Chapter 5:

Mandated Report—Medicaid in Puerto Rico

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Key Points

- Medicaid is central to health care in Puerto Rico, covering almost half of the population in 2017.
- Puerto Rico is generally considered a state for Medicaid purposes. It is subject to most federal requirements and shares many of the same roles, responsibilities, and administrative structures as other Medicaid programs.
- Medicaid in Puerto Rico operates in a challenging environment of widespread poverty, high prevalence of chronic illness, and poor economic conditions worsened by hurricanes in September 2017.
- The statutorily defined Medicaid financing parameters—a capped allotment and a 55 percent federal matching rate—have resulted in chronic underfunding of the program.
- Underfunding has led Puerto Rico to establish more limited benefit packages and lower income eligibility levels, set lower provider payment levels, and adopt and upgrade key administrative systems and processes more slowly than other states.
- Additional federal funds provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) and the Bipartisan Budget Act of 2018 (P.L. 115-123) have allowed Puerto Rico to continue providing services to enrollees and strengthen its administrative capacity.
- Despite this additional federal funding, spending remains constrained. For fiscal year (FY) 2020, projected spending per full-year equivalent enrollee is 38 percent lower than the state with the lowest spending, even after adjusting for differences in enrollment mix and covered benefits.
- Expiration of these additional funds in September and December 2019 will result in a federal funding shortfall of at least $1.01 billion in FY 2020.
  - At current enrollment, Puerto Rico could eliminate optional prescription drug and dental benefits and still not achieve the level of savings needed.
  - To continue benefits at current levels, Puerto Rico would have to reduce enrollment by 36 to 53 percent.
- Although full exhaustion of federal funds may not occur until March 2020, Medicaid will be affected earlier due to uncertainty about future availability of funds.
- An additional infusion of temporary funds would keep Medicaid afloat but would not address underlying issues with the program or its financing structure, and would not support program administrators in planning and implementing program improvements.
- Over the long term, reliable, sustainable access to care for the Medicaid population will likely require changes to the existing financing arrangement that provide a higher level of federal investment over a longer period of time than past interventions.

CHAPTER 5: Mandated Report—Medicaid in Puerto Rico

In the report accompanying the fiscal year (FY) 2019 Labor, Health and Human Services, and Education funding bill, the House Committee on Appropriations requested that MACPAC examine possible options for ensuring long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico. Puerto Rico's Medicaid program operates in a challenging environment, characterized by high rates of poverty and poor economic conditions that were worsened by Hurricanes Irma and Maria in September 2017. In particular, the program's financing structure has resulted in chronic underfunding. The territory has a capped federal allotment that does not change in response to internal or external program cost drivers; moreover, territorial expenditures are statutorily matched at only 55 percent up to the capped allotment amount. As a result, Puerto Rico has historically taken on a larger share of program costs than would be expected given its statutory matching rate; moreover, total spending is constrained to a greater degree than any state. Although Congress has at times provided Puerto Rico with additional federal Medicaid funding, these supplements have always been time-limited, reacting to immediate needs without addressing long-term needs.

This chapter responds to the Appropriations Committee's request by analyzing Puerto Rico's Medicaid program and the factors affecting its future. We begin by providing background information on Puerto Rico, including its relationship to the federal government of the United States, the economic and fiscal challenges it is experiencing, and health indicators of its population. We then describe Puerto Rico's Medicaid program, focusing on program administration, eligibility, covered benefits, and the delivery system. We also highlight its financing arrangement and how it differs from the one used in the 50 states and District of Columbia. Subsequent sections analyze historical and future spending in a variety of different policy scenarios. Given that Puerto Rico is facing a major reduction in federal Medicaid funding beginning in September 2019 and full exhaustion of federal Medicaid funds as early as December 31, 2019 (also referred to as the fiscal cliff), we also highlight the implications of the spending reductions expected to occur if Congress does not act, including major cuts to benefits and enrollment.

The fiscal cliff has important implications for Puerto Rico's ability to provide services to Medicaid beneficiaries over the long-term. Puerto Rico faced similar financing challenges in 2011, 2017, and 2018, when additional temporary federal funds were set to expire or be exhausted; these challenges were averted with last-minute infusions of federal funds. These cycles of crisis and congressional response have caused a great deal of uncertainty and make it difficult for the Puerto Rico to make long-term plans or improvement efforts. Although an additional time-limited allotment of federal funds would prevent a fiscal cliff and shock to Puerto Rico's health system in 2020, it would not address existing challenges with Puerto Rico's Medicaid financing structure or support Puerto Rico's ability to plan, manage, and sustain an effective Medicaid program that offers long-term, reliable access to care for its beneficiaries.

Background

Puerto Rico is the oldest and most populous U.S. territory with a population of 3.2 million in 2018 (Census 2019). It is comprised of one main island and six smaller ones.

Relationship to the federal government

Puerto Rico's relationship to the federal government has evolved over time. It was declared an unorganized territory of the U.S. in 1898 following the Spanish-American War, and Puerto Ricans were granted U.S. citizenship in 1917 with the passage of the Jones Act (P.L. 64-368). Puerto Rico was established as a commonwealth of the United States in 1948 after Congress approved the Constitution of Puerto Rico (Webber 2017).

As a U.S. territory, Puerto Rico is subject to congressional authority, though it retains authority for most matters of internal governance. In general, U.S. law applies to Puerto Rico unless otherwise indicated. Puerto Ricans may travel to or establish residency in any state on the mainland without restriction. While residing in the territory, they cannot vote in U.S. presidential elections and do not have a voting representative in Congress. Puerto Ricans generally do not pay federal income taxes except on income over a filing threshold from sources outside of Puerto Rico; however, they pay most other federal taxes, including Medicare and Social Security taxes imposed by the Federal Insurance Contributions Act and unemployment taxes imposed by the Federal Unemployment Tax Act (IRS 2016). They are eligible for many federal programs, including Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), but are ineligible for others including Supplemental Security Income (GAO 2014).

Historically, Congress has determined whether and how to apply federal laws or programs to Puerto Rico on a case-by-case basis (GAO 2018). Many of the decisions about the treatment of Puerto Rico were made in the early and middle portions of the 20th century, and have not been adjusted since.

Economy

Although the effects of Hurricane Maria on Puerto Rico's economy and infrastructure have garnered media attention, Puerto Rico has long experienced significant structural, fiscal, and economic challenges.

Economic decline. Puerto Rico's economic challenges have compounded over the last two decades. The commonwealth experienced a major economic decline beginning in 2006. A key contributor to this decline was the phasing out of federal tax breaks important to the private sector beginning in the mid-1990s (FOMB 2018, Perreira et al. 2017). In every year since 2005, the economy has contracted: between 2005 and 2015, real gross domestic product (GDP) decreased by 8 percent and labor force participation decreased by 9 percent (IMF 2018, ASPE 2017). Today, manufacturing remains Puerto Rico's most important economic sector, accounting for approximately half of GDP in 2017 (BDE 2019). However, manufacturing employment has declined in every year since 2006 and is projected to decline by over 10 percent between 2014 and 2024. Other sectors, including construction and government, have also experienced employment losses (DOLETA 2017).

Puerto Rico's population also declined almost 12 percent between 2010 and 2017, predominantly driven by outmigration of young, working-age adults (FOMB 2018, ASPE 2017). In 2012, individuals age 16–30 made up one-third of those leaving Puerto Rico and one-fifth of the population overall (Abel and Deitz 2014). In 2016, the average age of a person leaving Puerto Rico was 29 (Velázquez-Estrada 2018). This has contributed to the aging of Puerto Rico's population; for example, in 2017, 20 percent of the population was age 65 or older, 4 percentage points higher than the U.S. average and higher than in all states except Florida and Maine (Census 2017). Consistent with this overall trend, Puerto Rico expects the Medicaid population to shift into older age brackets over the next several years (FOMB 2018). Outmigration trends have become even more pronounced following the hurricanes: between 2017 and 2018, Puerto Rico lost an estimated 123,399 residents to outmigration, almost double the amount observed in the previous three years (Census 2017).

Debt burden. The government of Puerto Rico faces a substantial debt burden. As tax revenue declined, Puerto Rico used bonds to finance services and general government operations, including its share of Medicaid program costs. By 2017, this amounted to $74 billion in bond debt and an additional $49 billion in unfunded pension obligations (FOMB 2018, Kobre & Kim 2018).

In response to the growing debt crisis, Congress passed the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA, P.L. 114-187) in June 2016. PROMESA created the Financial

Oversight and Management Board (FOMB), which was given discretion over the territory's budget and financial plans and the power to force debt restructuring with bondholders and other creditors.[1] As part of the fiscal plan certified in October 2018, the board established significant spending reduction targets across a wide range of areas and programs, including Medicaid (FOMB 2018).[2] Many stakeholders have expressed concern that these austerity measures, along with other actions taken by the board, are too aggressive, and will impede Puerto Rico's economic recovery (Torres 2018, Varney and Heredia Rodriguez 2018, Rosello 2017). Although the board signaled its willingness to reduce some spending reduction targets (including those for Medicaid) in March 2019, negotiations to establish revised targets are ongoing (AAFAF 2019a, b; FOMB 2019).

Economic indicators. Key economic indicators are significantly worse for families in Puerto Rico than in the United States overall. For example, in 2017:

- the unemployment rate was 16.4 percent in Puerto Rico versus 5.3 percent in the United States overall;
- the poverty rate was 44.4 percent versus 13.4 percent; and
- the median household income was $19,343 versus $60,336 (Census 2017).

It is important to note that the cost of living in Puerto Rico is high. The overall cost of living in the San Juan metropolitan area is currently slightly higher (0.6 percent) than the average of other metropolitan areas of the U.S. This represents a decrease from previous years: between 2015 and 2017, the cost of living in San Juan ranged from 6.7 to 15.4 percent higher than in other areas of the United States. San Juan consistently ranks in the top four most expensive cities in the United States for public utilities (surpassed only by cities in Hawaii and Alaska) and among the top 15 for supermarket items (IEPR 2015-2018).

Future growth. The government of Puerto Rico, FOMB, and others have described proposals to generate economic growth, including investments in infrastructure, reforms to public programs such as nutritional assistance, implementation of a local earned income tax credit program, and policies to promote ease of doing business. Many have pointed to the tourism industry as a potential source for economic growth, which currently generates 7 percent of GDP (WTTC 2019, FOMB 2018, Resnick-Ault and Brown 2018). However, Puerto Rico is still working to rebuild its infrastructure following Hurricanes Maria and Irma, including infrastructure needed to support tourism. Other factors inhibiting economic growth include an inadequate power grid, the current set of labor market regulations, and the commonwealth's exclusion from the capital market (FOMB 2018).

Health indicators and insurance coverage

Health indicator status among Puerto Ricans is mixed. Their life expectancy is similar to that of the overall U.S. population (79.3 years compared to 79.7 in 2015) (ASPE 2017). However, they have a higher infant mortality rate and higher prevalence of many chronic conditions—including hypertension, diabetes, and cardiovascular disease—than residents in most or all mainland states. Their self-reported health status is worse than in any mainland state (Table 5-1).

Puerto Rico has a lower overall uninsured rate than the United States as a whole (6.9 percent versus 8.7 percent in 2017), which is largely driven by higher rates of Medicaid coverage (Census 2017). Compared to the mainland, in 2017:

- the share of Puerto Ricans covered by Medicaid was more than twice as high (46.9 percent compared with 20.6 percent);
- the share of Puerto Ricans covered by Medicare was 40 percent higher (24.3 percent compared with 17.3 percent);

TABLE 5-1. Selected Health Indicators for Puerto Rico compared to U.S. Mainland States, Selected Years

Indicator	Puerto Rico	State median	State minimum	State maximum
Infant mortality rate, 2015 (per 1,000 live births)	7.6	5.9	4.2	9.3
Self-reported health status, 2017 (percent reporting fair or poor health)	37.1	17.7	10.8	25.9
Chronic disease prevalence, 2017				
Hypertension	44.7	32.3	24.4	43.5
Diabetes	17.2	10.5	7.1	14.2
Cardiovascular disease	7.2	3.9	1.9	7.4

Sources. ASPE 2017, CDC 2019a, b.

- 61.3 percent of Puerto Ricans had some form of public health insurance coverage compared with 35.5 percent of Americans overall; and
- only 38.9 percent of Puerto Ricans had private insurance (employer-sponsored or direct purchase) compared with 67.6 percent of the U.S. population (Census 2017).[3]

Due in part to the high insurance coverage rate, Puerto Ricans generally report being able to afford health care services when they are available (ASPE 2017).

Overview of Puerto Rico's Medicaid Program

Medicaid is a central part of the safety net and health care system in Puerto Rico, covering almost half (47 percent) of the population in 2017, or 1.6 million people (Census 2017). This figure is comprised of approximately 1.3 million enrollees covered by Medicaid (including about 250,000 dually eligible individuals) plus approximately 88,000 Medicaid-expansion CHIP enrollees plus an additional 145,000 enrollees covered with commonwealth-only funds (DS 2018).[4]

In general, Puerto Rico is considered a state for the purposes of Medicaid unless otherwise indicated (§ 1101(a)(1) of the Social Security Act (the Act)).

The Medicaid program in Puerto Rico is subject to most federal requirements and shares many of the same roles, responsibilities, and administrative structures as other Medicaid programs. For example:

- Medicaid provides health insurance coverage to enrolled individuals;
- eligibility for Medicaid is determined on an individual basis using modified adjusted gross income (MAGI);
- the commonwealth contracts with managed care organizations (MCOs) to deliver covered health services to enrolled populations; and
- the commonwealth oversees managed care plans, carries out program integrity functions, and reports data and other information to the Centers for Medicare & Medicaid Services (CMS).

The most significant difference in Puerto Rico's Medicaid program from Medicaid programs in the 50 states and District of Columbia is the capped allotment financing structure. Additionally, Puerto Rico has a statutorily defined federal medical assistance percentage (FMAP) of 55 percent. Although this financing structure also applies to the other four U.S. territories, there are significant differences in the design and structure of their programs (Box 5-1).

BOX 5-1. Medicaid in the U.S. Territories

Medicaid and the State Children's Health Insurance Program (CHIP) operate in the five U.S. territories—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. The Medicaid financing structure works similarly in all five: each territory has an annual Section 1108 capped allotment and a statutorily specified federal medical assistance percentage (FMAP) of 55 percent. However, the territories have chosen to operate their programs differently.

Guam and the U.S. Virgin Islands share similar program structures to Puerto Rico and the states: they use modified adjusted gross income (MAGI) to determine eligibility and cover individuals with income up to 133 percent of the local poverty level. Medicaid functions as health insurance coverage to these individuals, and services are delivered through fee-for-service Medicaid. They are subject to most federal Medicaid rules unless otherwise specified.

The Northern Mariana Islands and American Samoa operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§ 1902(j) of the Social Security Act). This provision allows the Secretary of Health and Human Services to waive or modify almost any Medicaid requirement, and allows these two territories to use alternative program structures.

- In American Samoa, Medicaid eligibility is not determined on an individual basis and there is no enrollment process. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with income that would have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent of the federal poverty level (FPL).
- The Northern Mariana Islands, the only territory participating in Supplemental Security Income (SSI), uses that program's income and asset standards to determine Medicaid eligibility, covering individuals who meet up to 150 percent of income and resource requirements for SSI but are not necessarily disabled.

In American Samoa, Guam, and the Northern Mariana Islands, the vast majority of all services are provided by each territory's one public hospital. Only Guam provides all mandatory Medicaid benefits, though all offer some optional benefits such as dental services and outpatient prescription drugs.

The financing arrangement has been historically insufficient to fund the federal share of Medicaid in all four of these territories, as in Puerto Rico. They similarly struggle with financing the nonfederal share needed to draw down their Patient Protection and Affordable Care Act (ACA, P.L.111-148, as amended) allotments, administrative capacity issues, and building and sustaining health care systems that promote access and quality of care. For more on the other four territories, see *Medicaid and CHIP in the Territories* and individual territory-specific fact sheets (MACPAC 2019b).

Program administration

Puerto Rico's Departamento de Salud administers the territory's public health programs and services, and the Administración de Seguros de Salud de Puerto Rico (ASES) administers the Government Health Insurance Program (GHIP), also called Vital, previously called Mi Salud and Reforma. GHIP

serves as an umbrella program for Medicaid, CHIP (operated as a Medicaid-expansion CHIP program), the Medicare Platino program (a Medicare Advantage program that provides wraparound services and cost sharing assistance for dually eligible individuals), coverage for enrollees whose income is too high to qualify for Medicaid (funded through Puerto Rico-only funds), and optional buy-in coverage for employees or retirees of the commonwealth government (ASPE 2017). GHIP was established in 1993 by the Puerto Rico Health Insurance Administration Act (Law 72) that also shifted much of the publicly financed health care system to the private sector. Prior to this, Puerto Rico provided health care to the vast majority of the population through a decentralized, government-financed system of local and regional hospitals and clinics (HHS 2013).

In recent years, Puerto Rico has taken steps to improve its program administration. It recently completed development of a Medicaid management information system (MMIS), which became operational in 2018 and is compliant and certified to report information to the Transformed Medicaid Statistical Information System (T-MSIS). In early 2019, it established a Medicaid fraud control unit (MFCU) responsible for investigating and prosecuting Medicaid provider fraud and patient abuse and neglect (CMS 2018a). Puerto Rico has also established a recovery audit contractor program, responsible for identifying and correcting improper Medicaid payments (ASES 2019g).[5]

These actions respond to concerns previously identified by Congress, the U.S. Government Accountability Office (GAO), and others. For example, a 2016 GAO report noted that increased federal funding to Puerto Rico merited establishment of a MFCU and reporting of service-level expenditure data (GAO 2016). In the Bipartisan Budget Act of 2018 (BBA, P.L. 115-123), $1.2 billion of the $4.8 billion of additional Medicaid funds was conditional on Puerto Rico making reasonable progress toward establishing methods of collecting and reporting reliable T-MSIS data, and establishing a MFCU (§ 20301(a)(2) of the BBA). Puerto Rico has met these targets on schedule and will receive the full amount of BBA funds (CMS 2018a).

Eligibility

Eligibility rules in Puerto Rico's Medicaid program differ in some ways from those in the states. Puerto Rico is permitted to use a local poverty level to establish income-based eligibility for Medicaid. The Puerto Rico Poverty Level (PRPL) is established in the Medicaid state plan and can be changed by the commonwealth government with CMS approval. Currently, Puerto Rico covers individuals with income up to 138 percent of the PRPL, which is $11,736 annually for a family of four or approximately 46 percent of the federal poverty level (FPL) for a family of the same size in 2019 on the mainland (ASES 2019c, ASPE 2019).

Through Medicaid-expansion CHIP, Medicaid covers children under age 19 whose incomes are below 271 percent PRPL ($23,052 for a family of four in 2019), which was approximately 90 percent FPL for a family of the same size in 2019 (ASES 2019c, ASPE 2019).[6,7] Because individuals residing in Puerto Rico are ineligible for SSI, Medicaid coverage for aged, blind, and disabled individuals is provided through the medically needy option, with a medically needy income level of $400 per month for an individual plus $95 for each additional family member (ASES 2019c).[8]

Additional individuals with incomes up to $22,344 for a family of four, or approximately 87 percent FPL for a family of the same size, are covered through commonwealth-only Medicaid; spending for this population is not matched by the federal government (ASES 2019c, ASPE 2019). Though Puerto Rico could seek CMS approval for policy changes that would permit receipt of federal matching funds for services provided to this population, given the commonwealth's relatively low uninsured rate, it has chosen to use its limited federal Medicaid funding for other priorities (ASES 2019g).

Covered benefits

Although the federal rules for Medicaid benefits generally apply to Puerto Rico, Puerto Rico currently provides only 10 of Medicaid's 17 mandatory benefits, citing insufficient funding and lack of infrastructure. For example, it does not cover nursing facility services (as few such facilities exist), or non-emergency medical transportation. It does, however, provide certain optional benefits, including dental services and prescription drugs (Table 5-2).[9] Small copayments for most services are charged to Medicaid and CHIP beneficiaries with incomes above 50 percent PRPL (CMS 2018a, CMS 2012, CMS 2014a).

Puerto Rico provides some cost sharing assistance to individuals who are dually eligible for Medicare and full Medicaid benefits. It does not provide Medicare cost sharing assistance to individuals who otherwise would qualify as partial dually eligible individuals through Medicare Savings Programs in the states because these programs are not available in Puerto Rico (HHS 2013).

Delivery system

Puerto Ricans tend to access health care in the same ways that people on the U.S. mainland do: in physician offices, health centers, and hospitals. As in many states, benefits are delivered through a managed care delivery system. ASES oversees and directly contracts with MCOs to provide services to beneficiaries.[10] MCOs provide commonwealth-wide acute, primary, specialty, and behavioral health services. They are paid risk-based capitated payments. MCOs contract with primary medical groups, which in turn create preferred provider networks (PPNs) (AAFAF 2018).

TABLE 5-2. Mandatory and Optional Medicaid Benefits Covered by Puerto Rico, FY 2018

	Mandatory Medicaid benefits	Optional Medicaid benefits
Covered	• EPSDT services for individuals under age 21 • Inpatient hospital services • Laboratory and X-ray services • Medical or surgical services by a dentist • Outpatient hospital services • Physician services • Tobacco cessation for pregnant women • Family planning services • FQHC services • Rural health clinic services	• 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 over in an IMD
Not covered	• Home health services for those entitled to nursing facility services • NEMT • Certified pediatric and family nurse practitioner services • Nurse midwife services • Nursing facility services for individuals age 21 and over • Emergency services for legalized aliens and undocumented aliens • Freestanding birth center services	• Hospice care • Private duty nursing services • Intermediate care facility for individuals with intellectual disabilities • Personal care services • Targeted case management services

Notes: EPSDT is early and periodic screening, diagnostic, and treatment. FQHC is federally qualified health center. FY is fiscal year. IMD is institution for mental diseases. NEMT is non-emergency medical transportation. Eyeglasses are provided only under the EPSDT benefit.

Source: GAO 2016.

Effective November 2018, Puerto Rico is implementing a major managed care system restructuring. Under the previous structure, plans provided coverage only to their own specific geographic region and rarely contracted with providers outside the region. Enrollees were not able to make changes to their assigned plan and needed to seek referrals for specialists or out-of-network services, creating access barriers. Under the new structure, plans provide commonwealth-wide coverage. Enrollees are auto-assigned to a health plan but may switch once per year, and no longer need referrals for specialists in their PPN. Enrollees appear to be exercising these new options; however, some reports have noted confusion among beneficiaries about the plan selection and referral processes (ASES 2019g, Rudowitz et al. 2019). Additionally, although plans have met network adequacy standards to date, they have noted challenges recruiting providers and building commonwealth-wide networks because of limited provider supply, constraints on provider payments, and low capitation rates (ASES 2019g, MMAPA 2018, Molina 2018). It is too early to assess the overall effect of the reforms on access, unmet need, or program efficiency.

Financing

Like states, Puerto Rico must contribute its non-federal share of Medicaid spending to access federal funds. However, unlike states, Puerto Rico may draw down federal dollars only up to the annual cap, referred to as the Section 1108 cap.

Puerto Rico's matching rate is set in statute at 55 percent (§ 1905(b) of the Act). Were it determined using the same formula used for states, its FMAP would be the maximum allowable rate of 83 percent (GAO 2014).[11] There are some exceptions to this FMAP: although Puerto Rico cannot claim the newly eligible FMAP available to states expanding to the new adult group, it receives the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which is 93 percent in calendar year 2019 (§ 1905(z)(2) of the Act, CMS 2016). Its matching rate for almost all program administration is 50 percent, although it is eligible for the enhanced matching rate for activities such as MMIS and MFCU implementation and operation and administration of electronic health record incentive payment programs (CMS 2019b, MACPAC 2019a).

Puerto Rico's annual cap was originally set in 1968 and is updated annually by the medical component of the Consumer Price Index for Urban Consumers (CPI-U). It is not clear what factors Congress considered when it initially set the cap. There are some exceptions to the cap, including spending for the establishment of electronic health record incentive program payments; and establishment and operation of eligibility systems and the MFCU. Puerto Rico also receives a separate allotment for the Enhanced Allotment Plan (EAP), which can be used solely to help low-income beneficiaries purchase Medicare Part D prescription drugs.[12] However, in general, Puerto Rico must cover the entirety of any Medicaid costs above the annual cap. As a result, Puerto Rico's FMAP has historically been effectively lower than 55 percent; at times, it has been 20 percent or lower (Muñoz et al. 2011; Acevedo-Vilá 2005).

Additional time-limited federal funds. Congress has provided additional federal Medicaid funds to Puerto Rico on a temporary basis on several occasions. For example, the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised Puerto Rico's annual cap by 30 percent for the period between October 1, 2009 and June 30, 2011 (§ 5001(d) of ARRA). Following the expiration of these additional funds, the ACA provided Puerto Rico with an additional $6.3 billion in federal Medicaid funds: Section 2005 of the ACA provided $5.4 billion, available to be drawn down between July 2011 and September 2019; and Section 1323 of the ACA provided an additional $925 million, available January 1, 2014 through December 30, 2019.[13]

Congress has since added to this additional funding on two occasions. Because Puerto Rico exhausted its Section 2005 allotment in late FY 2017 (earlier

than anticipated), the Consolidated Appropriations Act of 2017 (P.L. 115-31) added $295.9 million to Puerto Rico's ACA Section 2005 funds. Additionally, in response to the effects of Hurricane Maria on Puerto Rico's health system, Congress provided an additional $4.8 billion to be used in FYs 2018 and 2019 under the BBA (Box 5-2). Most of this funding—$3.6 billion—was provided without conditions. As noted above, the remaining $1.2 billion is dependent on the territory meeting certain conditions related to data reporting and program integrity, which the territory has met (CMS 2018a). These funds have a 100 percent federal matching rate, meaning Puerto Rico does not have to put up any territorial funding to access them.

These additional funds allow Puerto Rico to continue to access federal Medicaid matching funds after reaching the annual cap. For example, in FY 2019, the cap is $366.7 million, and federal Medicaid expenditures were projected at $2.58 billion (ASES 2019b, CMS 2018b).

Implications of the financing arrangement. Despite the infusion of temporary additional funds, Puerto Rico's Medicaid financing arrangement has constrained available resources, resulting in more limited benefit packages and lower eligibility levels than states, low provider payment levels, and slow adoption of key administrative systems and processes. Puerto Rico's Medicaid spending is lower than in all 50 states and the District of Columbia, even after adjusting for Puerto Rico's enrollment mix and excluding spending on long-term services and supports (LTSS), a costly benefit that Puerto Rico does not provide. (See the appendix for a description of our methodology.)

For FY 2020, Puerto Rico's projected federal spending per full-year equivalent (FYE) enrollee is $1,495. This is 38 percent lower than the state with the lowest federal spending per FYE ($2,402), 67 percent lower than the median ($4,550), and 85 percent lower than the state with the highest spending ($10,243). Moreover, Puerto Rico's total spending per FYE (at $2,144) is lower than the federal spending per FYE in all states, meaning that even if the federal government paid 100 percent of Puerto Rico's Medicaid costs, it would still spend less per FYE than in any state (Figure 5-1).

Challenges

The ACA and BBA funds have allowed Puerto Rico to continue providing services to eligible individuals, enhance program operations, and implement managed care reforms intended to improve access and promote efficiency. However, the island continues to face access and provider availability challenges due to outmigration of health professionals and chronically low provider payment rates. Although its managed care capitation rates are low compared to those in states, as reflected in benefit spending per FYE (Figure 5-1), the program has been directed by the Financial Oversight Management Board to achieve additional savings in per member per month (PMPM) costs over the next five years.

Access to health care facilities. As of 2015, Puerto Rico had 64 hospitals, or 2.68 beds per 1,000 people; this is similar to the United States overall, which had 2.9 beds per 1,000. There was considerable variation in hospital capacity across different regions of the territory. For example, in the San Juan metropolitan area, there were 4.2 beds per 1,000 people, while in the neighboring Bayamón region, there were just 1.3 beds. Puerto Rico's hospitals had few intensive care unit beds—70.1 per 1 million compared to 290.6 on the mainland—and just one trauma center (ASPE 2017). Because Puerto Rico does not have a federal disproportionate share hospital (DSH) allotment, hospitals serving a large share of Medicaid or uninsured patients do not receive DSH payments.[14]

The health system in Puerto Rico is particularly reliant on federally qualified health centers (FQHCs) compared to the U.S. overall; in 2015, 10 percent of the population received care from them compared to 7.5 percent nationally (ASPE 2017). Reliance on FQHCs has grown following the 2017 hurricanes: nearly three-quarters of centers experienced an increase in patients served, and one in 10 reported an increase of 10 percent or greater (Sharac et al. 2018).

BOX 5-2. Medicaid's Role in Responding to Disasters

Medicaid has served as an important tool in state responses to the health care needs resulting from disasters and emergencies, including hurricanes. In some cases, Congress has also authorized additional federal Medicaid funding to respond to increased need following a disaster, such as the funds provided to Puerto Rico and the U.S. Virgin Islands through the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123).

Additionally, a variety of flexibilities under the state plan and waivers under Sections 1135 and 1115 of the Social Security Act (the Act) allow states to provide a heightened response, for example by facilitating short-term changes to program rules affecting eligibility, benefits, and provider payment. The U.S. Department of Health and Human Services took a number of administrative actions to support the response to Hurricanes Irma and Maria, including declaring a public health emergency, which enabled the Centers for Medicare & Medicaid Services (CMS) to waive some conditions of participation and other requirements for providers under Section 1135 of the Act (CMS 2017b). CMS also granted a Section 1115 waiver allowing Puerto Rico to pay for off-island services for Medicaid beneficiaries eligible for the Federal Emergency Management Agency (FEMA) Transitional Shelter Assistance Program who were temporarily relocated to the states of New York and Florida, effective from November 12, 2017 to January 27, 2018. These individuals otherwise only would have received coverage for emergency services (CMS 2017a). CMS also allowed Puerto Rico to suspend eligibility redeterminations through June 2018, which meant that anyone who lost eligibility between September 2017 and June 2018 was automatically re-enrolled for another year (ASES 2019c).

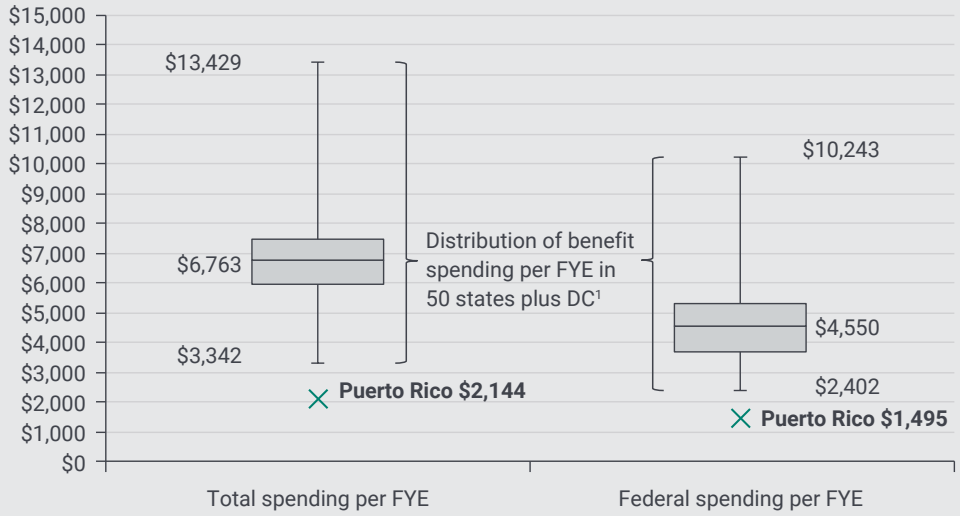
Congress and CMS have taken similar measures in responding to other disasters. Following Hurricane Katrina in 2005, CMS approved demonstration waiver programs for 32 states seeking to provide temporary eligibility to evacuees, which included streamlined eligibility processes and allowing self-attestation of eligibility factors (Katch et al. 2017, OIG 2007). Eight of these demonstrations included provisions for uncompensated care pools that allowed providers to be paid for providing necessary services to evacuees without insurance coverage (CMS 2005).

In February 2006, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) authorized the Secretary to pay the non-federal share of certain health care-related expenses to states with approved hurricane-related demonstration projects. Overall, the DRA made $2 billion available for services delivered to individuals by June 30, 2006, and for uncompensated care costs incurred by January 31, 2006. Of these funds, approximately $1.5 billion was allocated to Alabama, Louisiana, and Mississippi, the three states affected directly, for the nonfederal share of expenditures for existing Medicaid and CHIP enrollees (GAO 2007).

Although the measures taken in response to hurricanes in Puerto Rico are often compared to those taken in response to Hurricane Katrina in Louisiana and other states, it is important to note several key differences. Relief and recovery efforts have been more difficult in Puerto Rico due to its geographic isolation, disadvantaged infrastructure (including a weak power grid), and already strained health care system. In addition, Puerto Rico's capped Medicaid financing structure and upcoming fiscal cliff left it constrained financially until February 2019, when the BBA was enacted.

For more examples and further detail, see *Medicaid's Role in Disasters and Public Health Emergencies* (MACPAC 2018c).

FIGURE 5-1. Projected Medicaid Benefit Spending per FYE in Puerto Rico Compared to Distribution of Projected Medicaid Benefit Spending per FYE in 50 States and DC, FY 2020



Notes: FYE is full-year equivalent. FY is fiscal year. DC is District of Columbia. Total spending includes federal and state funds. Excludes Medicaid-expansion CHIP enrollees. Excludes spending for administration and long-term services and supports (LTSS). FY 2013 benefit spending from Medicaid Statistical Information System (MSIS) data were adjusted to reflect CMS-64 totals. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. FY 2013 spending per FYE for each eligibility group was trended forward to FY 2020 using CMS Office of the Actuary (OACT) projected growth rates for that eligibility group. For adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, FY 2017 benefit spending per FYE calculated from CMS-64 spending and enrollment data was trended forward to FY 2020 using OACT projections. To adjust for differences in enrollment mix across states and Puerto Rico, the enrollment mix across eligibility groups in each state was reweighted to match the distribution of enrollees across eligibility groups in Puerto Rico.

[1] Excludes Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

Sources: ASES 2019h, i,. OACT 2018. MACPAC 2019 analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2016; CMS-64 FMR net expenditure data as of July 20, 2018 and CMS-64 enrollment reports as of September 19, 2018.

Access to physicians and specialists. Though primary care physician, general surgeon, and dentist availability in Puerto Rico has tracked closely with the United States as a whole, provider availability varies across geographic regions (AAMC 2017, 2013). For example, 72 of Puerto Rico's 78 municipalities are designated as medically underserved areas, and 32 of them are designated as primary care shortage areas (HRSA 2019). Puerto Rico also lacks an adequate supply of certain types of specialists. Prior to Hurricane Maria, 23 percent of municipalities had a shortage of pediatricians and 68 percent had a shortage of obstetrician-gynecologists. In 2017, the supply of emergency room physicians, neurosurgeons, plastic surgeons, and ear nose and throat specialists was less than half the rate on the mainland (ASPE 2017). The availability of behavioral health services has been of particular concern following Hurricane Maria; a 2018 survey of health centers found that over 80 percent reported an increase in patients with depression, anxiety, and other mental health issues (Sharac et al. 2018). However, data to measure access or unmet need for these services are not available.

Concerns about Puerto Rico's declining physician workforce, a result of outmigration, predates Hurricane Maria. One report estimated that in 2014, 361 physicians moved out of Puerto Rico, and another found that in 2015, 500 physicians left (ASPE 2017). Reasons for outmigration among physicians include low salaries compared to the cost of living in Puerto Rico and salaries for similar positions on the mainland, as well as a lack of training opportunities. Anecdotal reports suggest that the trend is continuing, though there are no data for the period following the hurricane (Torres 2018, Perreira et al. 2017). Program administrators and others have struggled to adequately measure provider availability, in part because some providers leaving the island retain active licenses (ASES 2019g).

Lack of LTSS. Puerto Rico does not have an LTSS sector comparable to the mainland and, as noted above, LTSS are not covered as a Medicaid benefit. Few LTSS facilities exist in Puerto Rico (ASPE 2017). Though program administrators and other stakeholders have noted that the Medicaid population could be well served through home- and community-based services, such services are not covered due to lack of funds (ASES 2019g, MMAPA 2018).

Low provider payments for key types of service. Like other states, when faced with decisions about budget costs, Puerto Rico has often applied reductions to provider payment rates because other program costs (e.g., medical equipment or drugs) are relatively fixed (MMPHA 2018, Perreira et al. 2017). As a result, Medicaid physician fees are low in Puerto Rico compared to other states for certain services, including primary care and maternity services. For example, from July 2016 to July 2017 Medicaid physician fees were 19 percent of Medicare for primary care services and 50 percent of Medicare for maternity services, compared to the national average of 66 percent of Medicare for primary care and 81 percent of Medicare for obstetric care (ASES 2019d, Zuckerman et al. 2017).[15]

Specialists are better compensated. Certain specialties, such as cardiology, laboratory, and radiology, were paid at or above Medicare rates for the July 2016 to July 2017 period. Prior to the BBA, Puerto Rico's fiscal board proposed caps on physician payment at 70 percent of the FY 2016 Medicare fee schedule (ASES 2019d, FOMB 2018). These reductions were temporarily relaxed in light of the BBA funding for FYs 2018 and 2019; instead, Puerto Rico adopted a nonbinding guideline of 70 to 80 percent of the 2018 Medicare fee schedule, depending on the specialty.[16] However, Puerto Rico and FOMB have noted that the proposed reductions could be reinstated in the absence of additional federal Medicaid funds in FY 2020 (ASES 2019g, FOMB 2018).

Puerto Rico has indicated that the delivery system cannot support further reductions in provider payment rates, and may not be sustainable at current provider rates (ASES 2019g). It has worked to stabilize the situation by increasing payment rates, but has been constrained by the federal oversight board's restrictions on additional spending and by availability of federal funds. It is seeking to increase investment in provider payment rates by $170 million in FYs 2020 and 2021 by setting a payment floor of 70 to 80 percent of the Medicare fee schedule (AAFAF 2019b, ASES 2019g).

Pressure to further reduce spending from the Financial Oversight Management Board. In its fiscal plan certified in October 2018, the FOMB imposed mandatory spending reductions for the Medicaid program, starting with $122 million for FY 2019, rising to $827 million by FY 2023 (FOMB 2018). Most of these savings were to come from the new managed care system (see below); additional savings were assumed from Puerto Rico's improved ability to identify and address fraud, waste, and abuse, and adoption of new prescription drug cost controls. However, ASES, the government of Puerto Rico, and other stakeholders expressed concern that such changes would fail to achieve the required level of savings, necessitating dramatic reductions in benefits, coverage, or increases in cost sharing (ASES 2018, AAFAF 2019a).

Acknowledging these concerns, the board expressed willingness to revise targets to scale up to $671 million by FY 2023 (AAFAF 2019a, FOMB 2019). Puerto Rico's proposed revisions to the

fiscal plan, submitted in March 2019, include the same $122 million target for FY 2019, scaling up to a significantly lower target of $272 million by 2023 (AAFAF 2019b). These targets are still being negotiated.

Although they disagree on the amount of savings that can be achieved, the government of Puerto Rico and the FOMB both anticipate that the majority of savings will come from the new managed care system, which implemented additional requirements for plans intended to improve efficiency and produce savings:

- substantial changes to the capitation rate structure, which created 37 different rate cells to reflect eligibility pathway, age, gender, and medical condition, replacing the previous structure that paid one rate for all beneficiaries (ASES 2019i, AAFAF 2018);
- new care coordination requirements for beneficiaries with medically complex conditions; and
- an increased medical loss ratio (MLR) requirement of 92 percent.[17]

If medical expenses comprise less than 92 percent of the premium, plans must pay back the difference between the actual MLR and the MLR requirement. The new MLR requirement is 7 percentage points higher than the federal minimum and higher than the average MLR in all but eight states in 2017 (Palmer et al. 2018).

Medicaid Spending in Puerto Rico

Puerto Rico has used the additional funds provided by Congress in every year available. Although total Medicaid spending has grown in recent years, per person spending remains significantly lower than in states. At $2,144 in FY 2020, per person spending is projected to be 68 percent lower than the median for the 50 states and the District of Columbia. As Congress considers future funding needs, it is useful to consider spending by year and source of funds in the years since passage of the ACA, spending trends, and how spending would have been affected by alternative financing policies. The figures presented do not include Puerto Rico's spending on the commonwealth-only Medicaid population, which was $306 million in FY 2018 and not matched with federal funds (ASES 2019h).

Spending by year and source of funds

In all years from FY 2011 to FY 2018, federal spending for Medicaid in Puerto Rico exceeded the annual Section 1108 cap; spending in FY 2019 is also projected to exceed it (Figure 5-2). For FYs 2011–2017, this spending reflects use of the additional funds available under Sections 2005 and 1323 of the ACA, as well as a small amount of spending not subject to the cap (i.e., spending for EAP, electronic health record incentive program payments, and establishment and operation of eligibility systems and the MFCU).

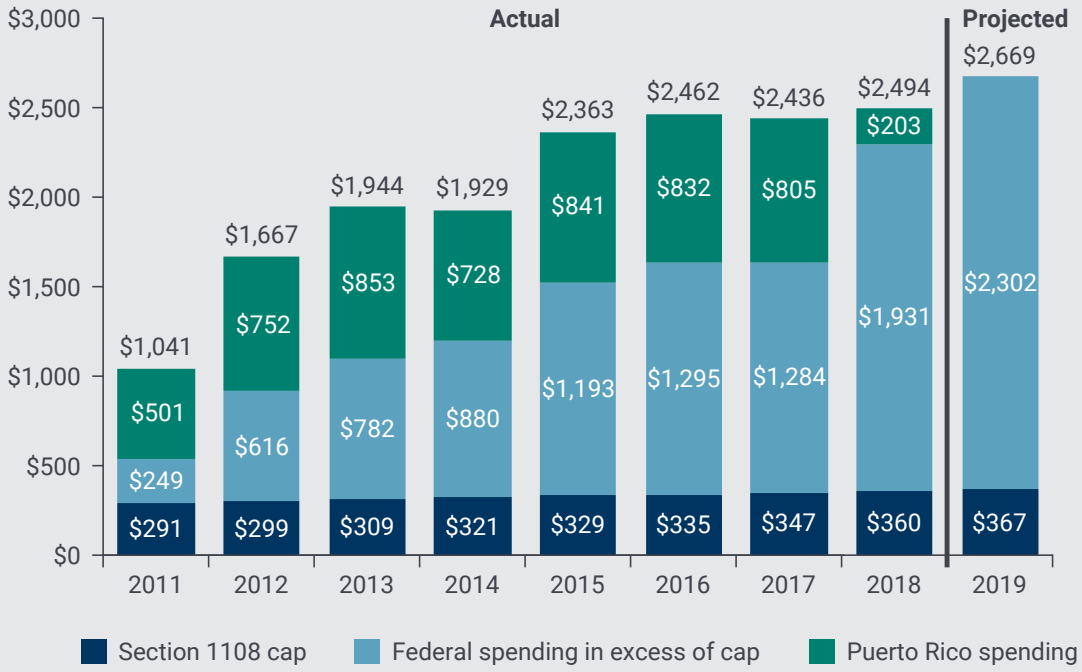
For FY 2018, Puerto Rico used funds available under the Section 1108 cap and a small amount of ACA Section 2005 funds. Because funds provided under the BBA are matched at 100 percent, Puerto Rico began using these funds as the sole federal Medicaid funding source when they became available in January 2018. The commonwealth plans to continue doing so through their expiration date at the end of FY 2019 (Figure 5-2).

Spending trends

Total spending in Puerto Rico grew between FYs 2011 and 2018. The largest increases occurred between FYs 2011 and 2012 (the year in which additional federal funding became available under the ACA) and between 2014 and 2015 (when the commonwealth adopted a managed care overhaul).

Following Hurricanes Irma and Maria in fall 2017, which caused significant damage to the commonwealth's health care infrastructure and disrupted the provision of services, Medicaid

FIGURE 5-2. Medicaid Spending in Puerto Rico by Year and Source of Funds, FYs 2011–2019 (millions)



Notes: FY is fiscal year. The Section 1108 cap refers to the annual cap on federal funds that territories receive under Section 1108(g) of the Social Security Act, whereas additional federal spending reflects utilization of the allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), as well as spending not subject to the cap (including enhanced allotment plan (EAP) spending, which cannot be backed out for these years using available data). Spending data for FYs 2011–2018 is actual spending; spending data for FY 2019 is projected. Spending projections for FY 2019 assume a federal matching rate of 100 percent for all types of Medicaid spending. For FY 2019, Puerto Rico is using only Bipartisan Budget Act (P.L. 115-123) funds, though the Section 1108 allotment is shown for illustrative purposes.

Sources: MACPAC, 2019, analysis of ASES 2019h and CMS-64 financial management report net expenditure data; CMS 2017c, 2016.

claims and utilization decreased (ASES 2019e). However, total spending increased by 2.2 percent, as spending per FYE increased by 3.1 percent. Although the growth rate was higher than in the previous year for Puerto Rico, it was significantly slower than the national annual trend in Medicaid spending per FYE, estimated at 5.8 percent (OACT 2018). Additionally, although outmigration accelerated, its Medicaid enrollment did not decline substantially, in part because eligibility redeterminations were suspended for up to one year (ASES 2019f, g). Moreover, no data are available on the rates of outmigration among Medicaid enrollees specifically. However, reductions in Medicaid enrollment are expected to lag overall outmigration trends (FOMB 2018).

Total spending is projected to grow by 7 percent between FYs 2018 and 2019; average premiums paid to plans will increase by 8 percent (ASES 2019h).[18] Enrollment is projected to decrease slightly; when redeterminations resumed in July 2018, enrollment began to decrease and continued to do so in six of the subsequent nine months. These decreases coincided with implementation of MAGI methodology for establishing income-based eligibility, which

has led to coverage losses (ASES 2019g, Pares Arroyo 2019). However, Puerto Rico is projecting relatively stable enrollment for the remainder of the fiscal year (ASES 2019a, h). In FY 2020, spending is projected to grow by 4.5 percent, rising to $2.8 billion. The average increase in premium expenditures is projected at 5.3 percent, with an enrollment decline of less than 1 percent (ASES 2019h).

Spending under alternative policies

Puerto Rico spends more of its own funds than it would were its FMAP determined by the same formula as used for states (i.e., 83 percent). Between FYs 2011 and 2017, the federal share of Puerto Rico's Medicaid expenditures ranged from 51.9 percent in 2011 to 66.4 percent in FY 2017 (Table 5-3).[19]

If Puerto Rico had received the statutory FMAP of 83 percent, its overall FMAP for the FY 2011–2017 period would have ranged from 82 to 84 percent. Assuming that Puerto Rico's total Medicaid benefit spending remained the same and that adequate federal Medicaid funds were available, federal Medicaid spending would have been $2.9 billion higher than under current law (Table 5-3).

Financing and Spending in FY 2020 and Beyond

Under current law, Puerto Rico is facing a federal funding shortfall in FYs 2020 and 2021. Below we examine possible financing scenarios for FY 2020, and show examples of benefit or enrollment reductions that would need to take place in the absence of additional federal funds. These analyses rely on spending and enrollment data and projections provided to MACPAC in January 2019. We also assume that CMS will permit Puerto Rico to access Section 1323 funds prior to its regular Section 1108 allotment in the first quarter of FY 2020, an assumption Puerto Rico has made in its projections; however, CMS has not yet confirmed that it will do so.[20] The analyses do not take into account the FOMB spending reduction targets because the final targets are still under discussion, and it is unclear how targets would change if Congress provided additional federal funds.

FY 2020 financing scenarios

Going into FY 2020, Puerto Rico will have a Section 1108 allotment of approximately $374 million, available for the full fiscal year. Puerto Rico will also have access to approximately $586 million

TABLE 5-3. Federal Share of Puerto Rico's Medicaid Spending under the Alternative FMAP (millions)

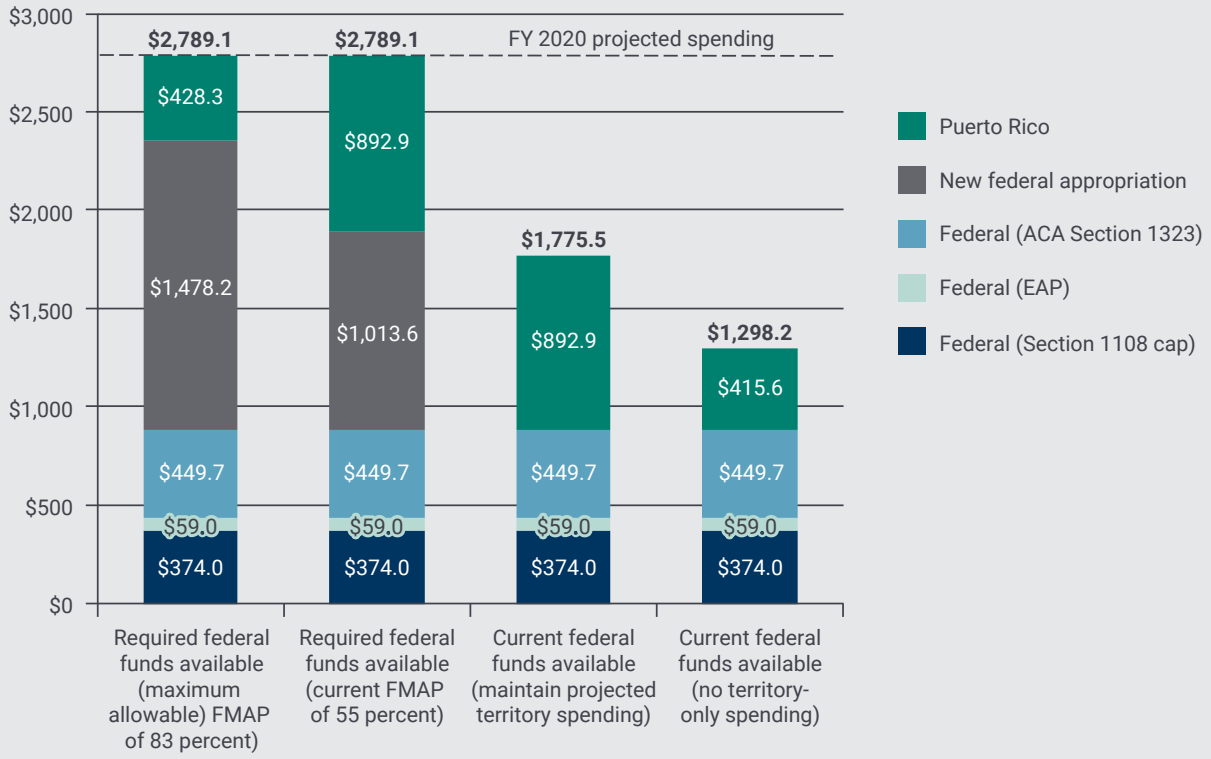
Fiscal year	Total benefit spending	Federal spending		Federal share of spending		Difference in federal spending
		Current law	FMAP 83 percent	Current law	FMAP 83 percent	
2011	$991.1	$514.7	$822.6	51.9%	83.0%	$307.9
2012	1,613.8	888.0	1,339.4	55.0	83.0	451.4
2013	1,837.5	1,011.0	1,525.1	55.0	83.0	514.1
2014	1,841.7	1,139.1	1,509.2	61.9	81.9	370.1
2015	2,280.4	1,467.4	1,887.1	64.3	82.7	419.7
2016	2,393.9	1,587.5	2,008.4	66.3	83.9	420.9
2017	2,317.7	1,540.0	1,955.9	66.4	84.4	415.8
2011-2017						**2,899.8**

Note: FMAP is federal medical assistance percentage.

Source: MACPAC, 2019, analysis of CMS-64 financial management report net expenditure data.

in remaining ACA Section 1323 funds, available through December 2019.[21] Based on projected spending, Puerto Rico will face a federal funding shortfall of $1.01 billion in FY 2020, exhausting available funds by sometime in March 2020 (Figure 5-3). If Section 1108 funds must be drawn down first, shortfall would increase by approximately $374 million, and the date of funding exhaustion would move up to December 31, 2019. In FY 2021, Puerto Rico will have only its Section 1108 allotment of approximately $382 million available, resulting in a federal funding shortfall of $1.54 billion (ASES 2019h).

FIGURE 5-3. Projected Medicaid Spending in Puerto Rico under Different Funding Scenarios by Source of Funds, FY 2020 (millions)



Notes: FY is fiscal year. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Section 1108 cap are the federal funds available under the annual ceiling on federal financial participation specified in Section 1108(g) of the Social Security Act (the Act). EAP is the Enhanced Allotment Plan, which can only be used to help pay for prescription drugs for low-income dually eligible beneficiaries (§ 1935(e) of the Act). ACA Section 1323 funds are additional federal funds provided under Section 1323 of the ACA, $925 million of which was directed to Puerto Rico. ACA Section 1323 funds are only available through December 2019. Required federal funds available are scenarios in which Congress has appropriated enough federals funds to fully match all projected spending in FY 2020. Current federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. These funds currently include the Section 1108 cap funding, the EAP, and ACA Section 1323 funds available through December 2019. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected $892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

Sources: MACPAC, 2019, analysis of ASES 2019h, i.

If no additional federal funds are available, Puerto Rico must either increase its own contribution to Medicaid to make up for the gap in federal funds, or reduce total spending by the same amount. In the period before ACA funds became available, Puerto Rico was able to use territory-only funds to make up for shortfalls in federal funding. However, raising the non-federal share has become more challenging than in the past due to a variety of factors, including diminished tax revenue caused by continued outmigration by working-age individuals, a damaged economy following Hurricane Maria, and loss of access to the capital market (Kobre and Kim 2018). Thus Puerto Rico will likely need to make substantial reductions in total spending, the size of which will depend on the commonwealth's own contribution. In FY 2020, if Puerto Rico maintains its expected contribution of $892.9 billion in FY 2020, it would need to reduce spending by $1.01 billion. If it only spends territory funds to the extent that these can be matched by federal funds, it would need to reduce total expenditures by a total of $1.49 billion (Figure 5-3).

Congress could address this funding shortfall by providing Puerto Rico with additional federal Medicaid funds. It would have to make several choices about how these would be structured, including regarding the amount, matching rate, and time period available. For FY 2020, it would need to provide at least $1.01 billion to allow Puerto Rico to access federal matching funds at the 55 percent FMAP available under current law. If Puerto Rico's FMAP were also raised to the maximum available level of 83 percent, the amount of federal funds needed would rise to $1.48 billion (Figure 5-3).

Effects of spending reductions in FY 2020 under different scenarios

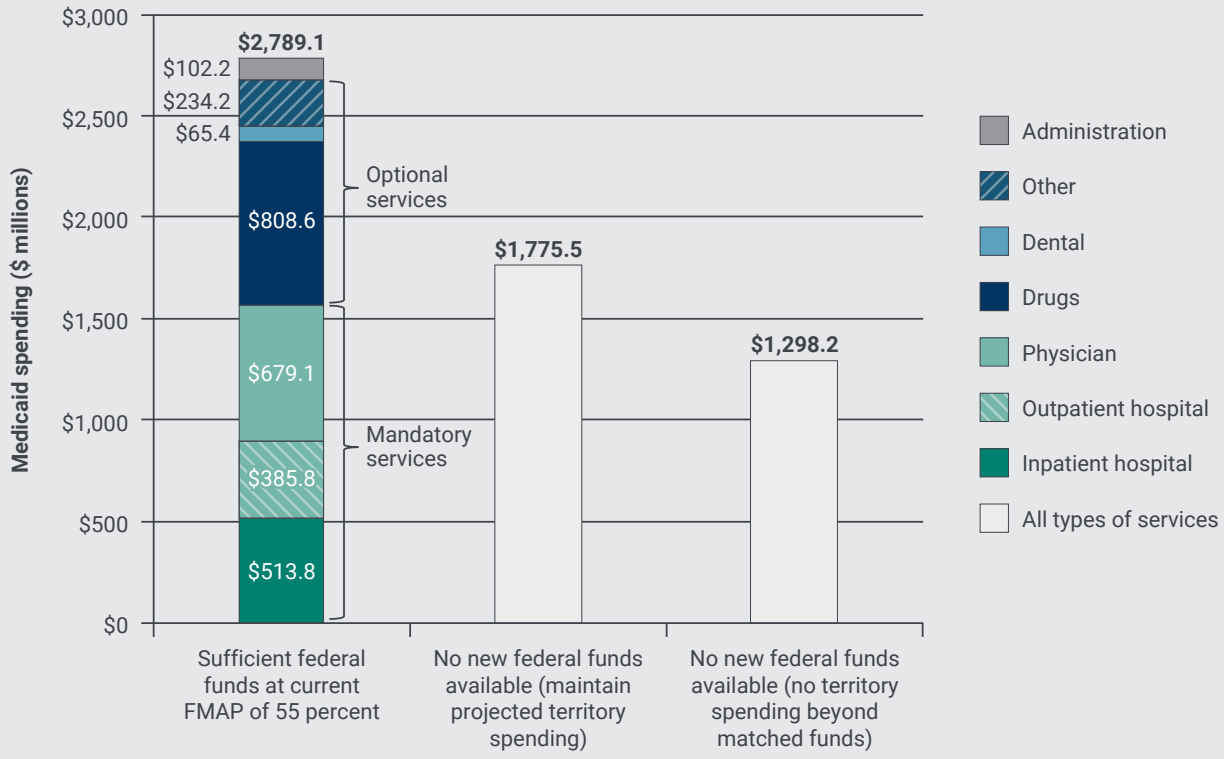
If Congress does not appropriate more federal Medicaid funds, Puerto Rico will have to reduce spending by cutting benefits, enrollment, or both. It is unlikely that spending reductions of this size would be realizable in Puerto Rico without substantial rollbacks of both eligibility and benefits. For instance, because actions such as eliminating outpatient prescription drugs and dental benefits would likely increase spending on inpatient or outpatient hospital services, Puerto Rico would need to combine such a benefit reduction with enrollment reductions. The effects shown below are intended to illustrate the magnitude of spending reductions that would need to occur, but do not represent policies that program administrators are likely to adopt. Neither do these constitute recommendations by MACPAC.

Benefits. To achieve spending reductions without decreasing enrollment, Puerto Rico could eliminate optional benefits or reduce the amount, scope, or duration of mandatory benefits. Puerto Rico's largest benefit category in terms of spending is outpatient prescription drugs. Gross federal spending for drugs (i.e., before rebates) is projected at $808.6 million for FY 2020, or 29 percent of spending for the fiscal year (Figure 5-4).[22] This is significantly higher than the national average, which is 13 percent (after excluding LTSS spending from the denominator). However, Puerto Rico's gross spending (i.e., before rebates) per FYE is more in line with other states: In FY 2017, it was about $497 per FYE, which was 21 percent below the 25th percentile of the 50 states and the District of Columbia and 32 percent below the median (ASES 2019i, MACPAC 2018b). This suggests that the high share of Puerto Rico's spending attributable to drugs is due to low spending in other categories.

Eliminating the entire optional prescription drug and dental benefits would still not achieve the level of savings needed. If Puerto Rico chose to stop spending territory funds once all available federal funds were exhausted, it would need to find additional savings through further reductions in benefits or administrative expenses (Figure 5-4).

Enrollment. Puerto Rico could choose to achieve savings by covering fewer people instead of reducing or eliminating benefits. Assuming no reductions in benefits, no additional federal funds,

FIGURE 5-4. Projected Medicaid Spending in Puerto Rico under Different Funding Scenarios by Category of Service, FY 2020 (millions)



Notes: FY is fiscal year. FMAP is federal medical assistance percentage. Sufficient federal funds refers to a scenario in which Congress has appropriated enough federals funds to fully match all projected spending in FY 2020 at the 55 percent FMAP. No new federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected $892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

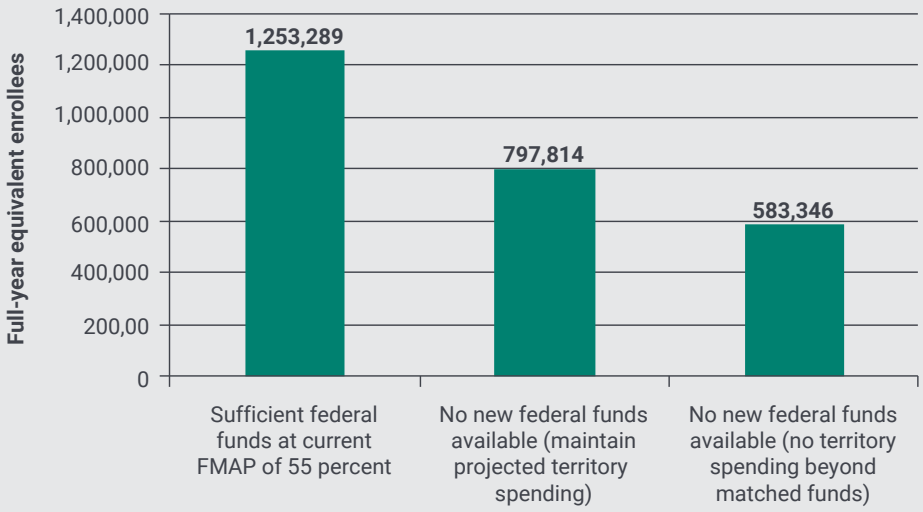
Sources: MACPAC, 2019, analysis of ASES 2019h, i.

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) (Figure 5-5).

Timeline for federal funding exhaustion

Puerto Rico has relied on additional federal funding sources to supplement funds available under the Section 1108 cap since they became available in FY 2011. Puerto Rico projects that available funding under the BBA will continue to be sufficient through FY 2019, but that it will experience a federal funding shortfall sometime in FY 2020. Annual funding under the FY 2020 Section 1108 allotment and remaining ACA Section 1323 funds are expected to last through at least December 2019, and as late as March 2020, depending on the order in which Puerto Rico is permitted to draw down these two funding sources. If CMS allows Puerto Rico to access ACA Section 1323 funds before its annual Section 1108

FIGURE 5-5. Projected Medicaid Full-Year Equivalent Enrollees in Puerto Rico under Different Funding Scenarios, FY 2020



Notes: FY is fiscal year. FMAP is federal medical assistance percentage. Sufficient federal funds is a scenario in which Congress has appropriated enough federals funds to fully match all projected spending in FY 2020 at the 55 percent FMAP. Spending assuming no new federal funds available are scenarios that reflect the amount of federal funds currently available to Puerto Rico for FY 2020. The maintain projected territory spending scenario assumes that Puerto Rico would spend up to the projected $892.9 million in territory spending even though not all of those funds would be matched with federal dollars. The no territory spending beyond matched funds scenario assumes that Puerto Rico would stop spending territory funds once all the available federal funds were exhausted.

Sources: MACPAC, 2019, analysis of ASES 2019 h, i.

allotment, Puerto Rico will be able to use these prior to their expiration in December and then switch to Section 1108 funds in January until their exhaustion sometime in March. If CMS requires that Puerto Rico exhaust its Section 1108 allotment before accessing ACA Section 1323 funds, no federal Medicaid funds will be available beyond December 2019.[23] In FY 2021 (beginning October 1, 2020), Puerto Rico will have access to only its annual Section 1108 allotment of approximately $382 million. It expects these funds to be sufficient only until sometime in December 2020 (ASES 2019h).

Although Puerto Rico may not exhaust all federal Medicaid funds until March 2020, its Medicaid program will be affected earlier. Specifically, both ASES and managed care plans report that the uncertainty around availability of funds affects their ability to negotiate adequate and efficient rates for the contract year that begins in October 2019. They have also noted considerable uncertainty among providers about whether they would agree to continue to participate in the program if Puerto Rico cannot guarantee payment after a certain date (ASES 2018, MMAPA 2018).

Looking Ahead

Congress has provided Puerto Rico with additional federal funding on multiple occasions, allowing Puerto Rico access to federal funds past its Section 1108 cap since 2011. It has taken additional steps such as extending enhanced matching rates for various populations (e.g., non-elderly, non-disabled adults) and administrative functions to Puerto Rico, and exempting certain types of spending from the cap (e.g., spending for establishment and operation

of the MFCU and MMIS). These measures have made it possible for Puerto Rico to strengthen its Medicaid program and enhance accountability and oversight capacity while also allowing it to expand Medicaid and continue providing services to covered populations.

However, the significant uncertainty about future availability of funds remains, as do financial pressures from within and outside the Medicaid program. These factors have significant implications for Puerto Rico's ability to operate its Medicaid program, which rests on the ability of program administrators to make and implement plans, the willingness of health plans and providers to participate, and the availability of health services for Puerto Rico's citizens. Uncertainty about the availability of funding past December 2020 threatens the progress the Medicaid program has made. It would almost certainly result in major benefit rollbacks, enrollment reductions, or both; worsen provider access for enrollees and services that remain covered; and reduce the commonwealth's administrative capacity.

An additional infusion of temporary funds would keep the Medicaid program afloat. In the long-term, reliable, sustainable access to care for the Medicaid population will likely require changes to the existing financing arrangement that provide a higher level of federal investment than what is currently available under the Section 1108 cap, and over a longer period of time than past interventions.

Endnotes

1 FOMB is made up of seven members chosen by the President of the United States from lists submitted by the Speaker and Minority Leader of the House of Representatives and the Majority and Minority Leaders of the Senate (§ 101(e) of PROMESA). The board's authorities to impose fiscal controls and force debt restructuring have been the subject of multiple lawsuits. In August 2018, a federal judge upheld the board's ability to enforce budgetary reforms but stated that the board cannot compel Puerto Rico to adopt, modify, or repeal laws that would allow for their implementation (Valentin Ortiz 2018). Another case, brought by bondholders and credit holders over the constitutionality of the appointment process for board members and seeking dismissal of the commonwealth's bankruptcy cases, is ongoing (Valentin Ortiz and Pierog 2019).

2 The board's certified fiscal plan includes major spending reductions that the board has conceded may not be realizable. It is in the process of working with the Office of the Governor of Puerto Rico to revise the specific spending targets (FOMB 2019).

3 Provisions in Title I of the ACA, including reforms to the group and individual markets and small business and premium tax credits, do not apply to Puerto Rico. Puerto Rico chose not to establish its own health insurance exchange, and residents of Puerto Rico are not eligible to purchase health insurance through the federal exchange (CMS 2014c).

4 Most of these enrollees are eligible based on their income, but approximately 10,000 of them are police officers receiving coverage through the government health plan (GHP). Although other public employees and pensioners may buy into GHP, only a small number choose to do so (ASES 2019a).

5 Puerto Rico received an exception from the recovery audit contractor program in 2010, but since then has voluntarily established one (Melendez 2011, ASES2019e).

6 Puerto Rico is statutorily exempt from requirements to extend poverty-related eligibility to children, pregnant women, (§ 1902(l)(4)(B) of the Act) (though these individuals are covered through the primary eligibility pathways for Medicaid and CHIP) and qualified Medicare beneficiaries (§ 1905(p)(4)(A) of the Act).

7 Puerto Rico is the only territory currently authorized to use its CHIP allotment to cover children from families whose incomes are too high to qualify for Medicaid; the other territories use CHIP funds to cover children in Medicaid (HHS 2013).

8 Under the medically needy option, individuals with higher incomes can spend down to the medically needy income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.

9 Puerto Rico does not currently provide coverage for hepatitis C medications except for patients with HIV (ASES 2019e).

[10] ASES also directly contracts with and regulates Medicare Platino plans (i.e., Medicare Advantage plans) (ASPE 2017).

[11] In 2014, CMS calculated a predicted FMAP of 91 percent based on Puerto Rico's per capita income; however, the federal FMAP limit is 83 percent (§ 1905(b) of the Act, GAO 2014).

[12] Puerto Rico does not receive a Medicaid disproportionate share hospital allotment (GAO 2014).

[13] With the funds from ACA Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. Neither Puerto Rico nor the other territories chose to establish an exchange.

[14] Puerto Rico hospitals can receive Medicare DSH payments, which are different from Medicaid DSH payments and are made under a different formula. Medicare DSH payments are made based on a hospital's Medicare and SSI patient days, but because Puerto Rico residents are ineligible for SSI, hospitals in Puerto Rico are disadvantaged relative to hospitals in the 50 states and District of Columbia (ASPE 2017).

[15] Although Puerto Rico's Medicare fee schedule is generally in line with, and in some cases slightly higher than, the national average, many have noted that rates should be higher, citing the high costs of practicing medicine in Puerto Rico and disadvantaged treatment under the Medicare geographic practice cost index (GPCI) formula (Perreira et al. 2017, Pierluisi 2015). Critics of the way that the GPCI has been applied for Puerto Rico note that it has not properly considered factors affecting the cost of practicing medicine in Puerto Rico. Specifically, they note that the high cost of utilities has not been factored in; that the national average cost of medical supplies is inadequate for Puerto Rico given the cost of shipping supplies to the island; and that the formula's reliance on residential rent data is inappropriate for Puerto Rico, which has a limited residential rental market (Pierluisi 2015). CMS acknowledged these issues and aligned Puerto Rico's GPCI values with the national average beginning in calendar year (CY) 2017, increasing the Medicare physician fee schedule. At the time of this change, GCPIs for the U.S. Virgin Islands were already aligned with the national average, and those for the three Pacific territories were already aligned with Hawaii (CMS 2016a).

[16] The change from the 2016 to the 2018 Medicare fee schedule is particularly notable because it captures changes made to the Medicare GPCI formula effective in CY 2017, which were intended to increase Medicare physician payments in Puerto Rico.

[17] The MLR requirement was 91.4 percent in FY 2018 and 90 percent in FY 2017 and 2016 (FOMB 2018).

[18] Spending projections for FY 2019 can vary based on the source of data and timing of when the projection was made. For example, Puerto Rico projected total spending of $2.4 billion on its February 2019 CMS 37 budget report submission, and $2.8 billion on its November 2018 CMS 37 budget report submission. To maintain consistency with the other projections of spending presented in this report, the $2.67 billion figure we show for FY 2019 is a projection based on detailed enrollment and spending data provided to MACPAC by ASES in January 2019.

[19] Although Puerto Rico's statutory FMAP under current law is 55 percent, it was 50 percent prior to July 1, 2011 (§ 2005(c)(2) of the ACA). Additionally, beginning in CY 2014, Puerto Rico was eligible for the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which was 78.6 percent in CY 2014 and has risen to 93 percent in calendar year 2019 (§ 1905(z)(2) of the Act). The enhanced matching rate for this population has caused the overall federal share of spending to increase.

[20] Current CMS policy is that Puerto Rico should draw down BBA funds first, Section 1108 allotments second, ACA Section 2005 funds third, and ACA Section 1323 funds last (CMS 2019a). Puerto Rico has requested that CMS allow it to use Section 1323 to cover spending in the first quarter of FY 2020 (prior to these funds' December 31, 2019 expiration) before switching to Section 1108 funds in January 2020. If CMS does not allow this, shortfall would increase by $374 million, and the date of the shortfall would move up to December 31, 2019.

[21] Puerto Rico expects to be able to use $449.65 million of this prior to the expiration date, leaving $136.7 million unspent (ASES 2019h).

[22] While Puerto Rico does not currently participate in the Medicaid Drug Rebate Program (MDRP), it has territory-specific rebates and purchasing arrangements with manufacturers. The Medicaid covered outpatient drug rule

in February 2016 changed the definition of states to include the territories, which would extend the rebates and coverage requirements of the MDRP to the territories beginning on April 1, 2017. Subsequently, the U.S. Department of Health and Human Services (HHS) issued an interim final rule on November 15, 2016 that delays the inclusion of the territories in the MDRP until April 1, 2020 (81 FR 80003). HHS has stated that the territories may waive out of the MDRP. Puerto Rico is evaluating whether or not it would benefit from joining the rebate program (ASES 2018).

[23] Current CMS policy is that Puerto Rico should draw down BBA funds first, Section 1108 allotments second, ACA Section 2005 funds third, and ACA Section 1323 funds last. Puerto Rico has requested that CMS allow it to use ACA Section 1323 funds first in FY 2020, but CMS has not yet confirmed that it will do so (CMS 2019a).

[24] MACPAC, 2019, analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report net expenditure data as of June 2016.

[25] MACPAC, 2019, analysis of CMS-64 Financial Management Report net expenditure data as of July, 20, 2018, and CMS-64 enrollment reports as of September 19, 2018.

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APPENDIX 5A: Methodology

MACPAC used data from several sources to calculate Puerto's Rico's projected Medicaid spending and compare its spending per full-year equivalent (FYE) to other states. Below we describe the data sources and adjustments used in this analysis.

For Puerto Rico spending, we used actuarial and financial data provided by the Puerto Rico Health Insurance Administration (ASES). These data included current enrollment and capitation rates by rate cell and population group for July 2017 through October 2018. Information related to capitation rates included information on the proportion of the rate attributable to major types of services such as inpatient hospital, outpatient hospital, physician services, and drugs. ASES also provided projections of enrollment and spending by population group for November 2018 through September 2021. For spending, the data included premium spending (i.e., capitation spending), non-premium benefit spending is paid outside of the capitation rate, and administrative spending. For rate cells that may include Medicaid populations with CHIP or other state-only groups (e.g., foster children), we allocated spending to Medicaid based on the proportion of Medicaid enrollees in that rate cell. For non-premium benefits paid outside of the capitation rate, we allocated spending based on the proportion of total Medicaid enrollment. After these allocations, we calculated overall Medicaid spending per FYE in FY 2020. We estimated the split between federal and commonwealth spending using the federal medical assistance percentage (FMAP) applicable to each rate cell and month. While Puerto Rico receives the statutory FMAP of 55 percent for most populations, it receives the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) which is 93 percent in calendar year (CY) 2019 and 90 percent in CY 2020. Based on the projected share of enrollment and spending for adults without dependent children, we calculated Puerto Rico's average federal share to be approximately 68 percent.

To calculate benefit spending per FYE in the 50 states and the District of Columbia, we used FY 2013 Medicaid Statistical Information System (MSIS) data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2016. FY 2013 MSIS data are the most recent data available that include enrollment and spending by eligibility group for the majority of the states. The MSIS data are adjusted to match total benefit spending reported by states in the CMS-64 data (MACPAC 2018a).[24] Because Puerto Rico does not provide long-term services and supports (LTSS), LTSS spending was excluded from the FY 2013 data. The FY 2013 non-LTSS spending per FYE in each state was trended forward to FY 2020 using projected trends for each eligibility group from the CMS Office of the Actuary (OACT) 2017 Actuarial Report on the Financial Outlook for Medicaid.

Because the MSIS data are from FY 2013 and do not yet include information on the new adult group, we used FY 2017 CMS-64 FMR net expenditure data as of July 20, 2018 and CMS-64 enrollment reports as of September 19, 2018 to calculate spending per FYE for the new adult group.[25] LTSS spending was removed from these data. The FY 2017 non-LTSS spending per FYE for the new adult group was trended forward to FY 2020 using OACT's projected growth rates for this group.

To adjust for differences in enrollment mix between Puerto Rico and the states, each state's enrollment was reweighted to match the enrollment mix in Puerto Rico. Using FY 2017 total Medicaid enrollment from the CMS-64 enrollment report, we distributed enrollment to children, adults, disabled, aged, and newly eligible adults based on the proportion of enrollment in Puerto Rico. For non-expansion states, we used Puerto Rico's distribution of enrollment excluding the new adult group to allocate enrollment to the child, adult, disabled, and aged eligibility groups. The FY 2020 spending per FYE estimates for each eligibility group were then multiplied by the FY 2017 enrollment estimates for each group to calculate an overall spending per FYE for each state that matched the enrollment mix of Puerto Rico.