PUERTO RICO Health & Insurance CONFERENCE 2012
Economic Transformation in Health

Economic Transformation in Health

Selected background data and reference material

Health Committee
Puerto Rico Chamber of Commerce 2012

The information presented in this document has the intention of presenting data and reported facts related to the economy and the health segment. The document does not contain, or intend to contain, any particular expression, statement, or view of the Chamber of Commerce, the Health Committee or its members.

Contents

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(1) Selected General Data - PR

Based on US Census Bureau Presentation (2011)

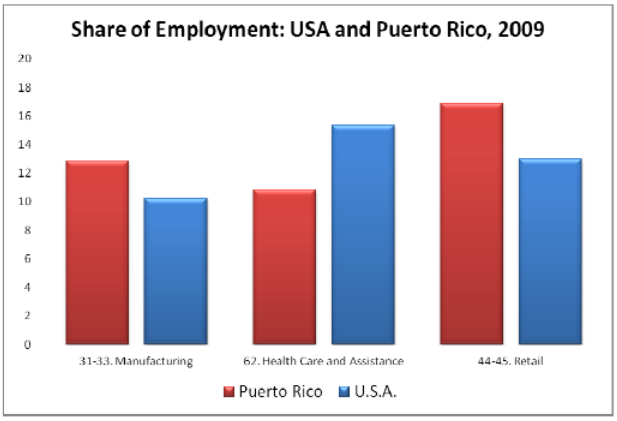
Top 5 Sectors by Employment for Puerto Rico (2009 CBP)

NAICS Sector	Industry Description	Employment	Annual Payroll (thousands)
44	Retail Trade	126,053	$2,161,956
31	Manufacturing	96,509	$3,183,077
62	Health Care and Social Assistance	79,471	$1,719,008
72	Accommodation and Food Services	71,957	$943,224
56	Administrative and Support and Waste Management and Remediation Services	69,515	$1,140,668

Negociado del Censo Estados Unidos Puerto Rico

Industrial Composition: USA and PR

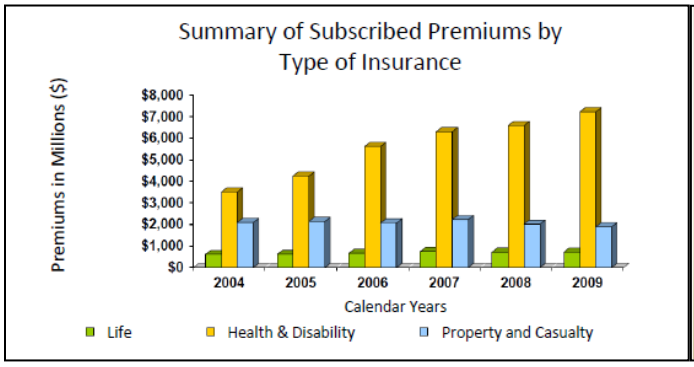
(Private Non Farm Economy)

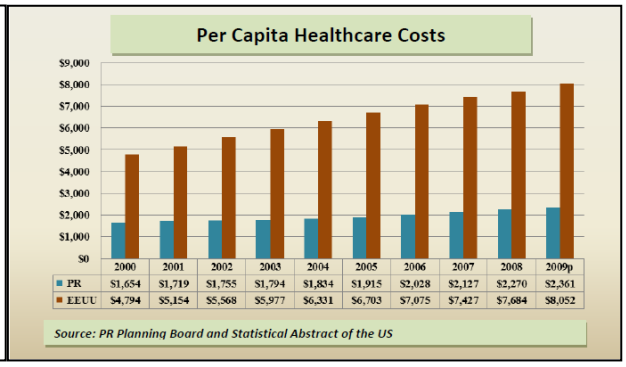


The economy in Puerto Rico is relatively concentrated in Manufacturing and Retail.

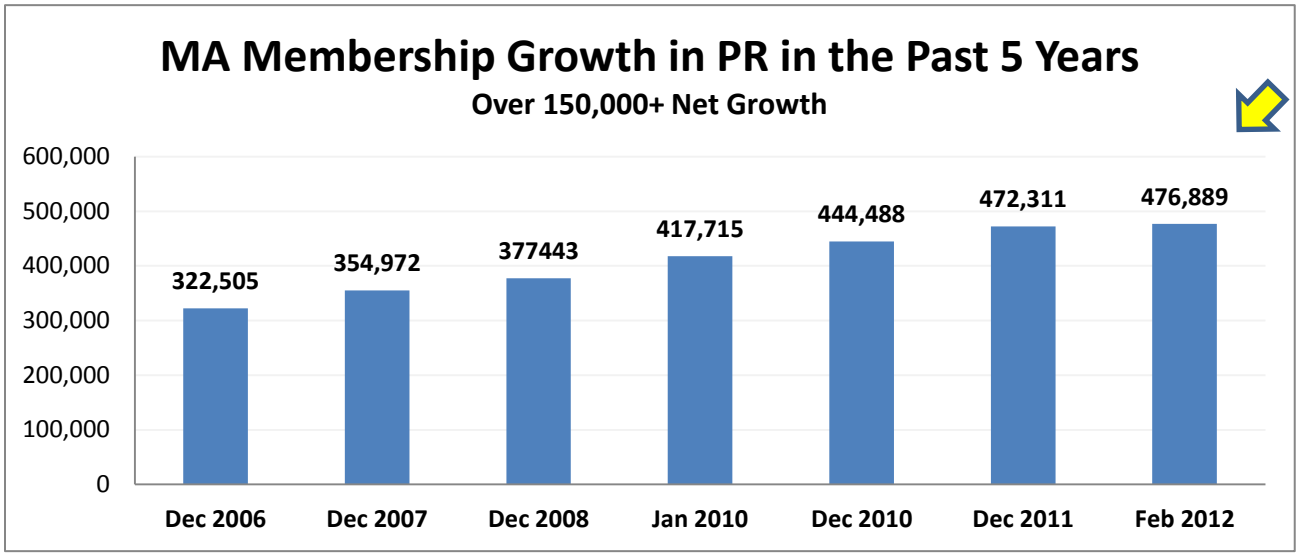
The healthcare sector is smaller.

- Manufacturing: 13% vs. 10%
- Retail: 17% vs. 13%
- Healthcare: 11% vs. 15%
- Other: 59% vs. 61%



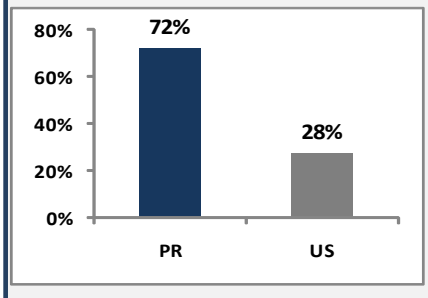


(2) Medicare



MA Penetration Feb 2012

	PR	US
MA	477,000	12,800,000
AB	530,000	43,000,000
AB, B or B	660,000	46,500,000
MA %	72%	28%



(A) 2007 Profile of Medicare Advantage in Puerto Rico

CMS Centers for Medicare & Medicaid Services

Medicare Advantage in 2007

Updated April 20, 2007

2007
Profile of Medicare Advantage
in
PUERTO RICO

How have Congressional policies supporting the Medicare Advantage option affected Puerto Rico?

Enrollment in Medicare Advantage	**337,124**
Extra Value*per beneficiary per month	**$195.06**

*Extra value means the additional MA plan benefits beyond the original Medicare benefit package, including: lower cost-sharing; enhanced coverage options; and reduced premiums. It also includes the difference between the average PDP basic premium in the region and the average MA-PD basic Part D premium (before rebates).

What would be the impact of limiting MA payments to 100 percent of FFS on Puerto Rico?

- **Reduced Benefits and/or Access** - Preliminary estimates of the impact in Puerto Rico of limiting payment to 100 percent of FFS are **-$4,715 million** over five years (FY 08-12, effective 1/1/09). The chart below illustrates that 99% of Puerto Rico counties, with 100% of Puerto Rico MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.

- **Enrollees in Floor Counties Most Affected** - The change would affect enrollees in urban or rural floor counties the most. These are the counties where Congress mandated benchmarks that are higher than FFS payment levels. In most cases, payment in the other county types is closer to the 100 percent of FFS level. However, only the "100 percent of FFS in 07" counties would see no decrease in payment levels.

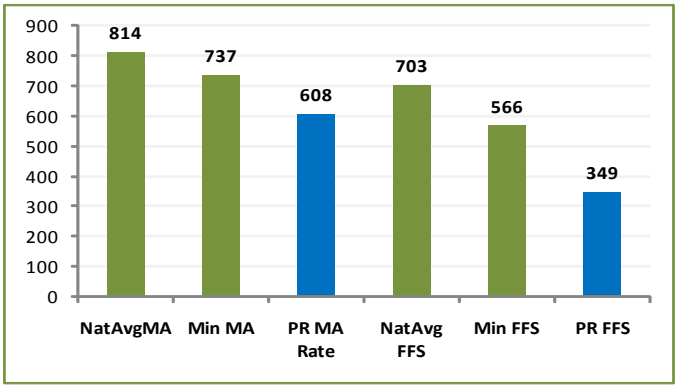
Distribution of Puerto Rico Counties and MA Enrollees Based on Impact of 100% of FFS Limit

	% of Counties	% of MA Enrollees
Total that Would Be Affected	**99%**	**100%**
Rural Floor	99%	100%
Urban Floor	0%	0%
Other Non-07 FFS *	0%	0%
Total that Would Not Be Affected (i.e. counties at 100% of FFS in 07)	**1%**	**0%**

*Reflects counties, other than rural and urban floor counties, receiving payments higher than 2007 FFS rates under Congressionally-mandated formulas, specifically those counties with the 100% of FFS in 04, 100% of FFS in 05, minimum update, and blend payment types.
Note that numbers may not always add to 100% due to rounding.

(B) PR MA Benchmark and FFS Cost Estimates – Based on CMS 2011 Data

2011 Benchmark and FFS Expense - Relative Situation of PR



(C) Excerpts of MedPac Report to Congress June 2009 (pg.179)

MA rate calculations for Puerto Rico

The MIPPA mandate specifically mentions the rate calculation for Puerto Rico as a potential concern. The small proportion of FFS beneficiaries in Puerto Rico with Part B coverage could compromise the accuracy of both calculated AAPCCs and risk scores.[14] Because only one *municipio* (the equivalent of a county) with a very small population has its benchmark set at an AAPCC rate, the Commission concludes that these are primarily theoretical issues that will come into play in the calculation of MA rates only in future years.[15]

[...]

Currently, only one *municipio* with a very small population has its benchmark set at an AAPCC rate that would be affected by these issues. All other *municipios* are paid at the statutory floor rate for Puerto Rico, which is now about 180 percent of local FFS. Thus, these issues will come into play only in the calculation of future rates. Should an adjustment be necessary in the future, the statute provides CMS with relatively broad authority to use actuarial methods to address situations in which the usual method of determining the AAPCC would yield an anomalous or potentially inaccurate result. In the case of Puerto Rico, CMS should expeditiously use its authority to employ an alternative calculation method to determine AAPCC rates if CMS finds that the current calculations are anomalous or potentially inaccurate, though we recognize that an alternative calculation may be difficult with the currently available data.

(D) CMS News – From Feb 1st 2012

News Release

FOR IMMEDIATE RELEASE
February 1, 2012

Contact: CMS Press Office
(202) 690-6145

Medicare Advantage premiums down 7 percent on average, enrollment up 10 percent

Medicare Advantage premiums have fallen by 7 percent on average and enrollment has risen by about 10 percent since this time last year, HHS Secretary Kathleen Sebelius announced today.

The enrollment numbers confirm projections from last September that enrollment in Medicare Advantage plans would continue to rise and average premiums would continue to fall. Average premiums have fallen from $33.97 in 2011, to $31.54 in 2012, while enrollment has risen from 11.7 million in 2011 to 12.8 million in 2012.

"The Medicare Advantage program is stronger than ever," said Secretary Sebelius. "Premiums are down on average, enrollment is up, and thanks to the Affordable Care Act we have unprecedented new tools to ensure that seniors and people with disabilities are getting the best value out of their coverage."
In addition to today's enrollment and premium numbers, there is more evidence that the Medicare Advantage program remains strong:

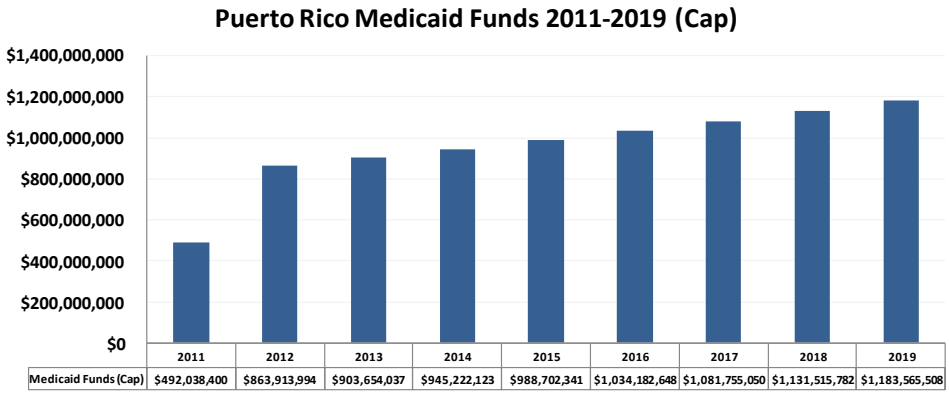
- On average, there are 26 Medicare Advantage plans to choose from in nearly every county across the country;
- Access to Medicare Advantage remains strong: 99.7 percent of Medicare beneficiaries have access to a Medicare Advantage plan; and
- Since 2010, when the Affordable Care Act was passed, Medicare Advantage premiums have fallen by 16 percent and enrollment has climbed by 17 percent.

"Not only are average premiums lower, but plans are better, with more beneficiaries enrolled in 4 and 5 star plans," said CMS Acting Administrator Marilyn Tavenner. "The Affordable Care Act has strengthened Medicare Advantage by motivating plans to improve the quality of their coverage."

In 2012, thanks to the Affordable Care Act, Medicare Advantage plans will start receiving incentives to achieve high quality scores through the use of quality bonus payments. As an extra incentive for high quality performance, CMS is allowing Five-Star Medicare Advantage and Part D plans to continuously market and enroll beneficiaries throughout the year.

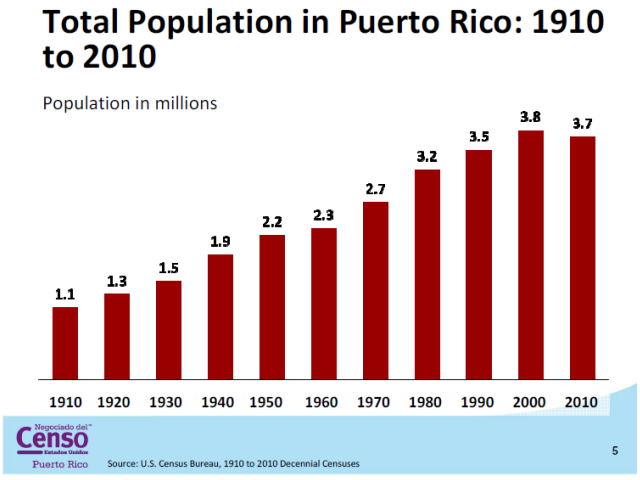
(E) Estimate of the New Medicaid Funds for PR ("New cap")

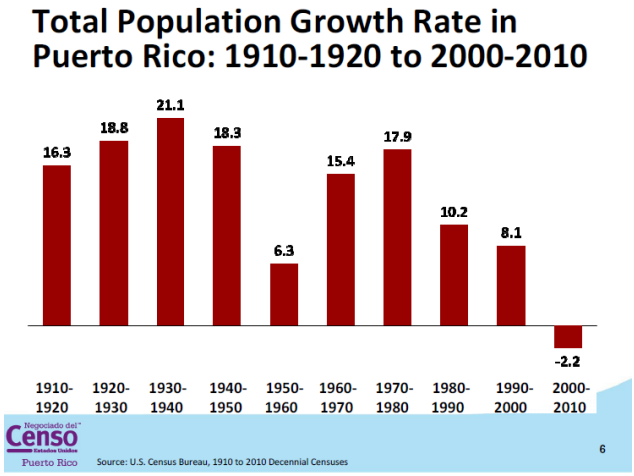
ASES has reported that according to the Congressional Research Service the estimated new Medicaid funds cap for PR in the next 10 years is as follows:

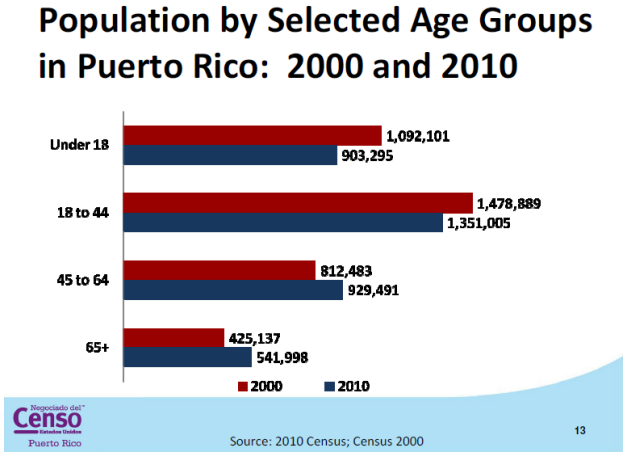


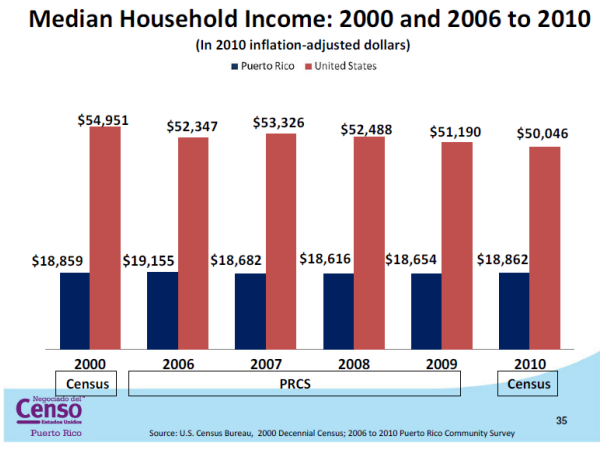
	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicaid Funds (Cap)	$492,038,400	$863,913,994	$903,654,037	$945,222,123	$988,702,341	$1,034,182,648	$1,081,755,050	$1,131,515,782	$1,183,565,508

(F) Puerto Rico Population Changes









(G) From Hispanic Population Census Bureau 2010

Table 3.
Detailed Hispanic or Latino Origin Groups With a Population Size of One Million or More for the United States and Regions: 2010
(For information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf*)

Origin	United States		Northeast		Midwest		South		West	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Hispanic	**50,477,594**	**100.0**	**6,991,969**	**13.9**	**4,661,678**	**9.2**	**18,227,508**	**36.1**	**20,596,439**	**40.8**
Central American	35,796,538	100.0	1,644,749	4.6	3,700,814	10.3	12,642,799	35.3	17,808,176	49.7
Mexican	31,798,258	100.0	918,188	2.9	3,470,726	10.9	10,945,244	34.4	16,464,100	51.8
Guatemalan	1,044,209	100.0	203,931	19.5	95,588	9.2	348,287	33.4	396,403	38.0
Salvadoran	1,648,968	100.0	270,509	16.4	61,894	3.8	655,184	39.7	661,381	40.1
Other Central American[1]	1,305,103	100.0	252,121	19.3	72,606	5.6	694,084	53.2	286,292	21.9
South American[2]	2,769,434	100.0	1,033,473	37.3	158,768	5.7	1,150,536	41.5	426,657	15.4
Caribbean	7,823,966	100.0	3,745,150	47.9	523,524	6.7	3,008,377	38.5	546,915	7.0
Cuban	1,785,547	100.0	197,173	11.0	62,990	3.5	1,376,453	77.1	148,931	8.3
Dominican	1,414,703	100.0	1,104,802	78.1	25,799	1.8	258,383	18.3	25,719	1.8
Puerto Rican	4,623,716	100.0	2,443,175	52.8	434,735	9.4	1,373,541	29.7	372,265	8.1
All other Hispanic[3]	4,087,656	100.0	568,597	13.9	278,572	6.8	1,425,796	34.9	1,814,691	44.4

[1] This category includes people who reported "Costa Rican," "Honduran," "Nicaraguan," "Panamanian," Central American Indian groups, "Canal Zone," and "Central American."

[2] This category includes people who reported "Argentinean," "Bolivian," "Chilean," "Colombian," "Ecuadorian," "Paraguayan," "Peruvian," "Uruguayan," "Venezuelan," South American Indian groups, and "South American."

[3] This category includes people who reported "Spaniard," as well as "Hispanic" or "Latino" and other general terms.

Source: U.S. Census Bureau, 2010 Census special tabulation.

Table 4.
Top Five States for Detailed Hispanic or Latino Origin Groups With a Population Size of One Million or More in the United States: 2010
(For information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf*)

Origin	Total	Rank				
		First	Second	Third	Fourth	Fifth
MEXICAN						
Area	United States	California	Texas	Arizona	Illinois	Colorado
Population	31,798,258	11,423,146	7,951,193	1,657,668	1,602,403	757,181
PUERTO RICAN						
Area	United States	New York	Florida	New Jersey	Pennsylvania	Massachusetts
Population	4,623,716	1,070,558	847,550	434,092	366,082	266,125
CUBAN						
Area	United States	Florida	California	New Jersey	New York	Texas
Population	1,785,547	1,213,438	88,607	83,362	70,803	46,541
DOMINICAN						
Area	United States	New York	New Jersey	Florida	Massachusetts	Pennsylvania
Population	1,414,703	674,787	197,922	172,451	103,292	62,348
GUATEMALAN						
Area	United States	California	Florida	New York	Texas	New Jersey
Population	1,044,209	332,737	83,882	73,806	66,244	48,869
SALVADORAN						
Area	United States	California	Texas	New York	Virginia	Maryland
Population	1,648,968	573,956	222,599	152,130	123,800	123,789
OTHER HISPANIC[1]						
Area	United States	California	Florida	Texas	New York	New Jersey
Population	8,162,193	1,393,873	1,221,623	1,030,415	917,550	516,652

[1] This category includes all remaining Hispanic groups with population size less than 1 million.

Source: U.S. Census Bureau, *2010 Census Summary File 1.*

REPORT BY THE PRESIDENT'S TASK FORCE ON PUERTO RICO'S STATUS

(Copy of Pages 58 to 62 Related to Healthcare)

★ ★

5. Promoting Access to Health Care

Medicaid

Issue

Established in 1965, Medicaid is a joint Federal-State program that finances health care coverage for certain categories of low-income individuals. To obtain Federal matching funds, States must operate their Medicaid programs within broad Federal guidelines and under federally approved plans.

The Federal Medical Assistance Percentage (FMAP), which represents the Federal share of spending in Medicaid programs, is based on average per capita income, relative to national per capita income. States may receive an unlimited amount of matching Federal dollars as long as they document valid expenditures under their State plans. In FY 2011, State FMAP rates range from 50 percent to 74.73 percent.

For Puerto Rico, however, the FMAP is statutorily set at 50 percent. In addition, total Federal Medicaid spending in Puerto Rico is subject to an annual dollar limit or cap. As a result, the Federal Government only matches every Medicaid dollar spent by Puerto Rico up to its limit, and any spending above the limit is not matched. When the capped Federal contribution is compared with Puerto Rico's contribution to the health care needs of Medicaid eligible beneficiaries, the effective FMAP rate is estimated to be approximately 18 percent.27 Thus, the cap limits Federal funding to a level below what it would be if Puerto Rico were treated as a State.This is not because of its size; the Medicaid-eligible population in Puerto Rico is approximately 885,000, or greater than the Medicaid-eligible populations of 29 States.

The impact of the Medicaid cap on the range of coverage for certain mandatory and many optional services is considerable. There are a number of Medicaid beneficiaries affected by the lack of access to the full spectrum of services provided under this program.For example, many children aged 0-18 years who are below the Federal poverty level receive limited benefits from the Early Periodic Screening, Diagnostic, and Treatment Program. Furthermore, elderly Puerto Ricans over the age of 65 and Puerto Ricans with disabilities are impacted because there are no available funds for home and community-based waiver programs or the innovative Program of All-Inclusive Care for the Elderly. Many of these individuals receive care from family members or in government-licensed homes with limited support services or medical supervision. In addition, Puerto Rico faces significant challenges in financing costs of nursing homes and certain care facilities for people who are developmentally disabled.

Puerto Rico was not included in the legislation that established the Medicaid disproportionate share hospital (DSH) program, which provides supplementary payments to hospitals that serve large numbers of Medicaid and low-income uninsured patients. This further limits Puerto Rico's ability to adequately serve its residents.

Recommendation

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (together, the Affordable Care Act) provide an FMAP increase for Puerto Rico from 50 percent to 55 percent effective July 1, 2011.The Affordable Care Act also increases the overall Federal limit for territories by

$6.3 billion from July 1, 2011 through September 30, 2019.Additionally, the Affordable Care Act provides $925 million that Puerto Rico may elect, if it establishes a health insurance Exchange, to use for providing premium and cost-sharing assistance to residents obtaining coverage through the Exchange, or obtain an equivalent increase in its Medicaid funding cap. Furthermore, ARRA provided temporary increases to Puerto Rico's annual Federal spending limits from the first quarter of FY 2009 through the first quarter of FY 2011.In August 2010, Congress extended this assistance for an additional six months, through June 2011.

The Affordable Care Act and ARRA each made substantial progress toward achieving a more equitable health care delivery system, including by making progress on Medicaid funding concerns for Puerto Rico.

The Task Force recommends that the Administration work with Congress to build on this foundation and work toward further progress in achieving a more effective, efficient, and equitable health care system for Puerto Rico. This may include exploring options for improving health coverage and benefits, encouraging delivery system innovations, considering additional adjustments to the Medicaid funding cap, and supporting the potential establishment and operation of an Exchange.

The Task Force further recommends that Federal agencies work together to ensure that the Affordable Care Act provisions are implemented to maximize the availability of health services to Puerto Ricans.

Timeline

Over the long term, Puerto Rico's Medicaid program should continue to be monitored closely, and post-Affordable Care Act needs should continue to be studied so that the Administration acquires the information necessary to work with Congress to further strengthen Puerto Rico's health care system.

Expanding Health Care Access in Puerto Rico

Issue

Puerto Rico's health care delivery system is faced with the growing demands of treating, chronic illnesses, malnutrition, and infectious diseases, as well as more advanced medical challenges, such as cardiovascular disease, substance abuse, mental illness, and cancer.The distribution of available clinical resources and health care professionals is focused in the large metropolitan areas, while the outlying communities and rural areas have limited access to care and treatment.

A Pan American Health Organization survey of medical facilities found that Puerto Rico had 67 hospitals in 2002–2004.29 In terms of distribution, 38 percent (27) of the hospitals were in the San Juan metropolitan region; 16 percent (11) in the Ponce region; 13 percent (9) in Arecibo, Caguas, and Mayagüez; and 7 percent (5) in Bayamón. The metropolitan region had the highest proportion of hospitals per population (1 per 40,420), while Bayamón had the lowest. The distribution of available beds per 1,000 persons also varied significantly. The national average was 3.3 beds per 1,000 persons, but the metropolitan region accounted for 40 percent of the 12,642 beds. Currently, there are 59 acute care hospitals, 39 of which are accredited by the Joint Commission for the Accreditation of Hospitals and Healthcare Organizations.

In addition to hospitals, Puerto Rico has 19 Federally Qualified Health Centers operating a total of 41 individual sites. Furthermore, there are currently 1,385 provider facilities that offer health care services to Puerto Rico's population of approximately four million residents. Ambulatory surgical centers, hospitals, home health agencies, hospices, dialysis facilities, community mental health centers, and skilled nursing facilities make up the largest number of provider types. According to the registry of health professionals,

there were 54,120 active health professionals in 2001-2004 (38.8 percent were concentrated in the metropolitan region).

The Administration is taking steps to address health care access issues for Puerto Rico's Medicare beneficiaries by proposing to set Medicare Advantage payment rates in Puerto Rico in a more generous manner. Under Medicare Advantage, beneficiaries can choose to receive their Medicare benefits from private insurance contractors. The Centers for Medicare & Medicaid Services' (CMS) proposed methodology was developed to address the unique characteristics of the Medicare program in Puerto Rico.

Recommendation

The Task Force recommends that the U.S. Department of Health and Human Services (HHS) work with Puerto Rico to take the following steps to improve health and health care access in Puerto Rico:

- Explore Critical Access Hospital (CAH) designation for rural hospitals on the Island. A hospital must meet certain statutory criteria to be designated a CAH. Eligible facilities are reimbursed 101 percent of reasonable costs for treating Medicare beneficiaries.
- Explore methods to better inform beneficiaries in Puerto Rico about Medicare Part B eligibility and the penalties for late enrollment. Medicare Part B is a voluntary program that provides coverage for doctors' services and outpatient care. Part B requires the payment of a monthly premium. Enrollment is automatic for eligible residents of the mainland United States who are receiving Social Security; however, Puerto Ricans must "opt-in" by contacting their local Social Security Office. While it would serve the cause of equity to automatically enroll Puerto Ricans in Part B, there is also a risk that a substantial number of those who are eligible would elect not to participate in the program because they may find the premiums to be unaffordable. Those who fail to disenroll would have premiums deducted from their Social Security payments. On the other hand, some people in Puerto Rico may not understand that they need to enroll separately in Medicare Part B. If they choose to enroll on their own but not at the appropriate time, they are charged a late fee. This policy applies to all Medicare beneficiaries who enroll outside of the initial enrollment period. Only about 78 percent of eligible beneficiaries in Puerto Rico are enrolled in Part B, compared to approximately 94 percent of eligible beneficiaries across the United States.

  The Task Force recommends extensive beneficiary education and outreach activities to better inform beneficiaries regarding Medicare enrollment policies. The Task Force also recommends that HHS explore using its demonstration authority to waive the late penalties during the education and outreach transition period and for a limited time after this period to evaluate whether the penalties significantly affect beneficiary selection as well as enrollment rates.
- Prepare a report on the amount of Medicare DSH payments needed to account for the higher cost of serving low-income beneficiaries in Puerto Rico, particularly in light of changes made to Medicare DSH payments and Medicaid eligibility in the Affordable Care Act. A hospital's Medicare DSH payments are based, in part on the proportion of Medicare inpatient days attributable to Medicare beneficiaries who are recipients of supplemental security income (SSI) relative to all Medicare inpatient days, and in part on the proportion of Medicaid (non-Medicare) inpatient days to total inpatient days. Medicare DSH payments to hospitals in Puerto Rico are limited because of the statutory ineligibility for SSI payments to most residents on the Island. This results in significantly lower Medicare DSH payments. However, the Affordable Care Act made changes in the Medicare DSH formula by allowing a significant part (75 percent) of the formula to be based on the level of uncompensated care provided to uninsured individuals. The Affordable Care Act also increased Medicaid eligibility. The effect of these changes on Puerto Rico's hospital payments should be evaluated before proposing legislation in this area.

Under the Medicare Modernization Act of 2003, low-income Part D eligible persons residing in Puerto Rico are not eligible for premium and cost sharing subsidies available to residents of mainland United States. Instead, an enhanced Medicaid allotment is provided to Puerto Rico for use to cover Medicare Part D medications based on a locally developed plan. To better understand the effects of these policies, the Task Force recommends that CMS conduct a study to assess to what extent Puerto Rico beneficiaries are unable to access affordable prescription drugs. This study should explore options to ensure access to necessary drug coverage in Puerto Rico.

Timeline

PRDOH has identified potential sites that may qualify for a CAH designation, and is working with HHS to explore that option. Several steps must be completed before a facility can receive a CAH designation. Therefore, even if this option is feasible, it would be a long-term process.

By January 1, 2012, CMS should develop a plan for the outreach activities regarding Medicare enrollment policies, coordinating with the Social Security Administration as appropriate.CMS should begin implementing this plan by July 1, 2012.

CMS should provide the final report based upon its study of the extent to which Puerto Rico beneficiaries are unable to access affordable prescription drugs by July 1, 2012.

Combating the Dengue Fever Outbreak

Issue

Dengue fever is caused by any one of four related viruses transmitted by mosquitoes, and is a leading cause of illness and death in the tropics and subtropics. More than one-third of the world's population lives in areas at risk for transmission, and as many as 100 million are infected yearly.

Although dengue fever rarely occurs in the continental United States, it is endemic in Puerto Rico. Puerto Rico has a dengue surveillance program and reports cases of dengue on a weekly basis. In 2010, the PRDOH reported over 22,000 suspected cases; approximately 50 percent of those cases have been confirmed. According to the Centers for Disease Control and Prevention (CDC), 33 people died of dengue fever during that epidemic.

There are not yet any vaccines to prevent infection with dengue virus and the most effective protective measures involve avoiding mosquito bites. Early recognition and prompt supportive treatment can substantially lower the risk of developing a severe case.

Recommendation

The Task Force recommends that CDC work with PRDOH to build on their partnership to identify best practices, to develop and to share mitigation strategies, and to monitor outbreaks of dengue fever.

In the medium term, Puerto Rico and CDC should increase their collaboration on mitigation and monitoring activities. Collaboration between CDC and PRDOH has led to the development of work groups to develop plans and applications for potential funding opportunities. The work groups are focused on the following areas:

- Dengue diagnostics—laboratory support
- Routine dengue surveillance
- Vector surveillance and control
- Database development and support
- Dengue information resources center

Timeframe

Collaboration between CDC and PRDOH is ongoing.

HIV Outreach and Education Initiative for Veterans

Issue

Veterans in Puerto Rico are disproportionately affected by Puerto Rico's high per capita rate of HIV-positive residents.In addition to the transmission risk due to sexual activity, they are at an increased risk due to the high incidence of substance abuse and mental health problems among veterans.

Recommendation

VA should continue raising Island-wide HIV/AIDS awareness and providing onsite clinic testing to ensure that veterans living in high-risk population areas are afforded an opportunity to be tested, treated, and enrolled into the VA health care system.The targeted outcome of this initiative should be 100 percent testing of veterans who consent to be tested and enrollment in health care services for any HIV-positive veteran residing in Puerto Rico who is eligible for services.

Timeline

This initiative is ongoing.VA participated in awareness events on November 17 and 22, 2010.Metrics from these events are being analyzed to inform future events.VA and HHS should work together in the coming year to expand this program beyond veterans, where possible.

(Copy of Pages 96-97 Related to Healthcare for Vieques)

Health Care for Residents of Vieques

Better health care facilities are an urgent need for the people of Vieques.The Task Force recommends that HHS work closely with the governments of Puerto Rico and Vieques to improve the quality of health care for the residents of Vieques.Among other things, the Task Force believes that a needs assessment should be completed to identify the most effective and efficient way to ensure that the people of Vieques receive the care, including expertise in environmental medicine, that they need.

In the near term, the Task Force recommends that HHS assist Vieques and PRDOH in exploring two programs that could improve health care on Vieques.

First, HHS and Puerto Rico should explore funding for health centers under the Health Center Program established by section 330 of the Public Health Service Act.In August 2010, HHS announced the availability of up to $250 million in New Access Points grants for the delivery of primary health care services for underserved and vulnerable populations under the Health Center Program.The funds, made available by the Affordable Care Act, will be awarded by the Health Resources and Services Administration.Additional health center funding opportunities under the Affordable Care Act will be available over the next 5 years.Vieques could partner with an existing health center (several of which are located on Puerto Rico's main island) to apply for health center funding.HHS is working with Puerto Rican officials as they consider their options.

Second, HHS and Puerto Rico should explore CAH designation.Certain facilities participating in Medicare can become critical access hospitals, which are eligible for reimbursement based on 101 percent of reasonable costs for treatment of Medicare beneficiaries.A hospital must meet certain criteria to be designated a CAH, including the following:

- ••Be located in a State (a category which, under section 210 of the Social Security Act, includes Puerto Rico) that has developed a Medicare Rural Hospital Flexibility Program;
- ••Be located in a rural area;
- ••Furnish 24-hour emergency care services, using either on-site or on-call staff;
- ••Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, a CAH may also operate as a distinct part of a rehabilitation or psychiatric unit, each with up to 10 beds;
- ••Have an average annual length of stay of 96 hours or less; and

- ••Be located in an area more than 35 road miles from a similar hospital, or, in the case of mountainous terrain or in areas with only secondary roads, be more than 15 miles from a similar hospital.

This payment approach ensures small hospitals in rural areas will have their costs of caring for beneficiaries covered.The Medicare Improvements for Patients and Providers Act of 2008 further improved CAH payments by permitting CAHs to receive 101 percent of cost payments for lab services under certain conditions.

Timeline

HHS should work with Puerto Rico to conduct a study of the health care needs of the people of Vieques and develop options for best addressing those needs.

In the short term, HHS Regional Office staff should continue working with PRDOH and Vieques officials to explore the feasibility of a section 330 health center program application.If this proves to be a viable option, it would be critical for PRDOH to support this effort and work with the Vieques community to develop a strong application, since the application process is considered extremely competitive.

Several steps must be completed before a facility can receive a CAH designation.The HHS Regional Office should continue to work with PRDOH to determine if the Centro de Salud de Familia facility in Vieques meets the statutory requirements for CAH designation. Receiving a CAH designation would require a longer time period.