

Policy Paper

Puerto Rico's Looming 2019 Medicaid Fiscal Cliff



September 2019

A note on the U.S. territories:

This policy paper focuses on the imminent fiscal cliff faced by Puerto Rico's Medicaid program due to inequitable federal funding treatment. These same federal funding disparities affect American Samoa, Guam, the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands which also face looming fiscal cliffs requiring urgent Congressional action. Absent immediate action to address the funding shortfalls for FY 2020 and beyond in all U.S. territories, basic healthcare access to hundreds of thousands of vulnerable Americans is in jeopardy. All eligible U.S. citizens and nationals (in the case of American Samoa) as well as eligible legal immigrants residing in the U.S. territories should have access to a strong, vibrant, and adequately funded Medicaid healthcare system.

Medicaid’s Mission:

“to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.”

Social Security Act, Sec. 1901. [42 U.S.C. 1396]

Congressional Task Force on Economic Growth in Puerto Rico:

“The Task Force believes that the future financing of the Medicaid program in Puerto Rico is a serious and urgent issue facing federal policymakers attempting to address the territory’s economic and social challenges.”

Congressional Task Force on Economic Growth in Puerto Rico
Report to the House and Senate – 114th Congress
December 2016

The Financial Oversight & Management Board for Puerto Rico:

"Going forward, the Board believes that federal financing of the Medicaid program in Puerto Rico should be more closely tied to the size and needs of its low-income population and that the Commonwealth’s recovery and fulfillment of PROMESA’ s objectives will be significantly aided by the Congress legislating a long-term Medicaid program solution to mitigate the drastic reduction in federal funding for healthcare in Puerto Rico that will happen later this year absent congressional action."

Statement of Natalie Jaresko, Executive Director
Financial Oversight & Management Board for Puerto Rico
House Committee on Energy and Commerce, Subcommittee on Health
Hearing: “Strengthening Healthcare in the U.S. Territories for Today and Into the Future”
June 2019

Medicaid and CHIP Payment and Access Commission (MACPAC):

“We find that the statutory financing arrangement for Puerto Rico’s Medicaid program has resulted in chronic underfunding of its Medicaid program. Medicaid spending is constrained to a greater degree than in any state, reflected, for example, in more limited benefit packages, lower eligibility ceilings, and lower provider payment levels. In addition, the territory has high rates of poverty and a weak economy, conditions that were worsened by Hurricanes Irma and Maria in September 2017.”

Medicaid and CHIP Payment and Access Commission
Report to Congress on Medicaid and CHIP
June 2019

Contents

Executive Summary.....	5
Introduction	9
Contents and Methods.....	10
Part I: Medicaid Program in Puerto Rico	11
Financing Structure and Expenditures	11
Federal Medical Assistance Percentages (FMAP).....	11
Section 1108 Medicaid Cap	12
Medicaid Spending per Enrollee	13
Eligibility and Enrollment.....	13
Service Delivery and Payment System	16
Mandatory, Optional Services and Waiver Authorities	18
Access to Care and Provider Availability	19
Temporary Supplemental Healthcare Funding	21
Looming Funding Cliff and Potential Catastrophic Effects.....	23
Part II: Fundamental Considerations for Policymakers.....	24
Economic Crisis	25
Fiscal and Debt Crisis	26
Demographic Crisis	27
Disaster Recovery and Reconstruction	28
Poverty and Income Disparities of the Disabled Population.....	29
Health Status and Disparities.....	29
Puerto Rico Healthcare Reform	31
Part III: Policy Recommendations and Conclusion.....	34
Annexes.....	36
Annex 1: Mandatory and Optional Medicaid Benefits	36
Annex 2: The Perils of Medicaid Block Grant and Per Capita Allotment proposals.....	37

EXECUTIVE SUMMARY

Ensuring basic healthcare services for the residents of Puerto Rico faces major risks in the coming months. As early as December of this year, a funding shortfall in Puerto Rico's Medicaid program is expected to affect healthcare access and coverage to 1.5 million U.S. citizens. Those at risk are Puerto Rico's most vulnerable: low-income families and children, pregnant women, the elderly, and people with disabilities.

Puerto Rico and its residents have experienced numerous crises and shocks in the last decades, including an economic depression dating back to 2006; a public debt crisis resulting in the largest municipal bankruptcy in U.S. history and a federally appointed fiscal oversight board pursuing deep budget cuts; a demographic crisis with population dropping by more than 600,000 residents since peaking at 3.8 million in 2004; and most recently, the devastation and cascading effects left by the hurricanes of 2017. The cumulative effect of these crises has taken a hard toll on the economic and social well-being of its people, disproportionately impacting the most vulnerable populations and communities. These interrelated crises feed on each other, propelling a vicious downward spiral.

Another potential shock is the territory's imminent Medicaid fiscal cliff, and ensuing public health crisis. In the past, temporary lifelines to Puerto Rico's Medicaid program have prevented a total system collapse, but by the same token, these short-term extensions of supplemental funding have thwarted efforts to completely reform the system and make it more effective. The uncertainty caused by this situation is highly detrimental to all stakeholders, especially people whose health and well-being depends on receiving vital care but have few resources to make ends meet in this challenging economic environment.

Differences in Puerto Rico's Medicaid Program

The U.S. Medicaid program was created to provide vital healthcare services to financially and medically needy populations. In Puerto Rico, however, that same population is adversely affected by a disparate and inadequate federal funding structure. Medicaid programs in the states benefit from an open-ended federal financing structure, receiving federal funds as a function of actual costs and needs. In Puerto Rico, where median household income stood at \$19,775 in 2017, compared to \$42,009 in Mississippi, the poorest state, and \$57,652 in the United States as a whole, the program has been chronically underfunded. In the poverty-ridden territory, funding limitations further constrain program delivery evidenced in the form of lower eligibility levels, lower federal funding, fewer mandatory benefits, lower provider payments, and lower spending per enrollee.

Lower eligibility levels: To determine income eligibility for participation in Medicaid, Puerto Rico uses the Puerto Rico Poverty Level (“PRPL”) and not the Federal Poverty Level (“FPL”) as in the states, which results in a significantly lower income eligibility threshold. The PRPL is approximately 45% of the FPL for an individual, and 34% for a family of four.

Lower federal funding: Medicaid programs in the U.S. benefit from an open-ended financing structure, receiving federal funds based on actual costs and needs. States with the highest per capita incomes of the U.S. enjoy a Medicaid federal matching rate of 50%, while the poorest, Mississippi, received a Federal Medical Assistance Percentage (“FMAP”) of 76.4% in fiscal year 2019. If Puerto Rico’s FMAP were “calculated by the same statutory formula used for the 50 states and D.C., Puerto Rico’s FMAP would be 83%, although the unbounded FMAP would be 93.34%.”¹ In addition to the lower federal share, Puerto Rico’s Medicaid federal financing is also subject to an annual ceiling or cap, operating effectively as a block grant. Puerto Rico receives an arbitrarily capped allotment, known as the Section 1108 cap, typically resulting in an effective Medicaid federal match rate below 15%. Puerto Rico’s federal funding was capped at \$367 million in FY2019, while Medicaid expenditures in the island totaled \$2.7 billion. The projected FY2020 cap is expected to be \$375.1 million, despite spending projections adding up to \$2.8 billion. As per current law, Puerto Rico will also have access to \$446 million under the Patient Protection and Affordable Care Act (“ACA”) Section 1323, and \$59 million under Social Security Administration (“SSA”) Section 1935(e), also referred to as the Enhanced Allotment Plan (“EAP”), which helps cover prescriptions drugs costs to beneficiaries dually eligible for Medicaid and Medicare, for a total of \$880 million in federal spending.

Fewer mandatory benefits: Notwithstanding the great needs and demands for acute and long-term care services – which will likely continue to grow in tandem with the aging population trend and the rising prevalence of chronic health problems – Puerto Rico’s Medicaid program does not cover all mandatory Medicaid benefits. Long-term services, home and community-based services to older adults and people with disabilities with functional limitations and chronic health conditions, are examples of support offered in U.S. states but not available to the residents of Puerto Rico.

Lower provider payments: Disproportionately low provider payment rates and its negative effect on provider availability, and quality and access to care, is a major obstacle for Puerto Rico. The majority of municipalities (i.e. 72 of 78) of Puerto Rico are deemed “medically underserved areas” due to the shortage of medical and healthcare professionals. The Medicaid provider reimbursement rate in Puerto Rico for primary care services from July 2016 to July 2017 was 19% of the Puerto Rico Medicare fee compared to 66% in the U.S. Similarly, maternity services were reimbursed at 50% of the Puerto Rico Medicare fee vs.

¹ Assistant Secretary for Planning and Evaluation (“ASPE”), “Evidence Indicates a Range of Challenges for Puerto Rico Health Care System”, January 12, 2017, available at https://aspe.hhs.gov/system/files/pdf/255466/PuertoRico_Assessment.pdf

81% in the U.S. The substantial differences between Puerto Rico's Medicaid reimbursement rates and those in the states and the uncertainties regarding the island's Medicaid financing structure, have played a role in the exodus of physicians and healthcare providers. The number of doctors has decreased from approximately 14,000 in 2006 to currently close to 9,000. There is a particularly acute deficiency of specialty care providers.

Lower Medicaid spending per enrollee: Total Medicaid spending per enrollee is significantly lower in Puerto Rico when compared to all 50 states. According to FY 2020 projections by the Medicaid and CHIP Payment and Access Commission ("MACPAC"), average benefit spending per full year enrollee in Puerto Rico will be \$2,144, representing 64% of the lowest per capita spending state (\$3,342), 32% of the median (\$6,763), and 16% of the highest per capita spending state (\$13,429).

Increased Healthcare Needs

Less funding has, in effect, translated to increased needs. The percent of adults reporting fair or poor health in 2017 reached 37.1% in Puerto Rico, compared to 25.3% in Mississippi, and 18.4% in the U.S. The healthiest jurisdiction, according to this indicator, was the District of Columbia reporting 10.8%. Disparities in chronic health indicators are also significant. Diabetes prevalence in Puerto Rico in 2017 was 17.2%, compared to 10.5% in the U.S. Asthma and high blood pressure prevalence was 12.2% and 44.7% in Puerto Rico, compared to 9.4% and 32.3% in the U.S, respectively. A robust healthcare system with adequate federal funding could help mitigate the high prevalence of chronic conditions on the island.

Necessary Congressional Action

The chronic underfunding of the island's Medicaid program has historically placed an undue fiscal burden on Puerto Rico's budget and prompted federal action. During the last decade, Congress has enacted legislation to provide limited, temporary supplemental funding and avoid a massive healthcare crisis. In 2009, additional federal funds for Puerto Rico's Medicaid program were appropriated through the American Reinvestment and Recovery Act ("ARRA"), followed by the ACA in 2010, the Consolidated Appropriations Act of 2017, and most recently, through the Bipartisan Budget Act ("BBA") of 2018 following the devastating 2017 Atlantic hurricane season. In the aftermath of Hurricanes Irma and Maria impacting the island on September 2017, Congress provided an additional \$4.8 billion to Puerto Rico's Medicaid program beyond the annual Section 1108 cap, time-limited funds that were made available from January 1, 2018 to September 30, 2019. The expiration date authorizing the use of that last tranche of funding is soon approaching, and all other temporary federal funds are expected to be exhausted shortly thereafter.

Only prompt Congressional action can help avert a health care crisis in Puerto Rico. If Congress fails to act, it could lead to catastrophic direct and indirect effects. The Medicaid and CHIP Payment and Access Commission (“MACPAC”) estimated that enrollment at the current level of benefits would need to decrease between 36% (455,475) to 53% (669,943) if no new federal funds are made available. The Fiscal Oversight and Management Board for Puerto Rico has warned that “absent action by Congress, by fiscal year 2021, the Commonwealth’s Medicaid costs are projected to comprise roughly 23% of the General Fund’s budget.”

The FMAP that applies to Puerto Rico’s Medicaid program should be computed using the same formula used for the states, considering the average per capita income of Puerto Rico relative to the U.S. national average. To ensure that the most vulnerable populations of Puerto Rico have access to a more robust, predictable, reliable, and accessible Medicaid healthcare system, **Congress must act quickly and remove the federal cap on Medicaid funding altogether and compute the FMAP using the same average per capita income-based formula as done for the states.** Providing Puerto Rico with an adequate level of federal funds for its Medicaid program will also help it return to a path of fiscal stability and economic growth. The urgency of this matter cannot be overstated. Congressional action is promptly needed to stave off another historic humanitarian crisis.

When designing the solution, policy deliberations and prescriptions must be framed within the proper context. Policymakers must remain keenly aware of the historic critical juncture Puerto Rico is traversing and the larger moral imperatives at play. Puerto Rico’s current dire economic, fiscal, demographic, and post-natural disaster recovery and reconstruction reality must be an essential part of the broader equation. This critical juncture presents an opportunity for Congress to redress a historical wrong, strengthen Puerto Rico’s fragile healthcare system, improve access to critical health services for vulnerable populations, and make headway towards putting Puerto Rico on a stronger fiscal and economic footing.

Further, more than a last-minute temporary fix is needed to provide Puerto Rico with a reliable and sustainable healthcare system. A permanent, long-term fix to Puerto Rico’s Medicaid program is needed to once and for all guarantee comprehensive, accessible, quality care to low-income families, children, the elderly, and people with disabilities.

Introduction

Puerto Rico's Medicaid program, which provides access to healthcare services to approximately 1.5 million² of the United States (U.S.) territory's financially and medically needy individuals, is facing an imminent fiscal cliff, with a funding shortfall possibly occurring as soon as December 2019. Puerto Rico has already suffered several crises during the last decade and a half, some natural, others man-made, putting at risk the livelihood and well-being of its 3.2 million American citizens.

Puerto Rico's economy has been on a downward spiral since 2006. Population displacement to the U.S. mainland, due mostly to dismal economic prospects on the island as well as difficult post-natural disaster conditions, has eroded Puerto Rico's economic and tax base, and its government is currently under bankruptcy proceedings after having filed for the largest municipal bankruptcy in U.S. history in 2017. Due to the fiscal and debt crisis, Puerto Rico has been placed under the purview of a federally appointed financial oversight and management board (the "FOMB") that has been pursuing budget cuts which are likely to deepen and lengthen the economic depression affecting Puerto Rico. Outlining all the factors that have led to this grim economic and social reality is beyond the scope of this policy paper, but it is pertinent to highlight that actions and omissions of both the local and the federal governments are to blame for the current beleaguered condition of Puerto Rico and its residents. Given that Puerto Rico is subject to the Territorial Clause of the U.S. Constitution, Congress bears great responsibility in crafting policy solutions to the island's multiple challenges. The looming Medicaid fiscal crisis in Puerto Rico poses an opportunity for Congress to permanently right a historical wrong, to strengthen the territory's public healthcare system, and put Puerto Rico on a path of fiscal stability.

The inadequate federal funding structure of Puerto Rico's Medicaid program is one factor that has contributed significantly to its unsustainable debt levels and fiscal troubles. The disparate treatment of Puerto Rico with regards to this critical healthcare program, serving the U.S. territory's most vulnerable populations, has historically placed an undue and unsustainable fiscal burden on the territory's budget.³ While the federal matching rate for this program ostensibly has been at least 50%, in practice Puerto Rico has had in certain years an effective federal matching rate below 15% due to the imposition of an arbitrary cap on federal funding. While temporary measures have been enacted during the last decade to enhance the federal contribution to Puerto Rico's Medicaid program, funds will soon be completely depleted. If no congressional action is taken, Puerto Rico's Medicaid federal funding shortfall may happen as soon as December 2019.⁴

² As of April 2019, 1,251,837 people residing in Puerto Rico were eligible under Medicaid, 88,944 children under its CHIP program, and 140,923 covered under a Puerto Rico-funded health program, for a total of 1,483,471 enrollees.

³ The Fiscal Oversight and Management Board for Puerto Rico, in a letter to the House Committee on Natural Resources in response to the Hearing on "The Insular Areas Medicaid Cliff", warned that if Congress does not take any action, by fiscal year 2021, Puerto Rico's Medicaid costs would account for approximately 23% of the General Fund's budget. Available at https://drive.google.com/file/d/1XeMmC0FCoq_S_uldOR_JZU3FIO02Tmz-view

⁴ As noted by the Medicaid and CHIP Payment and Access Commission in their May 2019 report titled "Medicaid and CHIP Payment and Access Commission": "The specific date of exhaustion will depend on actual spending in FY 2020 and whether CMS allows the territories to draw down their ACA

The U.S. Department of Health and Human Services estimated in January 2017 prior to Hurricanes Irma and Maria and massive population decrease, that nearly 900,000 Medicaid beneficiaries could lose their access to healthcare if Puerto Rico goes off the Medicaid fiscal cliff.⁵ In a more recent analysis, MACPAC estimated that enrollment would need to be reduced between 455,475 (36%) and 669,943 (53%) enrollees if no new federal funds are made available. Furthermore, the Kaiser Family Foundation has estimated that Puerto Rico will experience a funding shortfall of \$1 billion in FY 2020, increasing to \$1.5 billion in FY 2021, this out of a general fund budget of less than \$10 billion.⁶ Finally, funding uncertainties are already having detrimental effects, including adversely impacting managed care rate negotiations, provider participation, and creating unease among Medicaid beneficiaries.

Contents and Methods

This policy paper was commissioned by CNE to Olivier Perrinjaquet, Ph.D. student at the Reubin O'D. Askew School of Public Administration and Policy at Florida State University. It is divided into four main sections: **Part I** covers key characteristics of the Medicaid and Children's Health Insurance Program ("CHIP") program in Puerto Rico, including eligibility criteria and enrollment numbers; financing structure and expenditures; service delivery and payment systems, mandatory and optional services rendered; and access to care, laying out the U.S. territory's idiosyncrasies. **Part II** outlines critical context and background considerations to consider when formulating policy in Puerto Rico. **Part III** provides key actionable policy recommendations laying the foundation for Puerto Rico's Medicaid and CHIP programs to gradually achieve full parity with the states in all respects, safeguarding the health interests of the U.S. territory's most vulnerable populations.

This policy paper draws from a diverse set of sources including, but not limited to, peer-reviewed literature, reports and studies produced by the federal government and the government of Puerto Rico, reports and studies published by relevant nonprofit entities of the U.S. mainland and of the U.S. territory, and media sources. Several interviews were conducted to complement the analysis.

Section 1323 funds before tapping their annual Section 1108 allotments. Currently, CMS policy dictates that territories must draw down their annual Section 1108 allotments first."

⁵ Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "Nearly 900,000 Puerto Ricans may lose health coverage when Medicaid funds run out", January 12, 2017, <https://aspe.hhs.gov/pdf-report/nearly-900000-puerto-ricans-may-lose-health-coverage-when-medicaid-funds-run-out>

⁶ Kaiser Family Foundation, "Medicaid Financing Cliff: Implications for the health systems in Puerto Rico and USVI", May 2019, <https://www.kff.org/report-section/medicaid-financing-cliff-implications-for-the-health-care-systems-in-puerto-rico-and-usvi-issue-brief/>

Part I: Medicaid Program in Puerto Rico

There are substantial disparities between Puerto Rico's Medicaid program and those operating in the 50 states, as is evidenced by much lower eligibility levels, lower federal funding participation, fewer mandatory benefits, lower provider payments, and lower spending per enrollee. These historic disparities have ultimately resulted in a deficient healthcare system and have contributed to relatively worse health outcomes for the people of Puerto Rico.

Financing Structure and Expenditures

The most significant difference between Puerto Rico's Medicaid program and that of the 50 states is the U.S. territory's federal financing structure. While the states benefit from an open-ended funding commitment by the federal government, Puerto Rico's federal funding is capped, placing an undue burden on Puerto Rico's public coffers. This disparate treatment has resulted in recurrent fiscal crises that require last-minute infusions of supplemental funds to temporarily sustain the program and meet the basic healthcare needs of the island's most vulnerable populations. In a report to the U.S. House and Senate, the bipartisan Congressional Task Force on Economic Growth in Puerto Rico indicated "the future financing of the Medicaid program in Puerto Rico is a serious and urgent issue facing federal policymakers attempting to address the territory's economic and social challenges" and that "an equitable and sustainable legislative solution to the financing of Puerto Rico's Medicaid program should be enacted."⁷ The report also recognizes that the Medicaid funding disparity has been a "meaningful factor" contributing to Puerto Rico's troubled fiscal condition, recurring annual deficits, and unsustainable debt level. There are two key features of Puerto Rico's federal financing structure that must be rectified: (1) the Medicaid federal matching rate, known as the Federal Medical Assistance Percentage ("FMAP"), and (2) the inadequate federal funding cap, known as the Section 1108 cap.

Federal Medical Assistance Percentages (FMAP)

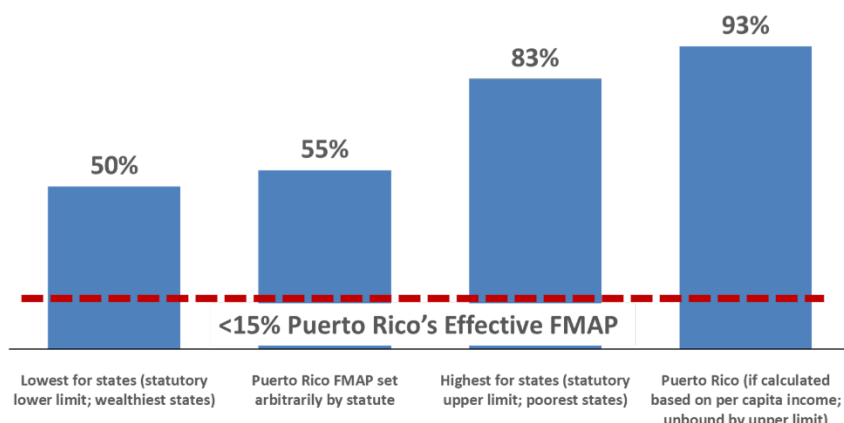
While the states' Medicaid federal reimbursement rate known as FMAP⁸ is calculated based on the state's per capita income relative to the nation's per capita income, providing higher rates to poorer states, Puerto Rico and the other U.S. territories were arbitrarily assigned an FMAP of 50%, and subsequently increased to 55% under the Patient Protection and Affordable Care Act ("ACA"). It is unclear how these rates were determined for the U.S. territories given that historically the territories have been among the poorest of all U.S.

⁷ Congressional Task Force on Economic Growth in Puerto Rico, "Report to the House and Senate", December 20, 2016, available at <https://www.finance.senate.gov/imo/media/doc/Bipartisan%20Congressional%20Task%20Force%20on%20Economic%20Growth%20in%20Puerto%20Rico%20Releases%20Final%20Report.pdf>

⁸ Congressional Research Service, "Medicaid's Federal Medical Assistance Percentage (FMAP)", April 25, 2018, available at <https://fas.org/spp/crs/misc/R43847.pdf>

jurisdictions. According to a policy brief by the Office of the Assistant Secretary for Planning and Evaluation (“ASPE”), the principal advisory group to the Department of Health and Human Services (“HHS”), if Puerto Rico’s FMAP were “calculated by the same statutory formula used for the 50 states and D.C., Puerto Rico’s FMAP would be 83%, although the unbounded FMAP would be 93.34%.”⁹

Puerto Rico's Effective Federal Medical Assistance Percentage (FMAP), Statutory Boundaries, and Unbound Scenario



Source: Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services

Section 1108 Medicaid Cap

The other component of the federal financing structure of Puerto Rico’s Medicaid program is the federal cap on funding, known as the 1108 federal cap. **The FMAP is applied until the “mandatory ceiling amount” is reached, giving Puerto Rico’s FMAP little meaning given the U.S. territory’s high Medicaid spending and relatively low annual federal cap.** At times the net, or *effective* federal matching rate for Puerto Rico’s Medicaid program has been lower than 15%. It was first set in 1968 at \$20 million, increasing to \$30 million in 1972, and \$45 million in 1981¹⁰. The funding cap increases at the rate of the medical care component of the CPI-U.¹¹ For many years, prior to the temporary Medicaid supplemental funds assigned through the ACA, the Bipartisan Budget Act of 2018, and other legislation, Puerto Rico’s effective federal matching rate was below 15%, due to the combined effects of the low FMAP and the arbitrary cap.

⁹ Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, “Evidence Indicates a Range of Challenges for Puerto Rico Health Care System”, January 12, 2017, available at https://aspe.hhs.gov/system/files/pdf/255466/PuertoRico_Assessment.pdf

¹⁰ Aileen Pagán-Berlucchi and Donald N. Muse, “The Medicaid Program in Puerto Rico: Description, Context, and Trends”, 1983, Health Care Financing Review, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191318/>

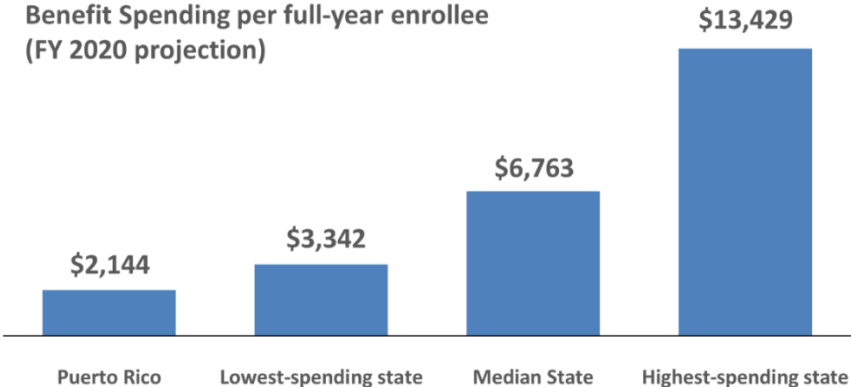
¹¹ Measuring Price Change in the CPI: Medical care, available at <https://www.bls.gov/cpi/factsheets/medical-care.htm>

Puerto Rico’s federal matching cap was set at \$359.5 million in FY2018, while total Medicaid expenditures in the island totaled \$2.5 billion. The projected 1108 cap for FY2019 is \$366.7 million, while estimated total Medicaid expenditures are \$2.7 billion. The projected FY2020 cap is set to be \$375.1 million with spending projected to be \$2.8 billion.

Medicaid Spending per Enrollee

Due to the funding disparities between Puerto Rico’s Medicaid program and that of the U.S. states, Puerto Rico Medicaid spending per enrollee is a fraction of U.S. Medicaid spending. According to FY2020 projections by MACPAC, average benefit spending per full year enrollee in Puerto Rico will be \$2,144, representing 64% of the lowest per capita spending state (\$3,342), 32% of the median (\$6,763), and 16% of the highest per capita spending state (\$13,429).¹²

Evident Disparities between Medicaid Programs in US States and Puerto Rico



Source: Medicaid and CHIP Payment and Access Commission, “Report to Congress on Medicaid and CHIP”, June 2019

Eligibility and Enrollment

Another key difference between Puerto Rico’s Medicaid program and Medicaid programs in the 50 states is eligibility standards. Puerto Rico has lower eligibility levels than the states for two principal reasons: (1) Puerto Rico’s Medicaid program does not cover all federally

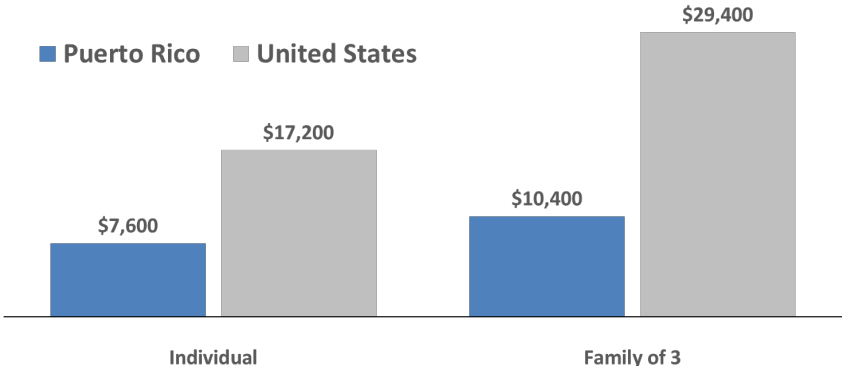
¹² The Medicaid and CHIP Payment and Access Commission projection excludes spending in administration and long-term services and supports (“LTSS”) and adjusts for differences in enrollment mix across states and Puerto Rico, reweighting to match the distribution of enrollees across eligibility groups in Puerto Rico.

mandated populations¹³, and (2) income eligibility depends on the Puerto Rico Poverty Level (the “PRPL”) and not the Federal Poverty Level (“FPL”) as in the states.¹⁴ The PRPL is materially lower than the FPL, significantly reducing the income eligibility threshold.

In 2019, an individual adult residing in Puerto Rico with an annual income of up to approximately \$7,600 (i.e. 138%¹⁵ of the Individual annual PRPL of \$5,508) was eligible for Medicaid. This compares to an income eligibility threshold of \$17,236 (i.e. 138% of the individual annual FPL of \$12,490) for an individual residing in one of the states that have expanded Medicaid. This means that the Medicaid income eligibility threshold for these states is more than twice that in Puerto Rico. Consequently, many low-income individuals residing in Puerto Rico are not provided the healthcare coverage they would normally be eligible for, if it were not for this unequal treatment of Puerto Rico’s Medicaid program. In the case of a family of 3, the maximum income amount to be eligible for Medicaid in Puerto Rico is close to \$10,000, compared to more than \$29,000 in Medicaid expansion states. This is almost three times the income eligibility threshold of Puerto Rico.

Wide Disparities in the Medicaid Income Eligibility Threshold of Puerto Rico and the U.S.

Annual income equivalent to 138% percent of poverty in Puerto Rico and the U.S. (2019) rounded to the nearest hundred



Source: Puerto Rico Department of Health – Medicaid Program; Centers for Medicare and Medicaid Services

¹³ Government Accountability Office, “Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources”, March 2014, available at <https://www.gao.gov/assets/670/661334.pdf>

¹⁴ Center on Budget and Policy Priorities, “Puerto Rico’s Medicaid Program Needs an Ongoing Commitment of Federal Funds”, April 22, 2019, available at <https://www.cbpp.org/research/health/puerto-ricos-medicaid-program-needs-an-ongoing-commitment-of-federal-funds>

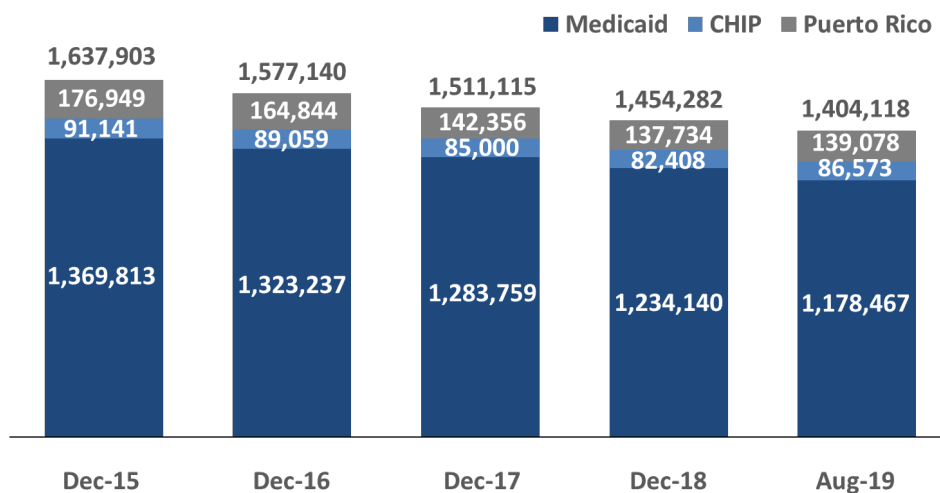
¹⁵ 138% is the effective upper income eligibility threshold which includes the established 133% of modified adjusted gross income plus an income disregard in the amount of 5%.

Despite these eligibility inequities with the states, Medicaid covers a large part of the population of Puerto Rico given the high poverty rate in the island. In Puerto Rico there are four main categories of Medicaid beneficiaries:

- (1) Federally funded Medicaid beneficiaries;
- (2) Federally funded CHIP beneficiaries;
- (3) Medicare “Platino” beneficiaries or the “dual eligible” who are eligible for both Medicare and Medicaid benefits; and
- (4) Puerto Rico-funded Medicaid beneficiaries.

As of August 2019, 1,178,467 people residing in Puerto Rico were eligible under Medicaid, 86,573 children under its CHIP program, and 139,078 covered under a Puerto Rico-funded health program, for a total of 1,417,223 enrollees.¹⁶ Roughly one quarter of the 1.2 million Medicaid beneficiaries are “dual eligible”, meaning that they qualify for both Medicare and Medicaid. Of the 1.4 million enrollees, approximately 425,000 are children, 305,000 are elderly and disabled individuals, and more than 17,000 are pregnant women. Given that the population estimated for Puerto Rico as of July 1, 2018 amounted to 3,195,153,¹⁷ Medicaid and CHIP enrollees represent roughly 45% of the population.¹⁸

Puerto Rico Public Health Programs Enrollees (2012-2019)



Source: Puerto Rico Department of Health, Medicaid Office, available at <https://medicaid.pr.gov/Statistics.aspx>

¹⁶ There are eight geographic regions broken down as follows by enrollee for August 2019: Arecibo (214,194), Bayamón (191,231), Caguas (186,644), Fajardo (128,654), Mayagüez (229,717), Metropolitana (212,514), Nivel Central (40), and Ponce (241,124)

¹⁷ According to the U.S. Census Bureau’s annual estimates of the Puerto Rico resident population as of July 1, 2018

¹⁸ July 2018 Medicaid beneficiaries totaled 1,579,546 (1,345,778 Medicaid, 87,919 CHIP, and 145,849 Puerto Rico funded program).

Service Delivery and Payment System

States and territories have broad discretion in choosing their Medicaid service delivery and payment systems, within federal parameters and core requirements.¹⁹ The two principal models employed are Fee-For-Service (“FFS”) or Managed Care, with most states having a combination of both. These models have their own strengths and weaknesses, with significant implications for incentive mechanisms and behavioral patterns. States have also been experimenting with innovative delivery and payment systems through pilot programs, seeking to align value, performance, and health outcomes with payment, promoting more patient-centered care, cost and quality accountability, and population health management.²⁰

Medicaid managed care, as defined by CMS, “provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and Managed Care Organizations (“MCOs”) that accept a set per member per month (capitation) payment for these services.”²¹ The capitated amount paid to MCOs for a prescribed period of time per enrollee covers medical services to the beneficiary and overhead expenses. Overhead expenses are often subject to a Medical Loss Ratio (“MLR”) standard to maximize the dollars going to customers’ medical claims and to set a limit to dollars going to administrative costs and profits. Under this system, the MCO bears the risk of any costs above the agreed upon actuarially sound rates established in the contract. However, if the MCO does not spend the capitated amount, it gets to keep the difference. Rates vary according to the enrollment group and corresponding service needs, and by geographic region.

Puerto Rico has been operating under a 100% risk-based managed care system²² since the mid-1990s for the delivery and payments of Medicaid systems. The Puerto Rico Department of Health manages eligibility while the Puerto Rico Health Insurance Administration (better known by its Spanish acronym ASES) established in 1993, contracts with private commercial insurers functioning as MCOs to manage the care of Medicaid beneficiaries. These MCOs, licensed by the Puerto Rico Commissioner of Insurance (“PRICO”), receive a set per member

¹⁹ In the early 1980s, starting with the Omnibus Budget Reconciliation Act of 1981 and reacting to a considerable growth in Medicaid spending, the federal government made a strong push towards devolution (i.e. delegating greater control and responsibility to state and local governments) and decentralization, providing states with greater flexibility on how to manage their respective Medicaid programs. State discretion has led to geographic inequities in access to Medicaid services given the differing levels of governing and fiscal capacity and commitment at the state-level to assist the poor in their healthcare needs (Thompson and Dilulio 1998). The adequate level of devolution to states has been and will continue to be a strong point of contention between those with polar views.

²⁰ For more on Provider Payment and Delivery System Reform, see Kaiser Family Foundation, “Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans”, March 5, 2018, available at <https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-payment-and-delivery-system-reform/>

²¹ Centers for Medicare & Medicaid Services, “Managed Care”, available at <https://www.medicaid.gov/medicaid/managed-care/index.html>

²² The Congressional Budget Office (“CBO”) defines a risk-based managed care system as “a system in which a health care program contracts with health plans, most of which are privately run, to provide a set of covered benefits for a fixed amount per beneficiary [capitation payment]. Those amounts may be adjusted to reflect the health risks of beneficiaries [risk-based capitation payments].”

per month (“PMPM”) payment, also known as capitated payments, for their services. MCOs in turn pay healthcare providers through capitated payment arrangements or on a fee-for-service basis. Medical specialists are often paid through a fee-for-service payment system.

The former Rosselló administration launched a new government health plan called “Plan de Salud Vital”, approved by the Center for Medicare and Medicaid and put into effect on November 1, 2018. Under the new managed care system, MCOs provide coverage to the entire island and beneficiaries are free to choose their managed care organization, their primary care provider (PCP), and their primary medical group (PMG) during a defined period of time. In the previous model, MCOs operated solely in one of the nine regions throughout Puerto Rico and Medicaid beneficiaries were assigned to participate in the region where they resided.

Under Vital, ASES has contracted with the following five MCOs: First Medical Health Plan, Molina Healthcare, Triple-S Salud, Plan de Salud Menonita, and MMM MultiHealth. The healthcare delivery system reform under Vital seeks to cut down healthcare spending, increase competition among the different players, enhance access through the island-wide model, improve administrative efficiencies, provide more choice to beneficiaries, and yield improved quality of care.

However, the rollout of Vital has been challenging.²⁴ MCOs, providers, and enrollees have all experienced some degree of difficulty during the transition to the new model. Uncertainties regarding total capitation payments to MCOs and provider reimbursements abounded during the rollout since insurance companies could not anticipate which MCO enrollees would sign up with each of them. Building Puerto Rico-wide provider networks has also proven quite difficult for MCOs, compared to region-wide networks “having operated in one limited region for years and dedicating resources to build programs in new regions that may only have a handful of enrollees.”

In addition, MCOs must adhere to a 92% Medical Loss Ratio (“MLR”), which requires that no more than 8% of total expenditures go to administrative costs and profits, a requirement that has been quite constraining, particularly when needing to build an island-wide network. MCOs had to operate within a 91.4% MLR in FY2018 and 90.0% in FY2017. The new 92% MLR requirement is seven percentage points higher than the minimum set by the federal government. The main challenges for providers have been “dealing with multiple MCOs, rates, and high cost-high need (“HCHN”) care models”, and handling “issues with contracting, reimbursement, and patient classifications”, among others. As it

²⁴ Kaiser Family Foundation, “Medicaid Financing Cliff: Implications for the Health Care Systems in Puerto Rico and USVI”, May 21, 2019, available at <https://www.kff.org/report-section/medicaid-financing-cliff-implications-for-the-health-care-systems-in-puerto-rico-and-usvi-issue-brief/>

often occurs when introducing new models and systems, enrollees have faced difficulties navigating through the unfamiliar system. To address these issues ASES responded by “standardizing referral and prior authorization processes, streamlining eligibility redetermination processes, and making certain rate guarantees during the transition.”

Mandatory, Optional Services and Waiver Authorities

There are certain federal parameters states and territories must abide by when it comes to Medicaid benefits and coverage. For example, they must provide all Medicaid mandatory benefits. “Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose”, and they cannot discriminate based on the beneficiaries’ conditions or diagnosis. Beyond these federal requirements, states have discretion to develop their benefits package. Beyond the mandatory benefits, states and territories may also cover optional services including prescription drugs, dental services, among others.

Puerto Rico’s Medicaid program does not cover all mandatory Medicaid benefits, covering only 10 of the 17 mandatory Medicaid benefits.²⁵ Of the five U.S. territories, Guam covers all 17 mandatory Medicaid benefits, the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands cover nearly all the benefits, and American Samoa and Puerto Rico cover 10 of the 17 benefits (see Annex 1 for a list of mandatory benefits and coverage in Puerto Rico). CMS has not enforced coverage of certain mandatory benefits in the territories and Puerto Rico has been exempted through waivers given a lack of adequate infrastructure and funding to meet the requirements.²⁶

Puerto Rico’s Medicaid program does not cover long-term services and supports (“LTSS”)²⁷. LTSS, which “encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities”²⁸ is a key benefit provided to Medicaid beneficiaries in the U.S., accounting for 20% of total Medicaid spending.²⁹ In Puerto Rico, Medicaid enrollees are often cared for by family and friends for their long-term care needs, with limited medical support. Guam is the only territory whose Medicaid program provides long-term services.

²⁵ Government Accountability Office, “Medicaid and CHIP: Increased Funding in U.S. territories merits improved Program Integrity Efforts”, April 2016, available at <https://www.gao.gov/assets/680/676438.pdf>

²⁶ According to the Centers for Medicare & Medicaid Services officials, Puerto Rico lacks an infrastructure of nursing home facilities. See Government Accountability Office, “Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources”, March 2014, available at <https://www.gao.gov/assets/670/661334.pdf>

²⁷ Long-term services and supports (“LTSS”), which “encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities” is a key benefit provided to Medicaid beneficiaries accounting for 20% of total Medicaid spending. Due to the limited coverage of LTSS through Medicare and the costly coverage through the private health insurance market, Medicaid has become the primary payer of long-term care. The sociodemographic changes driven by the graying of the population, coupled with the increasing prevalence of chronic health conditions, will continue to increase the demand of these services. There are mandatory LTSS benefits which Medicaid must cover, which include nursing facility and home health services, and optional LTSS benefits which include home and community-based services, and institutional LTSS. There has been an important shift, driven by the government and long-term care advocates, towards less use of institutional LTSS and greater use of home and community-based services (“HCBS”).

²⁸ Office of the Assistant Secretary for Planning and Evaluation, “An Overview of Long-term Services and Supports and Medicaid: Final Report”, August 8, 2018, available at <https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report>

²⁹ Centers for Medicare & Medicaid Services, “Long Term Services & Supports”, available at <https://www.medicaid.gov/medicaid/lts/index.html>

In general, Medicaid affords states and territories broad discretion and flexibility to shape and define their respective Medicaid programs. However, even greater flexibility may be obtained through demonstration waivers (Section 1115) which allows Medicaid programs to experiment with innovative financing and delivery systems.³⁰

The Northern Mariana Islands and American Samoa also have waiver authority under section 1902(j) of the Social Security Act that allows them to be exempt from almost all Medicaid requirements. While the other territories, Puerto Rico, Guam, and the USVI, do not operate their Medicaid programs under this type of waiver, there has been some discussion about extending this authority to these jurisdictions. It should be noted, however, that exempting territories from compliance with federal Medicaid requirements may further weaken their programs and care. These waivers will not help address the federal funding problems faced by the territories or improve access to healthcare, which should be the main objectives going forward.

Access to Care and Provider Availability

Timely access to healthcare providers, both to primary and specialty care providers, is a critical component of a robust health care program that results in a healthy, productive population.

Unfortunately, poor access to physicians, particularly specialty care providers, is too common in Puerto Rico. The MACPAC has developed a framework to assess access to Medicaid and CHIP programs, noting that “provider availability for Medicaid and CHIP populations is influenced by a community’s health care delivery system and the distribution of providers (its health care workforce and institutional resources), as well as state policies and providers’ responses to those policies (provider payment, provider participation rates, willingness to accept Medicaid, and workforce issues such as scope of practice).”³¹ Many of these factors adversely impact provider availability in Puerto Rico. According to the 2015 Puerto Rico Primary Care Assessment, 72 of Puerto Rico’s 78 municipalities are deemed “medically underserved areas” marked by a shortage of health services and providers.³² Low provider reimbursement rates also negatively impact provider availability and access to care, quality of services rendered, and healthcare outcomes of beneficiaries. The Medicaid provider reimbursement rate in Puerto Rico for primary care services from July 2016 to July 2017 was 19% of the Puerto Rico Medicare fee compared to 66% in the U.S. Similarly, maternity services were reimbursed at 50% of the Puerto Rico Medicare fee vs. 81% in the U.S. A study

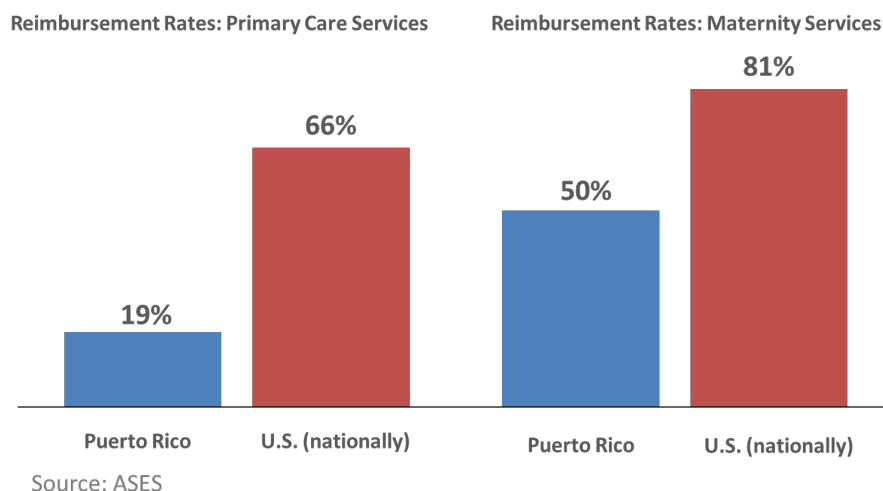
³⁰ Medicaid and CHIP Payment and Access Commission, “Waivers”, available at <https://www.macpac.gov/subtopic/waivers/>

³¹ Medicaid and CHIP Payment and Access Commission, “Examining Access to Care in Medicaid and CHIP”, March 2011, available at https://www.macpac.gov/wp-content/uploads/2015/01/Examining_Access_to_Care_in_Medicaid_and_CHIP.pdf

³² Puerto Rico Department of Health, “2015 Puerto Rico Primary Care Needs Assessment”, April 2016, available at <http://www.salud.gov.pr/Estadisticas-Registros-y-Publicaciones/Publicaciones/2015%20Puerto%20Rico%20Primary%20Care%20Needs%20Assesment.pdf>

found that “increasing Medicaid payments to primary care doctors is associated with improvements in access, better self-reported health, and fewer school days missed among beneficiaries.”³³

Very Low Provider Reimbursement Rates in Puerto Rico vs. Other Medicaid Programs



A key factor negatively impacting provider availability and access to care is the migration of healthcare professionals. Driven by several factors, including the lack of parity between Puerto Rico’s Medicaid reimbursement rates and those in the states and the perennial uncertainties regarding the island’s Medicaid financing structure, Puerto Rico has suffered an exodus of physicians and healthcare providers. Since physicians residing in Puerto Rico are certified by the same medical boards as their stateside counterparts and are American citizens, they can easily move to a state enticed by more lucrative job opportunities. The number of doctors has decreased from approximately 14,000 in 2006 to currently close to 9,000.³⁴

Due to the shortage of doctors, patients must wait at times more than one year to visit a specialist. There is a shortage of physician specialists in most areas of medical expertise, except in the case of ophthalmologists and psychiatrists. For example, there is only one cardiac pediatric surgeon who operates only on hearts and no other organ, and three geneticists island wide.³⁵ As noted by the Puerto Rico College of Physicians and Surgeons in a letter to Congress, the “demographic hemorrhage is also depriving the islands of its best and brightest physicians and ancillary health professionals, dangerously depriving the

³³ Diane Alexander and Molly Schnell, Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health”, April 21, 2018, available at https://economics.stanford.edu/sites/g/files/sbiybj9386/f/alexander_schnell_2018.pdf

³⁴ Physician migration data provided by the Puerto Rico College of Physicians and Surgeons.

³⁵ El Nuevo Dia, “Merma en la fuga de especialistas médicos en la isla”, April 21, 2019, available at <https://www.elnuevodia.com/noticias/locales/nota/mermaenlafugadeespecialistasmedicosenlaisla-2489187/>

remaining patients of adequate levels of access to specialists to attend Puerto Rico's normal healthcare needs, much less those required to confront Puerto Rico's frequently dengue, influenza and chikungunya epidemics, as well as the recent Zika virus pandemic, critically overloading geneticist, prenatal, neonatal, pediatric, neurological, and other resources.”³⁶

Healthcare providers also worry about being paid in an adequate and timely manner for the services they render to Medicaid patients given the government's tight cashflows. An Urban Institute site visit report found that “in April 2014, the Puerto Rico Health Insurance Administration (referred to as ASES) withheld payment from Medicaid MCOs, who then withheld payments from their contracting providers.”³⁷ The Government of Puerto Rico is pushing for higher provider payments to help stave-off the exodus of physicians, by establishing a payment floor of 70% to 80% of the Medicare fee schedule, requiring an investment of \$170 million in FY2020 and FY 2021.

Temporary Supplemental Healthcare Funding

To address the recurring funding shortfalls of Puerto Rico's Medicaid program during the last decade, Congress has provided temporary supplemental federal funding starting in 2009. As will be outlined subsequently, the first infusion of funds came from the American Reinvestment and Recovery Act (“ARRA”) of 2009, followed by the Patient Protection and Affordable Care Act (“ACA”) of 2010, the Consolidated Appropriations Act of 2017, and most recently, through the Bipartisan Budget Act (“BBA”) of 2018 following the devastating Hurricanes Irma and Maria which put even greater strain on the island's health infrastructure system and budget. Without these supplemental funds, which were often legislated at the last minute to address short-term needs, the health and wellbeing of many residents of Puerto Rico would have been put at considerable risk. These short-term extensions have at times raised the FMAP and artificially increased total Medicaid spending for Puerto Rico. Instead of fixing the underlying problems, these temporary block grants have thwarted efforts to completely reform the program. While these measures were critical in preventing a collapse of Puerto Rico's Medicaid program, a permanent solution is required to ensure the fiscal stability of Medicaid going forward.

The American Reinvestment and Recovery Act (“ARRA”) of 2009³⁸ included funding for health care and state fiscal relief, including Medicaid, along with assisting people with their employer-based health coverage after being laid off, and investment in Health Information Technology (“HIT”) to better serve Medicaid and needy patients, among other uses. Federal

³⁶ Puerto Rico College of Physicians and Surgeons, “Presentations to the Congressional Task Force on Economic Growth in Puerto Rico”, available at <https://www.finance.senate.gov/imo/media/doc/Puerto%20Rico%20College%20of%20Physicians%20and%20Surgeons.pdf>

³⁷ Urban Institute, “Puerto Rico Health Care Infrastructure Assessment”, January 2017, available at https://www.urban.org/sites/default/files/publication/87011/2001050-puerto-rico-health-care-infratructure-assessment-site-visit-report_1.pdf

³⁸ To address the Great Recession of 2007 to 2009, the worst economic crisis since the Great Depression, Congress enacted the American Reinvestment and Recovery Act (ARRA) of 2009, a large countercyclical program pushing forward a federal stimulus package amounting to \$787 billion.

allocations for states Medicaid costs totaled \$87 billion, \$142 million allocated for Puerto Rico.³⁹ This temporary increase was for the time period from October 1, 2009 to December 31, 2010 and was meant to help states pay for their Medicaid programs as demand for the program as a result of the deterioration of the economy and job market.

The Patient Protection and Affordable Care Act of 2010⁴⁰ resulted in several changes to Puerto Rico's Medicaid program.⁴¹ The federal law increased Puerto Rico's FMAP from 50% to 55%, expanded eligibility to adults with incomes up to 138 percent of the poverty level, and appropriated funds for a temporary increase in the federal cap, providing Puerto Rico with an additional \$5.4 billion between July 1, 2011, and September 30, 2019. The island was allocated an additional \$925 million through December 2019 to address the fact that Puerto Rico did not have access to premium tax credits for individual market coverage, and did not establish a state exchange. These supplemental funds were utilized faster than anticipated given the underestimation of Puerto Rico's Medicaid federal funding needs, and the heightened demand for Medicaid services. Congress appropriated an additional \$295.9 million through the Consolidated Appropriations Act of 2017.

Hurricanes Irma and Maria struck Puerto Rico on September 2017, decimating the territory's critical infrastructure systems, including its healthcare system. To address the critical situation and the humanitarian crisis that ensued, Congress provided another temporary lifeline to Puerto Rico's Medicaid program through the enactment of the Bipartisan Budget Act of 2018 ("BBA"). The BBA provided an additional \$4.8 billion beyond the annual Section 1108 cap. These funds were made available from January 1, 2018 to September 30, 2019 with an FMAP of 100% requiring no matching funds, giving the island's strained finances a much-needed respite. An initial \$3.6 billion was made immediately available, while the remaining \$1.2 billion was conditional on Puerto Rico meeting certain milestones regarding the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System ("T-MSIS") and on progress made on the establishment of a Medicaid Fraud Control Unit ("MFCU"). The Centers for Medicare and Medicaid Services certified compliance with these conditions, allowing access to the additional \$1.2 billion.⁴² Only after these BBA funds are disbursed can the remaining ACA funds be utilized.

³⁹ Kaiser Family Foundation, "American Recovery and Reinvestment Act (ARRA): Medicaid and Health Care Provisions", March 2009, available at <https://kff.org/wp-content/uploads/2013/01/7872.pdf>

⁴⁰ The Patient Protection and Affordable Care Act (PPACA) of 2010 was largely enacted to reduce the number of uninsured low-income adults in the United States. One avenue it sought to do so was through expanding Medicaid eligibility. The PPACA has extended health insurance to 30 million uninsured, approximately half through Medicaid. The constitutionality of the PPACA was challenged, in particular the provision regarding Medicaid expansion. In the landmark June 2012 US Supreme Court decision *National Federation of Independent Business v. Sebelius*, the court upheld as constitutional the individual mandate under Congress' taxing power, but struck down the mandatory expansion of Medicaid, ultimately making it optional for states. As of April 26, 2019, 37 states including D.C. have adopted the Medicaid expansion while 14 states have not.

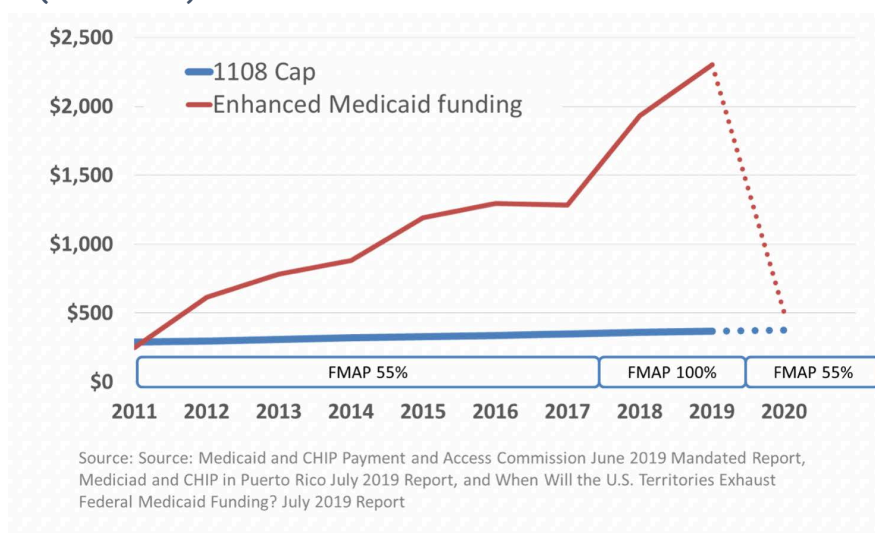
⁴¹ For more on the Medicaid changes through the Patient Protection and Affordable Care Act see Medicaid and CHIP Payment and Access Commission, "Overview of the Affordable Care Act and Medicaid", available at <https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid/>

⁴² Office of the Governor of Puerto Rico, "Federal Gov't Approves New Healthcare Model for Puerto Rico", available at <https://www.fortaleza.pr.gov/content/federal-gov-t-approves-new-healthcare-model-puerto-rico>

Looming Funding Cliff and Potential Catastrophic Effects

There are currently no other lifelines in place beyond FY2019 to stave-off the imminent Medicaid fiscal cliff. Beyond the annual cap of an estimated \$375.1 million, a projected use of \$446.3 million in ACA Section 1323 funds, and \$58.9 million in Section 1935(3) funds⁴³, for a total of \$880.4 million in federal Medicaid spending for Puerto Rico in FY2020⁴⁴, there are no other federal funds available to Puerto Rico for healthcare, placing an unsustainable burden on the island's cash-strapped public coffers and jeopardizing the healthcare coverage of hundreds of thousands of low-income families, children, and people with disabilities. In January 2017, prior to Hurricanes Irma and Maria of September 2017 and the exacerbated population decline, the Office of the Assistant Secretary for Planning and Evaluation of HHS, stated that “as many as 900,000 American citizens covered by Medicaid in Puerto Rico could lose coverage as a result of the depletion of these funds.”⁴⁵ In a more recent analysis, MACPAC posited the following when considering the effects of Congress not appropriating more federal Medicaid funds to Puerto Rico: “Assuming no reductions in benefits, no additional federal funds, and the same territorial contribution, Puerto Rico would need to reduce enrollment by 455,475 beneficiaries (36 percent). If Puerto Rico stopped spending territory funds once all the available federal funds were exhausted, it would need to reduce enrollment by 669,943 beneficiaries (53 percent).”⁴⁶

Puerto Rico's Medicaid Federal Funding Cliff (in millions)



⁴³ Section 1935(e) of the Social Security Act, also known as the Enhanced Allotment Plan (EAP), provides additional federal funding to low-income beneficiaries in the U.S. territories dually eligible for Medicaid and Medicare to cover prescription drugs costs.

⁴⁴ There are \$586.4 million in remaining ACA Section 1323 funds available through December 2019, but \$446.3 million are projected to be used. In May 2019, CMS determined to allow Puerto Rico and other territories to use ACA Section 1323 funds prior to other funds.

⁴⁵ Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services, “Nearly 900,000 Puerto Ricans May Lose Health Coverage When Medicaid Funds Run Out”, January 12, 2017, available at https://aspe.hhs.gov/system/files/pdf/255461/PuertoRicoEnrollment_DataPoint.pdf

⁴⁶ MACPAC, “Chapter 5: Mandated Report – Medicaid in Puerto Rico”, June 2019, available at <https://www.macpac.gov/wp-content/uploads/2019/06/Mandated-Report-Medicaid-in-Puerto-Rico.pdf>

If no Congressional action is taken to adequately fund Puerto Rico's Medicaid program, there are concerns this will further fuel and exacerbate the exodus of healthcare professionals to the U.S mainland.⁴⁷ Great uncertainty would ensue regarding the newly uninsured with no clear social safety net. Healthcare providers and beneficiaries of the remaining system would similarly suffer severe adverse effects. Undoubtedly, it will have an effect on the "5,000 doctors, 64 hospitals, 20 federally qualified health centers, 900 community pharmacies, and thousands of healthcare professionals" serving Medicaid beneficiaries.⁴⁸

Part II: Fundamental Considerations for Policymakers

When assessing Puerto Rico's healthcare system and its urgent unmet financial needs, and when formulating policies to guarantee appropriate access to quality care to the island's most vulnerable residents, the discussion and policy prescriptions must be framed within the proper context. Puerto Rico's current economic, fiscal, political, demographic, and post-natural disaster recovery and reconstruction reality must be front and center in the policy debate and final policy decision. Federal policymakers must remain keenly aware of the historic critical juncture Puerto Rico is traversing and the larger moral imperatives at play. The United States has risen throughout history when faced with morally compelling situations. Without the European Recovery Program (more commonly known as the Marshall Plan), post-World War II Europe's economic and political stability would have been at risk. In this instance, Puerto Rico's long-term social, economic, and fiscal health is at stake unless a bold, multidimensional approach is taken to address the intertwined crises. The U.S. Congress, a legislative body with plenary powers over Puerto Rico, has a legal and moral obligation to undertake the required action.

Health policy prescriptions and reforms will vary depending on the environment within which the healthcare system operates. Puerto Rico is currently facing what few, if any, U.S. jurisdictions have faced in the modern era. Its economy has been contracting for more than a decade; it declared bankruptcy due to unpayable debts; and the population shrinkage continues to erode an already weak economic and tax base. These interrelated crises feed on each other, propelling a vicious downward spiral. To make matters worse, in September 2017 the U.S. territory was subjected to another shock with the devastating strike of Hurricane Maria, the third costliest hurricane in U.S. history, only after Katrina and Harvey.⁴⁹

⁴⁷ Jaime Torres, "2019 Medicaid funding cliff could cause mass migration from Puerto Rico", March 30, 2019, available at <https://thehill.com/opinion/healthcare/436556-2019-medicaid-funding-cliff-could-cause-mass-migration-from-puerto-rico>

⁴⁸ Executive Director of the Puerto Rico Health Insurance Administration, "House Committee on Energy and Commerce oversight hearing titled Strengthening Health Care in the U.S. Territories for Today and Into the Future", June 20, 2019, available at <https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Avila.pdf>

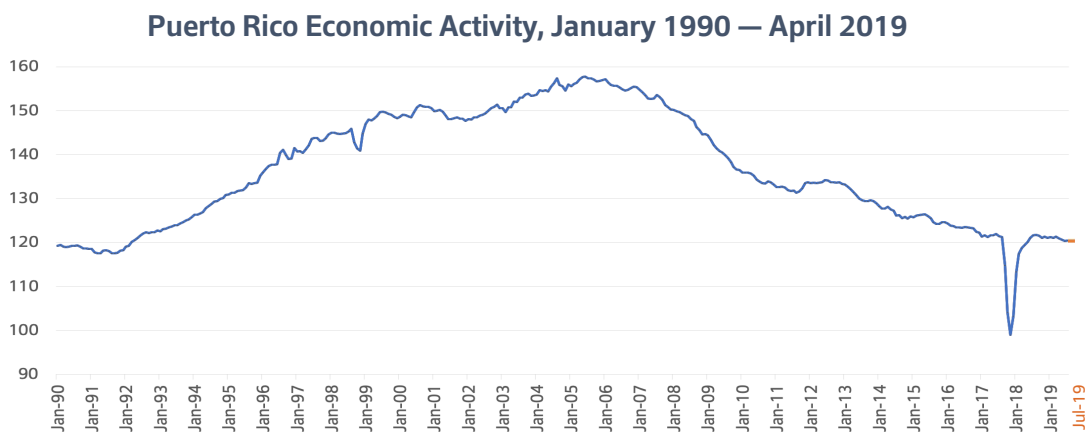
⁴⁹ For a lengthier discussion of post-hurricane recovery and reconstruction efforts and challenges see, Center for a New Economy, "Puerto Rico's Unfinished Business After Hurricane Maria", October 2018, available at http://grupocne.org/wp-content/uploads/2018/10/CNE-Policy-Paper_-Puerto-Ricos-Unfinished-Business-After-Hurricane-Mari%CC%81a-.pdf

The FOMB through its approved fiscal plan for Puerto Rico, is requiring draconian austerity measures in a wide range of governmental functions, including the healthcare sector. In sum, Puerto Rico is steeped in a protracted economic depression, it is navigating through bankruptcy proceedings beleaguered by powerful interests, faces difficult demographic challenges, the recovery and reconstruction efforts have been painfully sluggish with limited impact on the local economy, and the island is under a fiscal board proposing policies that are “leaving a legacy of debt and risk that may undermine the future of Puerto Rico’s economy.”⁵⁰ It is against this backdrop that federal policymakers should debate and determine how to appropriately and morally address Puerto Rico’s Medicaid crisis.

Economic Crisis

Puerto Rico’s economy has been contracting virtually incessantly since 2006, except for a short-lived uptick in 2012 driven by the federal fiscal stimulus provided by the American Recovery and Reinvestment Act. It’s real economic output as measured by the gross national product (“GNP”) has shrunk by more than 20% since the onset of the downturn, resulting in hundreds of thousands of lost jobs and driving outmigration. According to the certified May 9, 2019 fiscal plan, it is expected that billions of dollars in federal and private disaster relief and reconstruction funds will temporarily prop up economic activity during fiscal years 2019 and 2020, with projected real gross GNP growth rates of 4.0% and 1.5%, respectively. Beyond this fleeting boost to economic growth in the short-term, medium-, and long-term projections point to continued stagnation or contraction. Once recovery funds are depleted, there is much uncertainty regarding future potential growth drivers.

The latest Economic Development Bank’s Economic Activity Index (“EDB-EAI”), a coincident economic index highly correlated with Puerto Rico real GNP, points to a very sluggish, or nonexistent, economic recovery. The July 2019 index reached 120.5, still 0.7% below the August 2017 index of 121.3, the month prior to Hurricanes Irma and Maria.



Source: Economic Development Bank of Puerto Rico

⁵⁰ Martin Guzman and Pablo Gluzmann, “Puerto Rico’s Debt Dilemma”, May 2019, available at <http://espaciosabiertos.org/wp-content/uploads/Puerto-Ricos-Debt-Dilemma-Final-Report-May-2019.pdf>

Fiscal and Debt Crisis

Puerto Rico is not only grappling with a profound and prolonged economic downturn dating back to 2006 due to weak economic fundamentals and structural problems. It is also going through the largest municipal bankruptcy in U.S. history, saddled with over \$70 billion in outstanding debt and approximately \$50 billion in unfunded pension liabilities, dwarfing the city of Detroit's \$18 to \$20 billion bankruptcy filing in 2013. This fiscal and debt crisis led to enactment of the Puerto Rico Oversight, Management, and Economic Stability Act ("PROMESA") of 2016 which had two principal mandates: achieve fiscal stability and regain access capital markets. To achieve these goals, PROMESA (1) provided Puerto Rico with a bankruptcy framework which it previously lacked, (2) established a federally appointed financial oversight and management board ("FOMB") to oversee the finances of Puerto Rico and ensure fiscal discipline, and (3) required the FOMB to certify a fiscal plan.

One of the factors that drove Puerto Rico's government to issue excessive debt was the compelling need to provide essential healthcare services to its most vulnerable populations, combined with the inadequate federal financing structure of Medicaid. As Levis-Peralta affirmed "one of the principal, and often unnamed, causes of the Puerto Rico fiscal crisis is a federal policy which provides unequal treatment to the territories for Medicaid funding."⁵¹ Levis-Peralta, the Chief Executive Officer of Impactivo Consulting, a Puerto Rico-based social impact firm, estimated that "Puerto Rico spent over \$19 billion from 1998 to 2013, covering the local share of its spending on the medically indigent. Over the same period, the Puerto Rican government's primary fiscal balance totaled negative \$12.1 billion." Without the federal Medicaid cap, Puerto Rico's deficit would have been significantly lower. An Urban Institute report which surveyed barriers to access to quality healthcare in Puerto Rico also raised the issue of Puerto Rico incurring long-term debt to cover the current costs of providing health services for its indigent population, stating that "to pay for the cost of public services, including publicly funded health care services such as Medicaid, the commonwealth has routinely borrowed money by issuing municipal bonds."⁵² Furthermore, the Final Investigative Report on Puerto Rico's Debt commissioned by the Financial Oversight and Management Board identified the inadequate federal funding structure of Puerto Rico's Medicaid program as a key structural issue.⁵³

⁵¹ Maria Fernanda Levis-Peralta, "Your Money Or Your Life: Federal Policies And Health Disparities In Puerto Rico", Health Affairs Blog, June 13, 2016, available at <https://www.healthaffairs.org/doi/10.1377/hblog20160613.055275/full/>

⁵² Urban Institute, "Puerto Rico Health Care Infrastructure Assessment", January 2017, available at https://www.urban.org/sites/default/files/publication/87011/2001050-puerto-rico-health-care-infratructure-assessment-site-visit-report_1.pdf

⁵³ FOMB – Final Investigative Report – Kobre & Kim, August 20, 2018, <https://drive.google.com/file/d/19-lauVo3w9MPS03xYVe0SWhQin-Q6FEf/view>

Demographic Crisis

The economic and fiscal crises have also fueled an exodus to the U.S. mainland producing a demographic crisis. According to a study which analyzed net migration flows out of Puerto Rico before and after the 2017 hurricane season, “Puerto Rico’s out-migration is driven by long-term declining economic conditions as opposed to population displacement induced by Hurricane María.”⁵⁴

The population of Puerto Rico as of July 1, 2018, as estimated by the U.S. Census Bureau, was 3.2 million after reaching a peak of 3.8 million in 2004, a loss of roughly 600,000 people. While the negative natural birth rate, with deaths exceeding births since 2015, puts downward pressure on population growth, net out-migration is the main driver. As is well known, Puerto Rico has been facing an outmigration crisis for some time, adversely impacting the supply of healthcare providers on the island. For example, Puerto Rico’s population as of July 1, 2018 reached 3,195,153, a 3.9% or 129,848 decrease with respect to the previous 12 months. This downward trend in population is expected to continue.⁵⁵ The certified fiscal plan of May 9, 2019 projects the population to reach 2.9 million by FY 2024.

The aging demographics of Puerto Rico’s population also poses significant difficulties and exerts additional pressure on the healthcare system. In 2017, according to the U.S. Census Bureau’s American Community Survey, the age group of people 65 years and older represented roughly 18% of the total population and the median age was 40.1 years. However, as recently as 2010 this age group represented 14% of the total population, and the median age was 35.9. Population ageing is a trend that will continue into the future.

A large part of Puerto Rican residents migrating to the U.S. mainland will be eligible to receive Medicaid in their new home state. The Center for Economic and Policy Research (2017) estimated the potential costs to the federal government and states from 2018 to 2027 from Puerto Ricans moving to US states if current migration trends continue. It found that the federal government would incur costs of \$9.7 billion, while states would incur costs of \$6.1 billion. If these people had stayed in Puerto Rico, it would have cost the federal government and Puerto Rico \$4 billion, approximately four times less than on the mainland. The Center also estimated the costs in a more pessimistic scenario, (\$19.4 billion for the federal government and \$12.3 billion for states, vs. \$7.8 billion in Puerto Rico). Others have argued a similar point, positing that “Congress can save taxpayer money by avoiding Medicaid cliff in Puerto Rico.”⁵⁶ Impactivo Consulting published a report compellingly arguing “why

⁵⁴ News is My Business, “P.R. population not displaced by hurricanes for now — It’s the economy, study says”, March 21, 2019, available at <https://newsismybusiness.com/p-r-population-not-displaced-by-hurricanes-for-now-its-the-economy-study-says/>

⁵⁵ Financial Oversight and Management Board for Puerto Rico, “2019 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity”, May 9, 2019, available at <https://drive.google.com/file/d/13wuVn04--JKMEPKu-u-djZJHqTK-55aV/view>

⁵⁶ Carmelo Rios, “Congress can save taxpayer money by avoiding Medicaid cliff in Puerto Rico”, April 10, 2017, available at <https://thehill.com/blogs/congress-blog/politics/328138-congress-can-save-taxpayer-money-by-avoiding-medicaid-cliff-in>

providing Puerto Rico with equal treatment for federal health and human service programs is not only the right thing to do, it is also the fiscally responsible option.”⁵⁷

Disaster Recovery and Reconstruction

Amidst wrestling with a historic economic, fiscal, and demographic crisis, Hurricanes Irma and Maria⁵⁸ pummeled Puerto Rico in September 2017 causing \$90 billion in damages⁵⁹, according to the National Oceanic and Atmospheric Administration (“NOAA”).⁶⁰ Only Katrina (2005) and Harvey (2017) produced greater damage. Critical infrastructure systems, including the island’s healthcare infrastructure, suffered terrible losses. All of the Puerto Rico Electric Power Authority’s (“PREPA”) clients lost their electricity, some for an entire year.⁶¹ Almost all of the island’s hospitals, 92%, were devastated by the hurricanes, and many had to rely on diesel-fueled generators until power was restored.⁶² Many patients had to leave the island to receive adequate treatment in the mainland for their chronic health conditions, due to the lack of electricity and water in certain regions, among other reasons. The aftermath of the hurricanes made clear the importance of having a strong network of long-term care facilities to assist the elderly, who were disproportionately impacted by the hurricanes. The hurricanes also heightened income inequality dynamics, disproportionately impacting the poor.⁶³ The high levels of income and wealth disparities on the island became more conspicuous in the aftermath of the hurricanes, with those in the lower end of the income distribution having less capacity to recover and effectively cope with a myriad of challenges in the aftermath of the hurricanes.

The emotional and psychological impact of disasters should also be acknowledged. The trauma, fear, and anxiety disaster situations engender put a significant strain on people’s mental health.⁶⁴ In a study on Hurricane Katrina survivors, researchers found the “prevalence of probable serious mental illness doubled, and nearly half of the respondents exhibited probable PTSD.”⁶⁵ The same study found that “long-term health and mental health services are needed for low-income disaster survivors, especially those

⁵⁷ Impactivo Consulting, “Weighing the Effects of the Mass Exodus of Puerto Ricans to the U.S. on Health System Funding - How economic, social service and political trends and repercussions justify increased investments”, January 2018, available at <https://impactivo.com/index.php/2018/01/31/weighing-the-effects-of-the-mass-exodus-of-puerto-ricans-to-the-u-s-on-health-system-funding/>

⁵⁸ See Federal Emergency Management Administration’s (FEMA) 2017 Hurricane Season FEMA After-Action Report, July 12, 2018, available at <https://www.fema.gov/media-library-data/1531743865541-d16794d43d3082544435e1471da07880/2017FEMAHurricaneAAR.pdf>

⁵⁹ Include the United States Virgin Islands.

⁶⁰ National Oceanic and Atmospheric Administration, “National Hurricane Center Tropical Cyclone Report: Hurricane Maria”, February 14, 2019, available at https://www.nhc.noaa.gov/data/tcr/AL152017_Maria.pdf

⁶¹ The Rhodium Group found that Hurricane Maria in Puerto Rico produced the largest blackout in U.S. history (measured in customer-hours of lost electricity), and the second largest in the world, available at <https://rhg.com/research/puerto-rico-hurricane-maria-worlds-second-largest-blackout/>

⁶² See CNE’s Policy Paper “Puerto Rico’s Unfinished Business After Maria”, October 2018, available at <http://grupocne.org/wp-content/uploads/2018/10/CNE-Policy-Paper-Puerto-Ricos-Unfinished-Business-After-Hurricane-Mari%CC%81a-.pdf>

⁶³ Brookings, “Hurricanes hit the poor the hardest”, September 18, 2017, available at <https://www.brookings.edu/blog/social-mobility-memos/2017/09/18/hurricanes-hit-the-poor-the-hardest/>

⁶⁴ Kaiser Family Foundation, “Views and Experiences of Puerto Ricans One Year After Hurricane Maria”, September 2018, available at <http://files.kff.org/attachment/Report-Views-and-Experiences-of-Puerto-Ricans-One-Year-After-Hurricane-Maria>

⁶⁵ Rhodes, J., Chan, C., Paxson, C., Rouse, C. E., Waters, M., & Fussell, E. (2010). The impact of Hurricane Katrina on the mental and physical health of low-income parents in New Orleans. *American journal of orthopsychiatry*, 80(2), 237. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276074/>

who experience disaster-related stressors and loss.” Addressing this important issue would put additional pressure on an already highly strained healthcare system.

Poverty and Income Disparities of the Disabled Population

Children and adults with disabilities, including those with physical conditions, intellectual or developmental disabilities, and serious behavioral disorders or mental illness, depend on Medicaid for critically important healthcare services.⁶⁶ For people with disabilities with limited income, Medicaid often serves as their only or primary health insurance plan. Almost half of the Puerto Rican population with any disability in 2017 earned less than 100% of the federal poverty level, compared to 21.3% in the U.S.

Less Than 100 Percent of the Federal Poverty Level					
	Puerto Rico	Mississippi	Florida	New York	US
Total population	44.90%	21.50%	15.50%	15.10%	14.60%
Under 18 years	57.30%	30.20%	22.30%	21.30%	20.30%
18 to 64 years	42.10%	19.90%	14.80%	13.90%	13.70%
65 years and older	39.80%	13.10%	10.30%	11.50%	9.30%
With any disability	49.40%	26.80%	20.30%	24.10%	21.30%

Source: 2013-2017 American Community Survey 5-Year Estimates

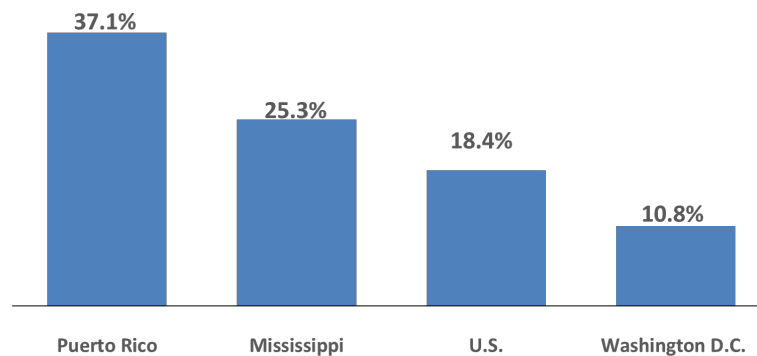
Health Status and Disparities

The lack of adequate federal funding for Puerto Rico’s Medicaid program is one factor leading to a number of health status disparities. While certain health indicators of Puerto Rico are comparable to the U.S. mainland, many others compare unfavorably. Life expectancy at birth in Puerto Rico is slightly higher than in the U.S., Puerto Rico’s reaching 79.97 years in 2017⁶⁷, while the U.S. life expectancy was 78.6 years. On the other hand, self-reported health indicators of Puerto Rico, as gathered by the Behavioral Risk Factor Surveillance System, are significantly worse. The percent of adults reporting fair or poor health from 2013 to 2017 has consistently been much higher in Puerto Rico, reaching 37.1% in 2017. Mississippi, one of the poorest states in the union, registered 25.3% in 2017, while for the U.S. the percentage reporting fair or poor health was 18.4% in 2017. The healthiest jurisdiction, according to this indicator, was the District of Columbia with a score of 10.8% in 2017.

⁶⁶ <http://nls.org/Disability/SocialSecuritySSIWorkIncentives/PolicyandPracticeBriefs/PP24>

⁶⁷ World Bank, Life Expectancy at Birth, Total for Puerto Rico, retrieved from FRED, Federal Reserve Bank of St. Louis, available at <https://fred.stlouisfed.org/series/SPDYNLE00INPRI>.

Self-Reported Health Indicators: Percent of Adults Reporting Fair or Poor Health (2017)



Source: Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2013-2017 Survey Results

Puerto Rico also faces higher rates of chronic conditions than the U.S. According to Centers for Disease Control and Prevention (“CDC”) data from the Behavioral Risk Factor Surveillance System (“BRFSS”), the prevalence of diabetes in Puerto Rico in 2017 was 17.2%, 14.2% in Mississippi, and 10.6% in Florida. The median for the U.S. was 10.5%. According to a study by Mattei et al. (2018) “Disparities in common chronic conditions also exist, with prevalence of 42% in Puerto Rico vs. 31% in U.S. for hypertension; 39% vs. 36% for high cholesterol, 16% vs. 10% for diabetes; and 9% vs. 6% for coronary heart disease or myocardial infarction; additionally, 66% of island residents have self-reported body mass index (“BMI”) consistent with overweight or obesity.”⁶⁸ A more robust healthcare system with adequate federal funding for primary care could help mitigate the high prevalence of chronic conditions on the island.

Chronic Health Indicators (2017)			
	Diabetes prevalence(1)	Asthma(2)	High Blood Pressure(3)
Puerto Rico	17.20%	12.20%	44.70%
Mississippi	14.20%	8.30%	40.80%
Florida	10.60%	7.50%	34.60%
U.S. (All states, D.C., and territories)	10.50%	9.40%	32.30%

(Median)

(1) Have you ever been told by a doctor that you have diabetes?

(2) Adults who have been told they currently have asthma

(3) Adults who have been told they have high blood pressure

Source: CDC, Behavioral Risk Factor Surveillance System (BRFSS)

⁶⁸ Josiemer Mattei, Martha Tamez, Carlos F. Ríos-Bedoya, Rui S. Xiao, Katherine L. Tucker and José F. Rodríguez-Orengo, “Health conditions and lifestyle risk factors of adults living in Puerto Rico: a cross-sectional study”, in BMC Public Health (April 12, 2018) available at <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5359-z>

Puerto Rico Healthcare Reform

On May 9, 2019, the FOMB certified its own fiscal plan⁶⁹, after rejecting the government of Puerto Rico's proposed fiscal plan submitted on March 10, 2019.⁷⁰ In this latest certified fiscal plan⁷¹, the FOMB requires the government to execute an ambitious and aggressive revamping of Puerto Rico's Medicaid program that ultimately results in \$638 million in run-rate savings by FY 2024 (off the FY 2024 baseline of \$3.3 billion). This savings target was reduced from an initial target of more than \$800 million by FY 2023.

As noted by Kaiser Family Foundation, "the fiscal plan calls for Medicaid cost containment measures such as reduced per member per month ("PMPM") payments to MCOs; new care programs for high-cost, high-need ("HCHN") enrollees; fraud and abuse reduction mechanisms; and provider fee reductions. Additional benefit cuts or increases in beneficiary copays could result if savings targets are not achieved."⁷² The government of Puerto Rico had warned that "meeting the original targets would require undue hardship to the Medicaid population in the form of service reductions." Given that the Medicaid program in Puerto Rico is already poorly funded and spending per enrollee is significantly lower than in any state, any funding reduction would likely result in "undue hardship to the Medicaid population."

The certified fiscal plan mandates the consolidation of six of the healthcare agencies into one Department of Health to achieve net savings of \$98 million by FY2024: The Department of Health ("DOH"), Medical Services Administration ("ASEM"); Health Insurance Administration ("ASES"); Mental Health and Addiction Services Administration; Puerto Rico and the Caribbean Cardiovascular Center Corporation; and Center for Research, Education, and Medical Services for Diabetes. According to the plan, "DOH must achieve \$73.9 million in personnel savings, \$36.9 million in non-personnel savings, \$8.9 million in compensation measures, and \$2.3 million in utility savings by FY2020.

While underscoring the need to reduce premium healthcare costs and criticizing the increase of PMPM disbursements by 6.3% from FY2017 to FY2018 and the projected increase of 32% from FY2018 to FY2024, the fiscal plan glaringly fails to mention that Medicaid spending per

⁶⁹ FOMB, "2019 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity", May 9, 2019, available at <https://drive.google.com/file/d/13wuVn04--JKMEPKu-u-djZJHqTK-55aV/view>

⁷⁰ The FOMB sent a letter to the Governor of Puerto Rico on March 15, 2019 outlining all the revisions required to for the fiscal plan to comply with PROMESA, including changes related to Medicaid. It requested the governor to exclude unlegislated sources of federal funds for Medicaid, provide information on assumptions related to a forecasted drop in Medicaid enrollment, provide information on assumptions related to population and PMPM expense growth, and on the Medicaid modeling methodology employed. For the full letter see https://drive.google.com/file/d/1sbw4T59Ez9YTKlq_KA0trQMlrYmGFeQo/view

⁷¹ The fiscal plan does not include unlegislated sources of federal funds for Puerto Rico's Medicaid program. If Congress were to provide additional funds beyond the capped allotment (Section 1108 caps), the FOMB would need to certify a new fiscal plan given the big impact more Medicaid funds would have on the fiscal plan's final outcome.

⁷² Kaiser Family Foundation, "Medicaid Financing Cliff: Implications for the Health Care Systems in Puerto Rico and USVI", May 21, 2019, available at <https://www.kff.org/report-section/medicaid-financing-cliff-implications-for-the-health-care-systems-in-puerto-rico-and-usvi-issue-brief/>

enrollee already is a fraction of that in the U.S. As explained above, projected Medicaid per capita benefit spending per full-year equivalent in Puerto Rico in FY2020 will be an estimated \$2,144, compared to a median in the U.S. of \$6,763, more than three times spending in Puerto Rico.⁷³ The distribution of Medicaid spending per full-year equivalent for FY2020 for all 50 states and D.C. fluctuated from a minimum of \$3,342 to \$13,429.⁷⁴ Similarly, according to Levis-Peralta et al. (2016), the average Medicaid PMPM payment in Puerto Rico in 2015 was \$167, compared to \$482 in the U.S., almost three times more.⁷⁵ Given the already relatively low Medicaid spending per enrollee, further “bending the curve” on premium inflation seems quite draconian and unrealistic.

The fiscal plan states that: “Starting in September 2019, however, the Commonwealth will hit a ‘Medicaid cliff’ whereby it will be responsible for multi-billion-dollar annual healthcare expenditures unseen since the Affordable Care Act provided additional federal funding in 2011. It is crucial, therefore, that ASES take advantage of the additional runway provided by the BBA funding to put in place reforms that reduce long-term health expenditure growth rates.”⁷⁶ It is impossible to sustain Puerto Rico’s current Medicaid program without additional federal funding beyond the imminent September 2019 fiscal cliff. No amount of reforms would avoid a collapse of Puerto Rico’s healthcare system.

The fiscal plan “does not preclude the possibility of optional benefit reductions and cost-sharing” if targeted savings are not met. However, it fails to mention that Puerto Rico already does not offer all of the mandatory services, and does not offer many of the optional services other jurisdictions do. Among the optional services that are offered in Puerto Rico are prescription drugs and dental services. Given the limited discretionary income of Medicaid enrollees, shifting the burden of purchasing prescription medications on them would be cruel and inhumane.

In FY2020 prescription drugs expenditures are expected to reach \$808.6 million while dental expenditures are forecast at \$65.4 million. Assuming a total of 1,253,289 full-year equivalent enrollees, Medicaid beneficiaries would have to cover an average of roughly \$700 annually for their prescription drugs and dental services. The relatively high cost of living in Puerto Rico would make their financial situation untenable. Furthermore, the federal government has restrictions on cost-sharing arrangements given that Medicaid beneficiaries are generally low-income, financially needy populations.

⁷³ MACPAC, “Draft of Mandated Report: Medicaid in Puerto Rico”, April 12, 2019, available at <https://www.macpac.gov/wp-content/uploads/2019/04/Draft-of-Mandated-Report-Medicaid-in-Puerto-Rico.pdf>

⁷⁴ MACPAC’s estimates exclude Medicaid-expansion CHIP enrollees, spending for administration, and long-term services and supports (LTSS). The estimates also adjust for differences in enrollment mix across states and Puerto Rico, matching states’ enrollment mix across eligibility groups to Puerto Rico’s.

⁷⁵ Urban Institute, “Puerto Rico Health Care Infrastructure Assessment: Site Visit Report”, January 2017, available at https://www.urban.org/sites/default/files/publication/87011/2001050-puerto-rico-health-care-infratructure-assessment-site-visit-report_1.pdf

⁷⁶ Financial Oversight and Management Board for Puerto Rico, “2019 Fiscal Plan for Puerto Rico: Restoring Growth and Prosperity”, May 9, 2019, available at <https://drive.google.com/file/d/13wuVn04--JKMEPKu-u-djZJHqTK-55aV/view>

Patient cost-sharing is not a viable option given the tightly constrained discretionary income of Medicaid beneficiaries. Although the Deficit Reduction Act of 2005 grants flexibility to states to limit benefits, coverage, and payments for medically necessary health care, there are limits on cost-sharing arrangements for “children, pregnant women, and certain populations who experience high health care needs.” As stated by the Social Security Act, the core purpose of the Medicaid program is “to furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” Eligible Medicaid beneficiaries are participants of the program precisely because they have insufficient income and resources to provide themselves with adequate healthcare services.

In sum, given that Puerto Rico’s Medicaid program is not adequately funded and spending per enrollee is significantly lower than the lowest spending state, any cuts to the program will result in undue hardships to the Medicaid population, including an increase in otherwise preventable deaths.

Part III: Policy Recommendations and Conclusion

The lack of equitable federal funding of Puerto Rico's Medicaid program has had and continues to have adverse, far-reaching consequences on Puerto Rico's healthcare system, broader economy, healthcare professionals, and its most vulnerable populations.

This unequal treatment has historically placed an undue fiscal burden on the island's limited budget, contributing to its unsustainable debt levels and fiscal distress. It has also negatively affected access to and quality of care, ultimately leading to subpar health outcomes. Furthermore, it has contributed to the shortage of healthcare professionals and their exodus to the U.S. mainland searching for more opportunities and higher incomes.

The government of Puerto Rico, for example, has been forced to absorb a larger share of Medicaid program costs than other U.S. states. Those circumstances, coupled with the island's dire economic and fiscal conditions, have stretched resources thin. There is simply no room for additional cuts. Of the total 17 mandatory benefits provided in other US jurisdictions, Puerto Rico already only offers 10.

Healthcare providers are reimbursed at much lower rates than their U.S. mainland counterparts. The Medicaid provider reimbursement rate in Puerto Rico for primary care services was 19% of the Puerto Rico Medicare fee compared to 66% in the U.S. Similarly, maternity services were reimbursed at 50% of the Puerto Rico Medicare fee vs. 81% in the U.S. Additionally, average benefit spending per full year enrollee in Puerto Rico will be an estimated \$2,144 in FY2020, representing 64% of the lowest per capita spending state (\$3,342), 32% of the median (\$6,763), and 16% of the highest per capita spending state (\$13,429).

Absent any immediate federal action, Puerto Rico will be forced to reduce the total eligible population and benefits offered to Medicaid beneficiaries, further worsening access to care, quality of care, and health outcomes. If adequate and needed investments towards a robust healthcare system are to be made, they would help mitigate the high prevalence of chronic conditions, stem the exodus of service providers, and ensure access to basic life-saving healthcare to those who need it the most.

During the last decade, Congress has enacted legislation to provide limited, temporary supplemental funding and avoid a massive healthcare crisis. In the coming weeks, Puerto Rico will be faced once again with the possibility of a massive healthcare crisis, one that affects over 1.5 million U.S. citizens.

Now, more than a last-minute temporary fix is needed to provide Puerto Rico with a reliable and sustainable healthcare system. The urgency cannot be overstated. Having Puerto Rico's most vulnerable populations suffer through another shock which can be averted is callous and morally wrong. A permanent, long-term fix to Puerto Rico's Medicaid program is needed to guarantee comprehensive, accessible, quality care to low-income families, children, the elderly, and people with disabilities.

Congress must act quickly and provide a permanent solution for Puerto Rico's Medicaid funding cliff to:

- **remove the federal cap on Medicaid funding; and**
- **compute the FMAP using the same average per capita income-based formula as done for the states.**

To ensure that the most vulnerable populations of Puerto Rico have access to a more robust, predictable, reliable, and accessible Medicaid healthcare system, anything other than a permanent fix is inadequate.

Annex 1: Mandatory and Optional Medicaid Benefits

Mandatory and Optional Medicaid Benefits Covered and Not Covered by Puerto Rico (FY 2018)

Mandatory Benefits

- ✔ Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services for individuals under age 21
- ✔ Inpatient hospital services
- ✔ Laboratory and x-ray services
- ✔ Medial or surgical services by a dentist
- ✔ Outpatient hospital services
- ✔ Physician services
- ✔ Tobacco cessation for pregnant women
- ✔ Family planning services
- ✔ Federal Qualified Health Center ("FQHC") services
- ✔ Rural health clinic services

✔ Covered

⊗ Not Covered

- ⊗ Home health services for those entitled to nursing facility services
- ⊗ Non-Emergency Medical Transportation ("NEMT")
- ⊗ Certified pediatric and family nurse practitioner services
- ⊗ Nurse midwife services
- ⊗ Nursing facility services for individuals age 21 or older
- ⊗ Emergency services for legalized aliens and undocumented aliens
- ⊗ Freestanding birth center services

Optional Benefits

- ✔ Clinic services
- ✔ Dental services
- ✔ Eyeglasses and prosthetics
- ✔ Outpatient prescription drugs
- ✔ Physical therapy and related services
- ✔ Diagnostic, screening, preventive, and rehabilitative services
- ✔ Inpatient psychiatric hospital services for individuals under age 21
- ✔ Inpatient hospital services for individuals age 65 or older in an Institution for Mental Diseases ("IMD")

- ⊗ Hospice care
- ⊗ Private duty nursing services
- ⊗ Intermediate care facility for individuals with intellectual disabilities
- ⊗ Personal care services
- ⊗ Targeted case management services

Source: Government Accountability Office (2016) and MACPAC (June 2019)

Annex 2: The Perils of Medicaid Block Grant and Per Capita Allotment Proposals

There have been numerous legislative proposals since the 1980s to change the financing structure of Medicaid from an open-ended matching grant entitlement program to a capped block grant (Lambrew 2005).⁷⁷ Some have also proposed a Medicaid per capita where states would receive a set amount for each Medicaid enrollee. Both the Medicaid per capita cap model and block grant would likely have significant negative implications for the program.⁷⁸

Block grants may be defined as “fixed-sum federal grants to state and local governments that give them broad flexibility to design and implement designated programs.”⁷⁹ Those who advocate for block grants argue that programs are more cost-effective, provide greater federal budget certainty, and give states and local governments greater flexibility to design their programs to suit their specific needs and idiosyncrasies. However, they have become tools for funding reductions to important social programs. As stated by Stenberg (2008), “although originally touted as vehicles for unshackling the states to achieve more creative and effective public management, block grants in the 1980s and 1990s increasingly morphed into tools for cutting the federal government’s costs.”

One of the problems with traditional block grants is that they are cyclical, meaning that they are independent of the performance of the overall economy and therefore do not adjust positively or negatively to the business cycle (Clemens and Ippolito, 2017).⁸⁰ The current Medicaid matching grant structure is countercyclical to a certain extent since federal spending increases if a recession hits, and more people are eligible to receive Medicaid benefits. As state Medicaid expenditures increase, federal payments increase accordingly and are not bound by a preset limit.

According to the Kaiser Family Foundation 2017 Survey on Medicaid Managed Care⁸¹, there was almost unanimous repudiation of Medicaid financing reforms proposals such as blocks grants or per capita caps.

“Plans were almost universally negative when responding to an open-ended question about federal Medicaid financing reform proposals (block grants or per capita caps). Responses described a multitude of anticipated beneficiary impacts, such as decreased enrollment, decreased or reduced benefits, and provider rate cuts that may lead to reduced provider participation/access. Some plans also specifically indicated that a block grant or per capita cap may put them at risk financially, lead to negative margins, or compromise the actuarial soundness of capitation rates.”

⁷⁷ Jeanne M Lambrew, “Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals”, March 2005, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690386/>

⁷⁸ Center for Law and Social Policy, “Medicaid Financing: Dangers of Block Grants and Per Capita Caps Lessons from TANF and CCDBG”, February 2017, available at <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/Medicaid-Financing-Dangers-of-Block-Grants-and-Per-Capita-Caps.pdf>

⁷⁹ Urban Institute, “Block grants: Historical Overview and Lessons Learned”, April 21, 2004, available at <http://webarchive.urban.org/publications/310991.html>

⁸⁰ Jeffrey Clemens and Benedic Ippolito, “Implications of Medicaid Financing Reform for State Government Budgets”, February 15, 2018, available at <https://econweb.ucsd.edu/~j1clemens/pdfs/BlockGrants>

⁸¹ Kaiser Family Foundation, “Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans”, March 5, 2018, available at <https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-executive-summary/>

The Center for a New Economy (CNE) is Puerto Rico's first and foremost policy think tank, an independent, nonpartisan group that advocates for the development of a new economy for Puerto Rico. Over the last 20 years, CNE has championed the cause of a more productive and stable Puerto Rico through its offices in San Juan, Puerto Rico and Washington, D.C. We seek to inform current policy debates and find solutions to today's most pressing and complex economic development problems by rigorously analyzing hard data and producing robust empirical research. CNE is organized as a 501(c)(3) nonprofit that does not solicit or accept government funding. It relies solely on funding by individuals, private institutions and philanthropic organizations.



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