

## Puerto Rico Health Care Community Letter

October 20, 2017

### VIA ELECTRONIC MAIL

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Ave, SW  
Washington, DC 20201

Dear Administrator Verma:

Thank you and your staff for your response to the current crisis in Puerto Rico resulting from hurricanes Maria and Irma. We are grateful for your leadership and extensive efforts to support the United States citizens of Puerto Rico in this extremely difficult time. In particular, we appreciate the time the HHS and CMS teams have spent working on crisis response efforts and we look forward to continued engagement as we navigate this difficult situation. In light of Hurricane Maria's devastation of the Island, we write to request that you take immediate action on critical Medicare payment policies, retroactive to October 1st, to ensure that those affected Americans have access to care in Puerto Rico, in response to the crisis.

Despite continuing to struggle with electrical grid challenges, managed care organizations (MCOs) are operational and continue to put all efforts in addressing the care of the most fragile. MCOs have implemented immediate administrative flexibility measures that have facilitated open access to care and accelerated payments to hospitals, while supporting the steadfast reactivation of provider operations and coordinated care. Even when progress is being made, the deterioration and underdevelopment of healthcare operations on the island is now more evident in the post-Hurricane Maria scenario. Addressing core funding anomalies now becomes crucial to support emergency response measures that give a real chance for meaningful change in our healthcare system.

We are encouraged by the fact that Congress is considering action to stabilize our Medicaid program through the CHIP Bill. However, the current proposal would only delay the funding cliff to the end of 2018. While this would be a positive and needed step, it is naturally insufficient in terms of the annual funding allocation. Therefore, we look forward to working closely with you and Congress in the coming weeks and months to provide a much-needed longer-term Medicaid solution.

Moreover, it is our strong request that CMS correspondingly act within its discretionary administrative power to help the Medicare Advantage (MA) beneficiaries in Puerto Rico. As you know, Puerto Rico is unique in that MA is the foundation and quality backbone of the Island's health care system. Puerto Rico has overwhelmingly embraced MA, with the nation's highest MA penetration rate (90% of eligible beneficiaries) and eighth largest enrolled MA population, despite ranking 30<sup>th</sup> in overall population for all US jurisdictions. The Puerto Rico MA program includes the nation's highest enrollment in MA Dual Eligible Special Needs Plans (D-SNPs) at more than 283,000, as well as over half of all Medicare End Stage Renal Disease (ESRD) patients on the Island. The popularity and accomplishments of the MA program are even more profound *when considering that Puerto Rico is the lowest funded Medicare Advantage program in the United States, receiving 43% less than the US average.* This often results in reimbursement pressure that is driving many providers to relocate to the mainland, and hindering the development of basic

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infrastructure. But despite all this the underfunded MA program accounts for approximately 50% of all funding to the Puerto Rico health care system and is central to care for the our most vulnerable residents.

The Island's MA Plans now face exponentially more difficult challenges as the impact of Hurricane María increases the resource gap for care in the healthcare system that has already been severely underfunded for many, many years. For example:

- As an immediate problem due to the impact of the natural disaster, many enrollees have evacuated to the mainland States, where they are receiving care for which we are financially responsible; these services are often two to three times more expensive than the care they would receive in Puerto Rico.

When Puerto Rico's MA beneficiaries leave the island, they most often seek medically necessary services from out of network providers that bill at rates greatly in excess of what providers receive on the island. MCOs in Puerto Rico are unable, due to the chronic underfunding, to pay these disproportionately higher rates compared to rates in the island. As you know this payment disparity for hurricane-related out of network care is not reflected in the current benchmark for Puerto Rico counties. Although health plans are committed in assisting our people in already difficult circumstances, plans are limited in their ability to assume risk for non-emergent services rendered to beneficiaries that have relocated to the mainland. We include more detail on this immediate issue - for MA, Medicaid and duals – as part of the attachment.

- It will now become more expensive to provide the care to those enrollees that remain in Puerto Rico. History has shown that patient acuties increase in the weeks and months following disasters of this type. Based on reports by the Puerto Rico Government, as of October 18, 35% of the population is still without running water, while most lack access to clean potable water, and over 80% do not have electricity.
- For similar reasons, the costs of ensuring continuous ESRD treatment will soon increase to an unsustainable level; and of course, the ESRD system in Puerto Rico was already underfunded before Hurricane Maria. Moreover, the costs will inevitably rise even more due to the increasing number of our ESRD beneficiaries moving to the US to get treatment. This increases costs automatically for the system and to Medicare, and without functioning in any way to support the strengthening of our unreliable dialysis services.

This fatal convergence of Puerto Rico's healthcare funding crisis and two natural disasters is magnified by the fact that the general population has decreased by 10% and the economy has contracted by 15% in the last decade all coupled with a debt-ridden government with extreme liquidity challenges and operational underdevelopment.<sup>1</sup> To meet these immediate challenges for the US citizens of Puerto Rico, we are requesting immediate and targeted relief to ensure ongoing access to care by those affected by Maria.

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<sup>1</sup> See Financial Oversight and Management Board for Puerto Rico, Letter to House and Senate Leaders (Oct. 4, 2017).

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We hope that you agree that the post-Maria relief and rebuilding of the Puerto Rico health care system must include addressing short term crises and longer-term disparities in Medicare reimbursement to the Island. Failure to do so would leave many dual-eligible and ESRD beneficiaries in an unstable program with plans and providers facing a death spiral that will impact more than 80,000 critical direct and indirect health care jobs and impair any chance of a viable economic recovery. The United States' default solution is to fund care for these US citizens at more than double the price tag to assist them in Puerto Rico, when they migrate to the United States mainland. The migration is increasing daily, and action needs to be taken now. Local sources have reported that over 50,000 people have left the island in the past 30 days.

To address these immediate and unanticipated issues, and to ensure that the primary sources of care in Puerto Rico – the MA MCOs – can continue to serve the Island's beneficiaries, the Puerto Rico's health care community requests the following two actions for post-María relief:

1. CMS should immediately issue an *Interim Final Rule* (using the authority of the official emergency declaration) to adjust Medicare FFS dialysis payments and MA ESRD benchmarks to use the national average as a proxy or, at a minimum, the US Virgin Islands (USVI) geographic factors, effective retroactively to October 1<sup>st</sup>, 2017. CMS should consider that many patients are leaving to get care in states that have rates much higher than the USVI, and also higher than the national average.
2. To address the need for reconstruction and long-term issues that beneficiaries residing in Puerto Rico will face, in the *2019 Advance Notice for MA & PD*, CMS should propose an adjustment to tie MA rates in Puerto Rico to the national average as a proxy, or that at least link the Puerto Rico MA rates to the level of the nearby territories. This could be done by establishing an average geographic adjustment (AGA) for Puerto Rico counties that is derived from the national average or that, as a minimum, uses the level of the USVI AGA for the calculation of the Puerto Rico MA benchmarks.

Details of these and additional proposals are attached. We have already been discussing these issues with CMS leadership and staff, so these proposals are therefore ready for implementation and not unfamiliar. The private structure of MA, closely regulated, and incentivized by performance measures, is a natural channel to support a stronger health system for the most vulnerable and needy, and to create the prospects for urgent investment in our healthcare infrastructure and our healthcare professionals. The parallel system currently being developed by the crisis management team on the ground in Puerto Rico is not sustainable, and does not take advantage of the core resources of the existing healthcare delivery system in the island.

Taking swift and bold action now to stabilize Medicare will (1) immediately enhance care for the most vulnerable beneficiaries, (2) motivate US residents and key healthcare providers to forgo additional migration, and (3) encourage future private investment in Puerto Rico health care system's infrastructure.

We thank you for your continued attention to these matters and stand ready to work with you and your staff.

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Sincerely,

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Attachment

A Path for a Rational & Accountable Reconstruction of Healthcare in PR

Immediately connect and act on the Rebuilding Phase:

1. **ESRD Patients** - HHS/CMS can adjust payments for ESRD patients in Medicare Advantage and FFS to tie it to the US national average, or at least the USVI levels, retroactive to October 1st, 2017. This would direct more resources specifically for this special population.
  - i. Payment disparity, particularly the wage index, has created access and market issues for the past years with dialysis services, and this has been documented by CMS and Puerto Rico health care stakeholders in the past 4 Medicare payment regulatory cycles.
  - ii. The current ESRD MA benchmark for 2018 is \$4,314, compared to \$5,996 in the USVI and \$6,955 in Florida. Similarly, the geographic factor for dialysis payments in Medicare FFS for Puerto Rico is 0.400, compared to 0.7108 in the USVI and 0.8146 in Florida.
  - iii. Statutory and data anomalies have created unsound results for payment factors in Puerto Rico, provoking and perpetuating a spiral to the bottom, and a continuous erosion of the stability and capacity of the Medicare programs in Puerto Rico.
  - iv. FFS Medicare payments can use the USVI level wage index.
  - v. MA benchmarks should change also, given that ESRD benchmarks are NOT part of the regular MA bid process. More than half of the ESRD patients are in MA (approximately 3,500).
  - vi. CMS can do this through an Interim Final Rule, supported by the President's emergency declaration and existing documentation of the issue.
2. **Medicare Advantage Benchmarks** - Provide stability and consistency in payment policy by proposing the use of the national average or of USVI geographic factors in the development of MA rates for Puerto Rico. This change is also urgent, since it needs to be included in the Advanced Notice 2019 which is being prepared by CMS right now (Q4 2017). This would still leave Puerto Rico 17% below the lowest MA benchmark average among the states (HI), but would close the gap that continues to create long-lasting harm in the system. The Island currently has 580,000 enrollees in MA, including over 280,000 Medicaid duals and 3,500 ESRD patients.
  - i. CMS already provided a similar fix under the Medicare Physician Fee Schedule with the use of USVI physician GPCIs for Puerto Rico starting 2017.
  - ii. The use of the USVI AGA for MA benchmarks in PR would still leave the island at 17% below the rates of lowest state. The average AGA factor for MA rates for Puerto Rico in 2018 is 0.49, compared to 1.03 in Florida, and 0.73 for the USVI.
3. **Medicare FFS, Part A** - We recommend that all Puerto Rico facilities be provided a geographic reclassification and assigned a wage index of at least 1.00 for a reasonable time period. We also recommend that additional consideration be given to providing Puerto Rico facilities with a Cost of Living adjustment, consistent with considerations due to geographic considerations afforded to Alaska and Hawaii. An immediate adjustment to the wage index and/or cost of living adjustments would provide critical funding necessary to support the higher operational cost entailed by the lack of basic resources. The higher payment rates would also provide the means for the facilities to make the capital investments necessary to reestablishing prior operating levels as well as the ability to retain the professional workforce that is vital in the recovery efforts.

The wage index adjustment should be included as well for the End-Stage Renal Disease Prospective Payment System, Hospital Outpatient Prospective Payment, and Ambulatory Surgical Center Payment Systems, among others. Finally, given the high penetration rate of Medicare Advantage programs, in particular for the dual eligible population, it is critical that the adjustments are incorporated into the

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Medicare Advantage benchmark development to ensure MA organizations are also in position to support the reconstruction and recovery efforts.

4. **Health Insurance Provider's Fee** – Section 9010 of the ACA imposes an annual fee on each covered entity engaged in selling health insurance. HHS has interpreted Title I of the ACA to not apply to the Territories. The Treasury Department should correspondingly use its discretionary authority to interpret section 9010 to not apply to the Territories. Otherwise, in 2018, the federal government will collect more than \$200 million in taxes from the hurricane devastated health care systems of Puerto Rico and the Virgin Islands in order to fund ACA Exchanges and cost sharing subsidies in the States. We have demonstrated to Treasury that they possess the legal authority to grant this relief.
5. **Non-emergency services for individuals who have temporarily relocated to the US** - While we work with Congress to address these funding issues, we also need your help at CMS. We are confronting immediate problems stemming from Puerto Rican Medicaid recipients leaving the island as a result of the hurricanes and seeking both emergency and non-emergent medical care in the states. Non-emergent services outside Puerto Rico are not covered by the Puerto Rican Medicaid program and Medicaid programs in other states have waiting period requirements; and therefore, health plans appeal to CMS aid in identifying alternate solutions to address the needs of Medicaid evacuees that have relocated to the mainland. For example, we understand that, in addition to the identification of additional funds, Section 1115 waivers played an important role in Hurricane Katrina's disaster response efforts. We are confident that you will work with ASES to provide Puerto Rico the authority needed to address the direct impact of the public health emergency.

Similarly, the most immediate problem we are confronting in MA relates to those who are leaving the island as a result of the hurricanes. When Puerto Rico's MA beneficiaries leave the island, they most often seek medically necessary services from out of network providers that bill at rates greatly in excess of what providers receive on the island. As you know this is not reflected in the current benchmark. Although health plans are committed in assisting our people in already difficult circumstances, plans are limited in their ability to assume risk for non-emergent services rendered to beneficiaries that have relocated to the mainland. We would appreciate additional guidance from CMS as to how they want us to treat these out of network beneficiaries and what resources will be available. We need your help in finding a solution to address the needs of beneficiaries that have relocated to the US.

6. **Dual Eligible Beneficiaries** - HHS/CMS can passively enroll in the integrated Medicare Platino program the remaining Medicare A/B beneficiaries that are in Mi Salud effective January 2018. There remain approximately 6,000 Medicare AB beneficiaries in Mi Salud who have not signed up for Medicare Platino. In enrolling these beneficiaries in Medicare Platino, ASES would only pay \$10 instead of \$170 monthly for these people. Beneficiaries would also get better care and more benefits. Puerto Rico would get more funding to serve them through the formal and quality-driven MA platform. This could save ASES \$14M+.
  - i. Another meaningful step to take regarding dual eligible beneficiaries in Puerto Rico would be to transition the 50,000+ Part A only members in Mi Salud to the Medicare Platino program – support them by waving Part B late enrollment penalties and paying the part B premium for them for a 2-year period, starting January 1<sup>st</sup>, 2018. This would strengthen the healthcare system by maximizing the MA program formula and organization. It could also save close to \$100M to ASES.