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March 5, 2018

The Honorable Alex Azar
Secretary of the US Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201

cc/ Seema Verma, CMS Administrator
Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director of the Part C & D Actuarial Group, OACT

COMMENTS

Many other constituents in the Puerto Rico service area have submitted myriad arguments, tables, graphs and detailed justifications that make the case for relevant and viable corrections to the benchmarks that apply to Puerto Rico counties. Rather than repeat those arguments, our intention is to add descriptive commentary that may help explain why PR benchmarks remain artificially low.

The Puerto Rico health care market has traditionally relied heavily on pre-negotiated discounted fee schedules promoted by local health plans to determine payment levels on the island, rather than on market driven UCR fee amounts. The result has been that the provider market at large has been subject to largely unilateral fee determination and market rules as imposed by local carriers.

In the case of Medicare Advantage, the profound reductions in premium funding that has occurred over the last seven years has translated into profound reductions in provider funding on the part of local MAOs, defending as much as possible both margins and funding for Part B buy-downs, since buy-downs are some of the most efficient marketing tools on the island. The reductions in provider funding have been accomplished through a combination of fee reductions, network reductions, stronger formulary controls, aggressive capitated arrangements, exclusivity contracts with certain large providers, and a proliferation of aggressive medical management and pre-authorization requirements. In summary, the provider community has borne the brunt of the significant funding reductions that the MA program has seen in Puerto Rico over the last few years. This has resulted in a severe degradation of the overall quality of health care on the island.

Last, it is very important that we address a widespread fallacy that is often used to describe the local MA market—that the funding is more than sufficient to meet the health care needs of our population. This is not true. On the contrary, we have been forced to live with deficient funding for years and the result is a health care system where patients have to bring their own pillows and blankets to hospital stays because there is no available funding for these 'extras.' As unbelievable as that sounds, it is actually commonplace as we resign ourselves to that level of care. Last year the island was hit by a Category 5

storm named María. It left the vast majority of our population without power for well over three months. We had to make do—there was no other choice. So, the question is, because we managed to scrape by with no electricity for months on end, does that mean that we should reach the conclusion that Puerto Rico can live without electric power—simply because we were able to? The same applies to our health care funding. Just because we have been able to get by on a shoestring budget for the last few years, does that mean that proper funding should not be available to us?

Thank you for your attention,

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