Submitted Electronically to AdvanceNotice2018@cms.hhs.gov
Comments and Proposals from the Puerto Rico Healthcare Community
To the CMS Part C & D Advance Notice and Draft Call Letter 2018

March 3, 2017

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

cc/ Patrick Conway, CMS Acting Administrator
Cynthia G. Tudor, Ph.D., Acting Director, Center for Medicare
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director of the Part C & D Actuarial Group, OACT

The Puerto Rico Healthcare Community requests CMS to consider urgent and critical policy adjustments to assure appropriate Medicare Advantage funding for 2018

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Section 1: Summary of Comments & Signatories

The *Puerto Rico healthcare community* ("the community") acknowledges the attention and work that CMS staff and HHS leadership have devoted to the unique case of Puerto Rico and the Medicare Advantage (MA) and Part D programs in the past years. However, the steps taken are far from a meaningful mitigation to the increasing disparity in MA funding, severely worsened by reductions from the ACA. The comments and proposals herein recognize some positive elements included in the Advance Notice 2018, but most importantly reiterate the urgent need to finalize meaningful policies in the *Final Announcement and Call Letter* to be released next April 3rd, 2017. The group of signatories endorsing these comments includes the members of *Governor Rosello's Task Force for Healthcare Parity,* and other important leaders from the healthcare stakeholder community that have voiced their concern about this issue for the past several years.

The ***Advance Notice and Draft Call Letter 2018 (AN2018)*** includes some previous temporary measures that address critical issues for the Part C and Part D programs in Puerto Rico. For example, the Community strongly endorses the proposed adjustments to the STAR rating methodologies for Puerto Rico, to more accurately reflect the quality of care delivered by Puerto-Rico's MA plans. These programs serve approximately **580,000** Medicare beneficiaries on the island which has the highest MA penetration in the nation and has suffered a **reduction of 21%** in MA benchmarks compared to **pre-ACA** rates. As of today,

reductions have left MA funding for beneficiaries in Puerto Rico at 43% below the US average, and **even 26% below the USVI**. In spite of the expected high single digit impact of the repricing of physician (GPCI) and inpatient claims due to the 2016 and 2017 updates done by CMS for Puerto Rico, our team of actuaries has estimated that the year to year change in net MA funds for Puerto Rico could be as low as 1.6% if the zero claim adjustment is not included in the 2018 benchmarks.[1] Consequently, it is crucial and urgent that critical proposals are addressed and finalized in the April 3rd Announcement and Final Call Letter (Final Rule). These proposals were also presented to CMS in a letter sent by the Puerto Rico healthcare community previous to the Advance Notice, in December 2016.

- **Proposal #1 – MA Benchmark Proxy.** We propose the use of a proxy MA benchmark for Puerto Rico considering the FFS data anomalies validated in new empirical analysis by The Moran Company Report (*See Appendix 1*). Our understanding is that the Medicare FFS program and data in Puerto Rico are still the core problem and will continue to produce anomalous results in rate setting.

In the alternative to the proposed MA benchmark proxy for Puerto Rico, we stress the need to:

- **Proposal #2 (A)** – **Maintain the 4.4% zero claims adjustment done for 2017.** Maintain this adjustment for the anomalous proportion of zero-claimants in FFS Medicare in Puerto Rico within the unique scenario of PR, which is affected by a history of statutory differences in Medicare FFS.
- **Proposal #2 (B)** – **Dual bias in MA Benchmark.** Define adjustments at the MA benchmark level to reflect the minimal and biased representation of dual eligible beneficiaries in Puerto Rico's FFS population.
- **Proposal #2 (C) – No rebasing reductions.** Avoid additional reductions originated from the rebasing of cost calculations.

- **Proposal #3 – Address the unique & harmful situation of the ESRD MA benchmark in Puerto Rico.** Regardless of the MA benchmark proxy for Puerto Rico, or its alternatives proposed, we assert the need to remediate the proposed drop in rates for treatment of **End-Stage Renal Disease (ESRD) beneficiaries** in Puerto Rico, as an urgent matter for the Final Rule.

- **Proposal #4** – **Support for Part B member premium as a core A/B benefit for duals**. CMS should consider Part B member premium reductions for full benefit duals, as part of the core A/B benefit in Puerto Rico. Due to historic program differences in statute, full dual beneficiaries in Puerto Rico are not part of a Medicare buy in program or Medicare Savings Programs (MSPs).

Separate from the above, we acknowledge and strongly support the CMS proposals to maintain critical adjustments in the stars rating methodologies, as well as the update of pricing adjustments in the FFS cost estimates. In the case of Puerto Rico, the latter includes the full implementation of the new proxy for the GPCI factors in PR **for 2018, to be the same as the USVI (1.0)**, as formalized in the 2017 Medicare Physician Fee Schedule Final Rule.

All these proposals are vital for a real and meaningful impact to the situation of our 580,000 MA beneficiaries in 2018.

Without the implementation of the zero-claimants adjustment, a temporary proxy for the MA ESRD benchmark, and the fix for risk score adjustments, the MA program in Puerto Rico could lose over $200 million in resources for the system for 2018.

[1] These estimates include the reinstatement of the health insurance providers' fee/tax for 2018 (Section 9010 of the ACA).

We are committed to the continued improvement in the quality of the Medicare programs in Puerto Rico, demonstrated by the progress made through critical times in recent years. With the fair and needed adjustments we have been proposing, there is no doubt **Puerto Rico can continue to make progress towards operating the most cost-effective *high quality* MA and Part D programs in the Nation.** The April 3rd Final MA Announcement and Call Letter for 2018 is the most immediate opportunity for HHS and CMS to take meaningful administrative action to mitigate ACA cuts and enhance access and benefits for over 580,000 Medicare Advantage beneficiaries in Puerto Rico.

Sincerely,

Hon. Luis Gerardo Rivera Marín
Secretary of State
Government of Puerto Rico
Chairman, Governor's Task Force for Parity in Healthcare

Hon. Dr. Rafael Rodríguez Mercado
Secretary of Health
Government of Puerto Rico
Governor's Task Force for Parity in Healthcare

Mr. Carlos Mercader
Executive Director
Puerto Rico Federal Affairs Administration
Government of Puerto Rico
Governor's Task Force for Parity in Healthcare

Mrs. Angela Avila
Executive Director
Puerto Rico Health Insurance Administration
Government of Puerto Rico
Governor's Task Force for Parity in Healthcare

Mrs. Luz Cruz Romero
Executive Director
Medicaid Program
Government of Puerto Rico
Governor's Task Force for Parity in Healthcare

Hon. Angel Martínez
Chairman of Health Committee
Senate of Puerto Rico
Governor's Task Force for Parity in Healthcare

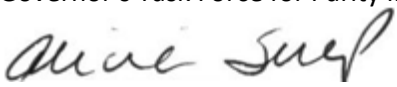
Hon. Juan O. Morales
Chairman of Health Committee
House of Representatives of Puerto Rico
Governor's Task Force for Parity in Healthcare

Roberto García, Esq., President
Medicaid & Medicare Advantage Products
President, Association of Puerto Rico (MMAPA)
CEO, Triple-S Management
Governor's Task Force for Parity in Healthcare

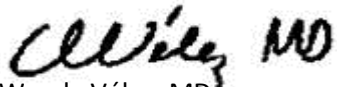
Lcdo. Jaime Plá-Cortés
Executive President
Puerto Rico Hospital Association
Governor's Task Force for Parity in Healthcare

Lcda. Idalia Bonilla
President
Puerto Rico Community Pharmacies Association
Governor's Task Force for Parity in Healthcare

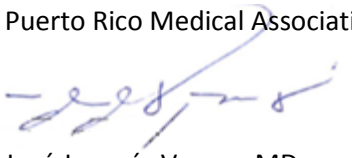
Víctor Ramos, MD
President
Puerto Rico College of Physicians and Surgeons
Governor's Task Force for Parity in Healthcare



Alicia Suárez
Executive Director
Primary Health Association of Puerto Rico



Wanda Vélez, MD
Former President
Puerto Rico Medical Association

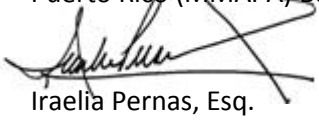


José Joaquín Vargas, MD
President
Puerto Rico IPA Association

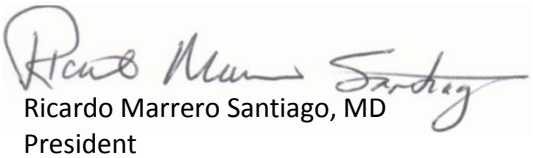
David Rodríguez
President & Chairman of the Board
Puerto Rico Chamber of Commerce

Ramón Pérez Blanco, Esq.
President, Puerto Rico Products Association
President, Fulcro Insurance, Inc.

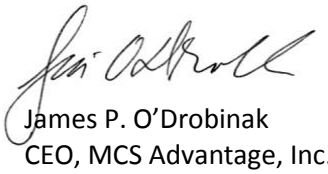
Juan L. Dominguez
Senior VP Corporate Development, First Medical
Medicaid & Medicare Advantage Products Association of Puerto Rico (MMAPA) Board



Iraelia Pernas, Esq.
Executive Director
Association of Insurance Companies of Puerto Rico



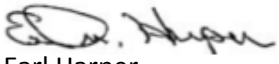
Ricardo Marrero Santiago, MD
President
Puerto Rico Medical Association



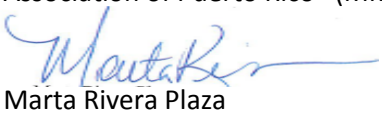
James P. O'Drobinak
CEO, MCS Advantage, Inc.
Former President, Medicaid & Medicare Advantage Products Association (MMAPA)

Ramón Alejandro Pabón, Esq.
President, Puerto Rico College of Healthcare Services Administrators

Rick Shinto
CEO, Medicare y Mucho Mas
Medicaid & Medicare Advantage Products Association of Puerto Rico (MMAPA) Board



Earl Harper
President, Humana Puerto Rico
Medicaid & Medicare Advantage Products Association of Puerto Rico (MMAPA) Board



Marta Rivera Plaza
President
Hospital Association

Elliot Pacheco
Vice-president, Entrepreneurs for Puerto Rico
Former President, PR Community Pharmacies Assoc.

About Signatories:

The Governor's Task Force for Parity in Healthcare:
On January 16, 2017, the Governor of Puerto Rico, Hon. Ricardo Rosselló, issued an Executive Order (Administrative Bulletin No. OE-2017-012) by which he created a public-private multi-sectoral Healthcare Working Group (the "Working Group"), also known as the Governor's Task Force for Parity in Healthcare. The Working Group coordinates efforts and establish joint strategies with the Governor and the Resident Commissioner at the federal level, aimed to achieve that the US citizens residing in Puerto Rico receive equitable treatment in comparison with the States with regards to the disbursement and management of funds in the Medicare and Medicaid programs.

Medicaid and Medicare Advantage Products Association (MMAPA)
MMAPA is a non-profit association composed of the leading Medicaid and Medicare Advantage organizations in Puerto Rico: First Medical, Humana, MCS, MMM/PMC, Molina Healthcare and Triple-S. Over 75% of all Medicare eligible in Puerto Rico choose Medicare Advantage for their healthcare needs and 45% of the island's residents participate in the Medicaid program.

Puerto Rico Hospital Association (AHPR by its Spanish acronym)
The Puerto Hospital Association was founded in 1942 and it is affiliated to the American Hospital Association. PRHA is a non-profit association composed of 67 public and private hospitals in the island, as well as other health institutions such as: Ambulatory Care Centers, Treatments and Diagnostics Centers, and distinguished members of the healthcare sector.

Puerto Rico Community Pharmacies Association (AFCPR by its Spanish acronym)
The AFCPR is a non-profit organizations that was established in 1952 to educate its members and improve the pharmaceutical services to patients and advocate for the wellbeing of the local community pharmacies. The AFCPR has more than 700 member community pharmacies around the island. They collectively serve more than 85% of the government Medicare and Medicaid beneficiaries through the government health insurance plan.

Puerto Rico Medical Association
The Puerto Rico Medical Association is a non-profit organization founded in 1902 and created to protect the health of Puerto Rico and better the Medical Education. The PR Medical Association is affiliated to the American Medical Association.

Puerto Rico IPA Association
The Puerto Rico IPA Association is non-profit association that serves more than 800,000 patients currently under its membership. The association is composed of the primary care groups, who collectively serve through the government health insurance plan for the past 20 years.

Primary Health Association of Puerto Rico (ASPPR by its Spanish acronym)
The ASPPR is a non-profit associations that represents, influences and empowers the 330 Centers' prevention and primary health network. The ASPPR promotes quality standards through technical assistance, training and support to its network, in order to improve health services in the island.

Puerto Rico College of Healthcare Services Administrators (CASS by its Spanish acronym)
CASS is a non-profit organization that brings together professionals in the administration of healthcare services. CASS was created by law No. 2 of February 23, 1990.

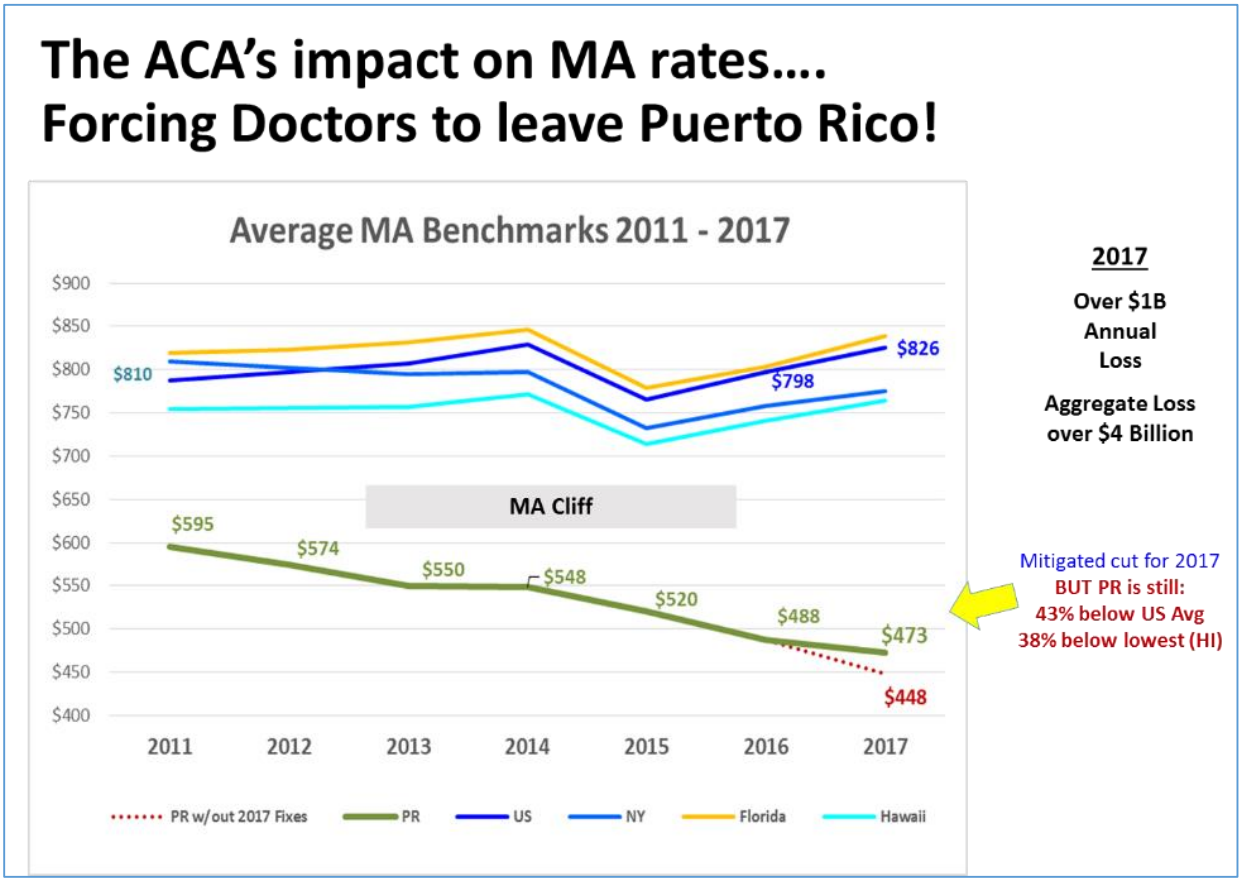
Puerto Rico Chamber of Commerce (PRCC)
The Puerto Rico Chamber of Commerce is the island's principal multisector organization advocating on behalf of the private sector. PRCC is the "Voice and Action" of Puerto Rico's private sector and one of seven State Chambers "Accredited by the U.S. Chamber of Commerce."
The PRCC is a private, non-profit organization comprised of individuals, professional organizations, entrepreneurs, and private employers representing small, medium, and large businesses from all economic sectors of Puerto Rico.

Entrepreneurs for Puerto Rico
The organization of Entrepreneurs for Puerto Rico is a non-profit organization that was founded in 2013 to group various local product and service companies from a wide range of commercial sectors in the island. They represent more than $6 billion in retail sales and more than 1,000 commercial establishments.

Products of Puerto Rico Association
The Puerto Rico Products Association is a non-profit organization incorporated in 1967. The Mission of the Association is to protect and promote manufacturing services offered by companies whose base of operation are in Puerto Rico. Its partners are companies from manufacturing, processing, marketing, distribution and export of products that, as members of the Association, used the seal "Made in Puerto Rico". We have more than 100 companies that provide services to other partners and the community in general.

Section 2: Critical Background - The Current Context for MA in Puerto Rico

We support the initial steps taken in the AN2018 and urge CMS to make the proposed specific adjustments needed as described herein. The estimated impact to Puerto Rico is a change of **1.6% from 2017 to 2018**, which is far from a meaningful adjustment considering that MA base rates for Puerto Rico have been **reduced by 21% since 2011**, and are now **43% below the national** average in 2017. The island is already losing over $1 billion per year in MA funds versus 2011 and the AN2018 does not include any permanent solutions for the disparity in the MA program. Even with these adjustments, Puerto Rico would be an outlier at the bottom of MA funding nationally, considering MA benchmarks currently average around **38% lower than the average of the next lowest state**.

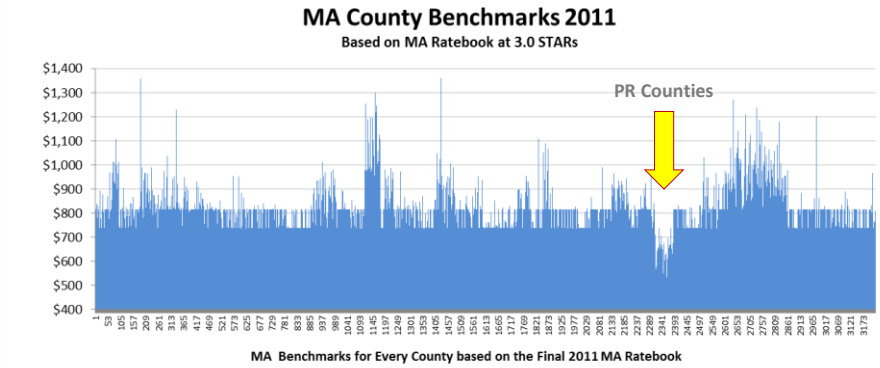


Extreme funding disparity continues in 2018: The independent study conducted by ***The Moran Company*** concluded that deficiencies in the FFS program and data make it inadequate for rate setting. At **38% below the lowest state (HI) and 26% below USVI**, this scenario for 2018 MA rates leaves Puerto Rico with no meaningful progress to mitigate the cuts of the past 6 years that currently impact 580,000 beneficiaries.

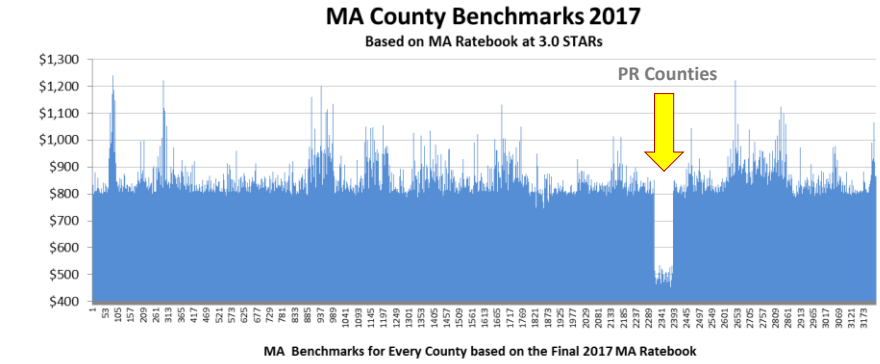
<u>Much higher cost pressures</u>: Projected cost trends in healthcare are 4%-7%, which is significantly higher than the projected year to year change in MA payment rates for PR. [2,3,4,5] More pressures to reduce costs in benefits and provider networks are inevitable considering that components like prescription drugs, equipment, and medical devices respond to national market pricing levels and trends. Supported by additional analysis of the Medicare FFS data for Puerto Rico, the Puerto Rico Healthcare Community had proposed several policy changes for 2017.

Increasing PR Funding Disparity in MA

Increasing Disparity in the MA Benchmark – The Poor are Now Poorer



<u>2011</u>
US Avg = $787
PR Avg = $595
PR 24% lower



<u>2017</u>
US Avg = $826
PR Avg = $473
PR 43% lower

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[2] http://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html PWC, Behind the Numbers 2017 projects a medical cost trend of 6.5%.

[3] http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ Average annual growth in Medicare per capita spending is expected to be **<u>4.3% during 2015-2025</u>**.

[4] ***Healthcare costs will outpace Medicare Advantage payments in 2018, report says***. Healthcare Finance. http://www.healthcarefinancenews.com/news/healthcare-costs-will-outpace-medicare-advantage-payments-2018-report-says?mkt_tok=eyJpIjoiWldZME1qaG1ZalpoTlRBMiIsInQiOiJ2SEdyQUtRVWJ0eUE3VUJTWDV1eUhleEpRY0dEUFNHTHJDdFhSM2VcLytTWmJiUWxvVk9qXC9nUFRQcGNCWFRCcDF5VXRiME5ZMTNQdnlQbldyaTd4dUpHUGpIQ3ZQcnF6UFcxK3NnZU9jOGp1WVNjQnJLdUtqam4xMTRZYkdCYktQIn0%3D

[5] *<u>2018 Advance Notice: Changes to Medicare Advantage Payment Methodologies and the Potential Effect on Medicare Advantage Organizations</u>*. February 22, 2017, GLENN GIESE. Josh Sober. Randall Fitzpatrick.

Section 3: Description of the Proposals and Requests to CMS

Primary Action Proposed: Establish an MA Benchmark Proxy

1. **Proposal 1 - Define an MA benchmark proxy, tied to similar geographic areas.**

Establishing an **MA Benchmark Proxy** for Puerto Rico would address the increasing evidence of anomalies in the FFS program and data that are routed in historic statutory differences compared with other jurisdictions (***See* FFS Data study by The Moran Company in *Appendix 1***). It is evident that the FFS program that Congress considered as a standard for MA rate setting is rapidly eroding in Puerto Rico and no longer fits the assumptions underlying its use for MA benchmarks in the mainland US. The use of an MA benchmark proxy would not be an unprecedented policy adjustment. Consistent with other proxy adjustments in Medicare policy, CMS could establish the proxy using the MA benchmarks defined for USVI, using its wide discretion to best estimate the average per capita cost for MA benchmarks. This level of payments would still be 17% lower than the average in the state with the lowest MA payments. The minimum MLR rules (85%), the formal CMS bid process and market competition assure the use of resources for benefits and provider payments. CMS could use its authority under Section 1876(a)(4) of the Social Security Act to estimate average adjusted per capita cost for Puerto Rico, based on actual experience "in a similar [geographic] area," as well as "appropriate adjustments to assure actuarial equivalence." At $643, the MA benchmark would still be **15% lower than Hawaii, the state with the lowest average MA benchmark**. In addition, this solution would be in alignment with President Trump's **Executive Order of January 20th, 2017** on the ACA, which restates administration policy to repeal the ACA as soon as possible. The MA benchmark proxy is a viable administrative solution to counter the harmful impact of the MA rate cuts for Puerto Rico as a result of the ACA.

Alternative Technical Adjustments to proposed MA Benchmark Proxy
In the alternative, and only as a path toward a more permanent solution, we still propose the following set of actions if a proxy is not done:

2. **(A) Key Adjustment for Zero-Claimants in FFS Data:** Puerto Rico may lose over $150 million in 2018 if CMS does not maintain the adjustment for the high proportion of members with zero claims that was 4.4% in 2017 ("**zero-claims adjustment**"). The AN2018 language proposes the use of the same adjustment, but explains that it is under evaluation. We urgently request this adjustment to be maintained (***See Appendix 2*** *for a brief from Milliman related to this issue*).
    a. This adjustment supported a 4.4% adjustment in 2017, and eliminating it would mean a loss of over $150M for Puerto Rico in 2018.
    b. Not having this adjustment would be a major set-back in relation to the recognition of the historic statutory differential treatment to beneficiaries in Puerto Rico, and the anomalies exhibited in the data.
    c. Moreover, without the zero-claimants adjustment, the position of the payment levels for MA in Puerto Rico would continue to deteriorate, increasing the disparity with other jurisdiction and fueling the continuing exodus of beneficiaries and healthcare providers to the states.

2. **(B) Dual Bias in Benchmark:** Define adjustments at the MA benchmark level to reflect the minimal and biased representation of dual eligible beneficiaries in the FFS population (***See Appendix 3***). The difference in dual proportion in MA vs FFS Medicare in Puerto Rico is so large that risk scores alone cannot fix the large discrepancy that exists between the two populations without an adjustment at the base rates (MA benchmarks).

2. **(C) No Rebasing reductions:** Considering the new analysis and evidence of particularities in FFS for Puerto Rico, CMS should avoid additional reductions originated from the rebasing of cost calculations. This would be independent of updates for repricing and other adjustments.

Other Critical Proposals Needed (regardless of the outcome of Proposal 1 or its alternatives 2A, 2B & 2C)

3. **MA ESRD Benchmarks – Puerto Rico an Outlier at the Bottom:** In reviewing the AN2018, it fails to present a clear solution to the issue of the level of reimbursement for ESRD patients in the MA program in Puerto Rico. CMS has already done a comprehensive review of the FFS payments for dialysis in Puerto Rico, and recognized critical disadvantages for the program in the island. Likewise, there are harmful issues with the MA ESRD benchmark process and resulting rates for Puerto Rico. The situation of dialysis patients and access to care continues to deteriorate. The PR MA benchmark for ESRD is $4,238 in 2017, while the national average is $6,648, and the USVI rate is $5,800. This is 40% below 2012 and creates a fundamental issue of providing even the core, basic health care services such as dialysis required for these patients.

   Moreover, the AN2018 did propose a change in the normalization factor for ESRD benchmarks which may generate another **8% reduction** in the rates for Puerto Rico.

   <u>Current MA ESRD Benchmarks are NOT Including Part A and B Pricing Updates</u>

   The Medicare FFS ESRD costs and payments for Puerto Rico are impacted by significant changes in FFS pricing for Part A, Part B and dialysis payment anomalies identified in recent years by CMS, and documented in FFS regulation. However, the AN2018 does not reflect any updates in methodology or policy to address these core factors within ESRD rates. **Specifically, on the ESRD Benchmark, the data CMS is using is missing information based on claims paid by the local Medicaid Agency plans. This is caused by the fact that Puerto Rico has a difference in administration of a 90 day coordination with Medicaid vs. the 30 month period CMS typically has. This causes data that is paid on the Medicaid program that would typically flow through the CMS Fee to be missing from the rate making process**.

   Furthermore, as validated by CMS staff, CMS does not apply current fee schedules to the benchmark experience data. Therefore, the GPCI update for Puerto Rico that the AN2018 indicated will be factored into the pricing on the general Puerto Rico MA benchmark will not be included for the ESRD benchmark. Accordingly the significant changes in Part A pricing due to the new uncompensated care formula is also not being reflected in the ESRD MA benchmark calculation. These two pricing adjustments are critical in the case of Puerto Rico, and not doing them is contrary to CMS policy in terms of reflecting the latest pricing information known.

   We recognize that devising an actuarial methodology to account for the missing data and process is probably a longer term solution, and as such we are recommending that until such time the USVI ESRD Benchmark be used as a proxy for Puerto Rico. Only through proper funding can CMS assure that the MA program can function properly and provide the necessary services for this extraordinarily at risk population.

   a. There are 3,500 ESRD patients in the MA program in Puerto Rico. Current rates mean that CMS would provide approximately $90 million more in 2017 for the care of these beneficiaries if they resided in the USVI instead of Puerto Rico.
   b. There are no policies to address the extremely low ESRD MA benchmark. We urgently request CMS to evaluate these proposals for inclusion in the April 3rd Final Rule.
   c. Puerto Rico also is at risk of getting reductions from FFS cost rebasing.

4. **Part B Member Premium Support as Core Benefit for Duals:** In line with the policy to define Part A and B deductibles and cost-sharing as part of the A/B Bid, CMS should consider Part B member premium reductions for full benefit duals as part of the core A/B benefit in Puerto Rico. Medicare Savings Programs (MSPs) and Part B Buy-in programs are not available given the history of the statutorily fragmented and capped Medicaid program funding in Puerto Rico. Similarly situated beneficiaries residing in states get the Part B premium paid under Part B Buy-in programs and this helps to alleviate the benefit differential.

As acknowledged in the AN2018, the Final Rule should **maintain the current STARs methodology adjustments for Puerto Rico** considering the statutory exclusion of Part D LIS benefits. Even though MA plans and community pharmacies in the island have implemented joint strategies to address issues with access to medication adherence, there are still outstanding and unresolved financial constraints that hinder the quality of care. Therefore, the proposed adjustment is still needed. In addition, CMS should propose additional adjustments related to the uniqueness of the system (Getting Appointments Quickly), and the high proportion of dual eligible beneficiaries (Members Choosing to Leave the Plan).

Finally, we strongly support the **Part A and Part B pricing updates** in the calculation of the FFS cost for the MA rate formula, including the changes in Part A Uncompensated Care and **the full implementation of the new Part B GPCIs applicable in 2018**, as established in the 2017 Physician Fee Schedule Final Rule.

Section 4: Conclusion

The healthcare community in Puerto Rico is working together to avoid a continued loss of MA funds in 2018. **The April 3rd Final Rule represents the only tangible opportunity to get meaningful incremental funding into the Puerto Rico healthcare system for 2018.** The aforementioned solutions can be made administratively by HHS/CMS, in the normal course of their duties and calendar, and do not require US legislative approval. Also, these proposed changes are aligned with the Report issued by the Congressional Task Force on Economic Development in Puerto Rico (the "Task Force") as per PROMESA.[6]

Finally, we reiterate that inadequate MA funding in Puerto Rico directly impacts benefits and provider compensation, and consequently, beneficiaries' health and access to care. The deteriorating economics of the island's healthcare system have been aggravated by the accelerating migration of professionals. This deepening funding disparity in MA increasingly burdens a system that is trying to manage higher prices of inputs and a higher cost of living than the US average, but at the same level of quality of care. For example, primary care efforts between the plans and IPAs have resulted in improve quality measures of the MA population, in particular the dual beneficiaries. As a result, four out of five MA plans in the island have achieved 4 stars improving the quality of care. However, we have gotten to a point where the quality of care will not improve anymore if the funding resources to the system are not improved.

As we pointed out in our previous communication date **December 19th 2016** (***See Appendix 4***), it has been evidenced that Puerto Rico has a higher cost of living than the US average. In contrast, many of the anomalies that keep payments as a low outlier relate to relative cost indexes and geographic factors that pull payment levels to a distant bottom. In 2015, the Puerto Rico Institute of Statistics was able to formally

[6] Puerto Rico Oversight, Management, and Economic Stability Act ("PROMESA") specifically mandated the Task Force to examine the Island's health care system, including "equitable access to Federal health care programs and issue specific recommendations to the Federal government.

insert Puerto Rico in a national cost of living survey that confirmed the higher costs for most of the inputs needed for healthcare.[7] Operating with this spiral towards the bottom in Medicare payments has been possible only by artificially lowering labor costs, while other costs like prescription drugs and utilities continue to increase. This flawed payment structure is the key reason for the increasing migration of our health professionals, which some estimate at 2,000-3,000 departures in the past six years, around 20% of the estimated active physicians in Puerto Rico. In parallel, as per reports from the Puerto Rico Office of the Insurance Commissioner, margins for managed care organizations have been notably low, and even negative in the past recent years.

The aforementioned proposals presented for the CY2018 Final Rule are intended to break the downward spiral of the Medicare Advantage program in Puerto Rico. We thank you again for the steps taken so far to overcome the island's financial challenges in the healthcare system. Thank you as well for your attention and anticipated action in the April 3rd Announcement.

[7] http://www.estadisticas.gobierno.pr/iepr/Publicaciones/Proyectosespeciales/ICV.aspx