS beneficiaries on the island (about 10% of Medicare A&B) are no longer a reliable source under the current CMS methodologies.

Finally, as potential issues may require further study, temporary solutions that avoid increasing harm are inevitably needed, without further delay.

- **Appendix A – Legal Memorandum: Authority of HHS/CMS to take action for Medicare in Puerto Rico, Hogan Lovells Law Firm**
- **Appendix B – Analysis of the Puerto Rico Fee For Service Data – The Moran Corporation**