MILLIMAN REPORT

Puerto Rico Government Health Plan financial projections

Administración de Seguros de Salud (ASES)

Puerto Rico Health Insurance Administration (PRHIA)

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Background

The Administración de Seguros de Salud (ASES) engaged Milliman to develop the Government Health Plan (GHP) program cost projections for budgeting purposes as well as planning for use of federal funds. Our work also includes developing capitation rates. Certain GHP expenditures are eligible to receive federal fund matching according to the authorizing statutes in the Social Security Act (SSA) and the Children's Health Insurance Program (CHIP). In addition, the GHP provides health insurance coverage to a low-income population that does not meet federal income requirements for CHIP or Medicaid, known as the Commonwealth population, and therefore is fully financed with Puerto Rico funds.

Although the Federal Medical Assistance Percentage (FMAP) for Puerto Rico determines the matching percentage of federal funds, as happens with all Medicaid programs in the 50 States, the federal funds available for Puerto Rico in any given period are capped at an amount determined by Congress. In some periods, there are sufficient funds for the GHP to receive the fully allotted federal matching percentage; however, in other periods, additional local funds have to be used when the allotment is exceeded. In recent years the Patient Protection and Affordable Care Act (ACA), the Consolidated Appropriations Act of 2017, and the Bipartisan Budget Act of 2018 (BBA) have appropriated sufficient federal funds for Puerto Rico to receive the full FMAP for the period July 1, 2011, through December 31, 2019. In addition, the BBA approved 100% FMAP for Medicaid expenditures, from January 1, 2018, through September 30, 2019.

Because of the expiration of the BBA funds on September 30, 2019, ASES requested that Milliman project the GHP expenditures from federal fiscal year 2019 (FFY2019) through federal fiscal year 2024 (FFY2024). The projection includes a runout of the usage of federal grant funds and required federal funding amounts at an assumed FMAP of 83%.[1]

This report contains our projections and documents the methodology and assumptions used in the projections. In addition, the projections in this report will be used as supporting documentation for the Puerto Rico government's request to the U.S. Congress for the approval of federal funds for the GHP.

[1] Puerto Rico regular Medicaid FMAP is statutorily set at 55%.

Executive Summary

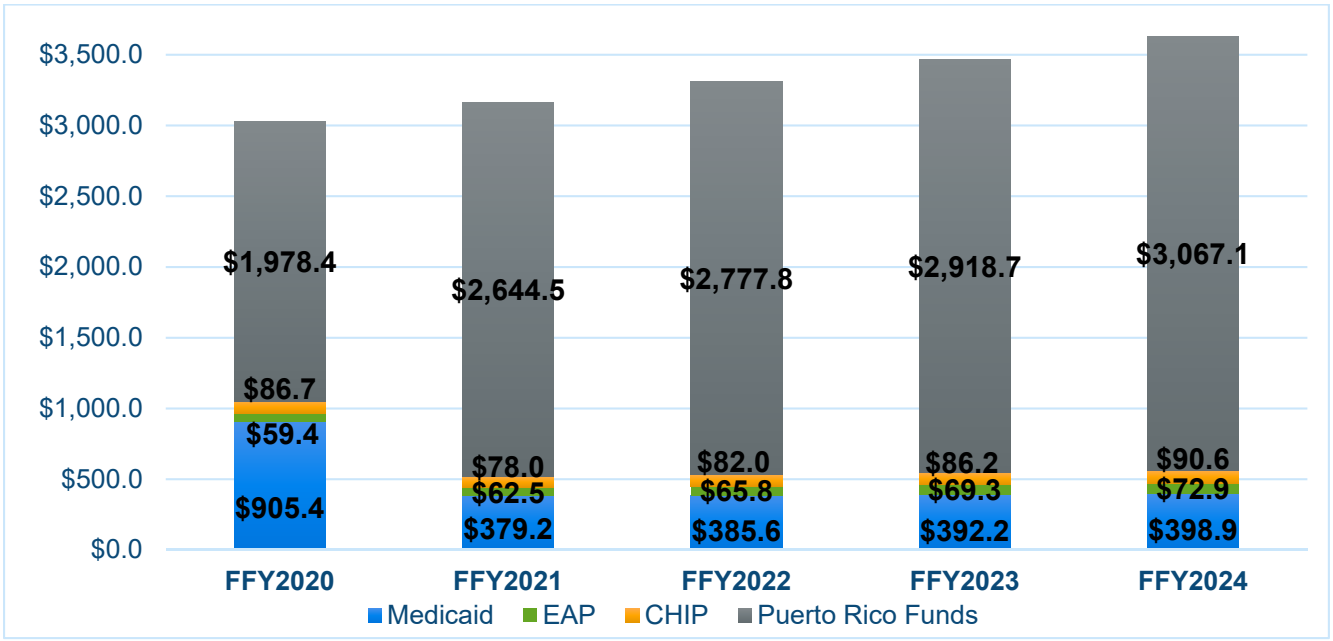
On September 30, 2019, the supplementary funds appropriated to the Puerto Rico Medicaid program through the 2018 Bipartisan Budget Act (BBA) will expire, along with the 100% Federal Medical Assistance Percentage (FMAP). After the expiry of BBA funds, Puerto Rico will utilize the remaining Section 1323 funds appropriated through the Patient Protection and Affordable Care Act (ACA) until its expiry on December 31, 2019. At that time Puerto Rico will rely on the Section 1108 capped funds and Enhanced Allotment Plan (EAP) funds to finance the Medicaid program. These funds are projected to be exhausted in the second quarter of federal fiscal year (FFY2020), based on program expenditures and reversion to the statutory FMAP of 55%.[2]

Federal funds are projected to be exhausted in March 2020 for the current Puerto Rico state fiscal year 2020 (SFY2020) ending June 30, 2020. After the exhaustion of the Section 1108 and EAP funds the entirety of the program will need to be financed with state funds. We estimate that for FFY2020, which begins October 1, 2019, the effective FMAP for Medicaid and CHIP expenditures will be approximately 34%.[3] For FFY2021 the effective FMAP will fall below 20%. Our estimate does not include amounts for Medicaid policy enhancements or critical sustainability measures, whose goals are to stabilize the Puerto Rico healthcare system and stem the exodus of physicians from the island. If these amounts are included, the effective FMAP will be lower.

Because of the exhaustion of supplemental federal funds, also known as the "Medicaid Cliff," and the island's strained fiscal situation, changes in the Medicaid program will be required to make up for the shortfall. These changes could be be in the form of benefit or enrollment cuts to offset the reduction in federal assistance. The planning and implementation of these changes must allow sufficient time for sound state budget planning and compliance with the fiscal plan.

Figure 1 shows the projected GHP program expenditures by source of funding, assuming no further federal funds are appropriated.[4]

FIGURE 1: PROJECTED GHP PROGRAM EXPENDITURES BY FUNDING SOURCE (MILLIONS)



[2] Puerto Rico has approximately $586.4 million remaining in Section 1323 funds to be used in the first quarter for FFY2020. At projected baseline expenditure and statutory FMAP levels, approximately $153.7 million of those funds will remain unused at their expiry on December 31, 2019.
[3] The Medicaid-only effective FMAP will be lower when excluding CHIP expenditures.
[4] Projection does not include amounts that are excluded from the capped funds such as establishment of a Medicaid Fraud Control Unit (MFCU) and establishment of operational and eligibility systems. d

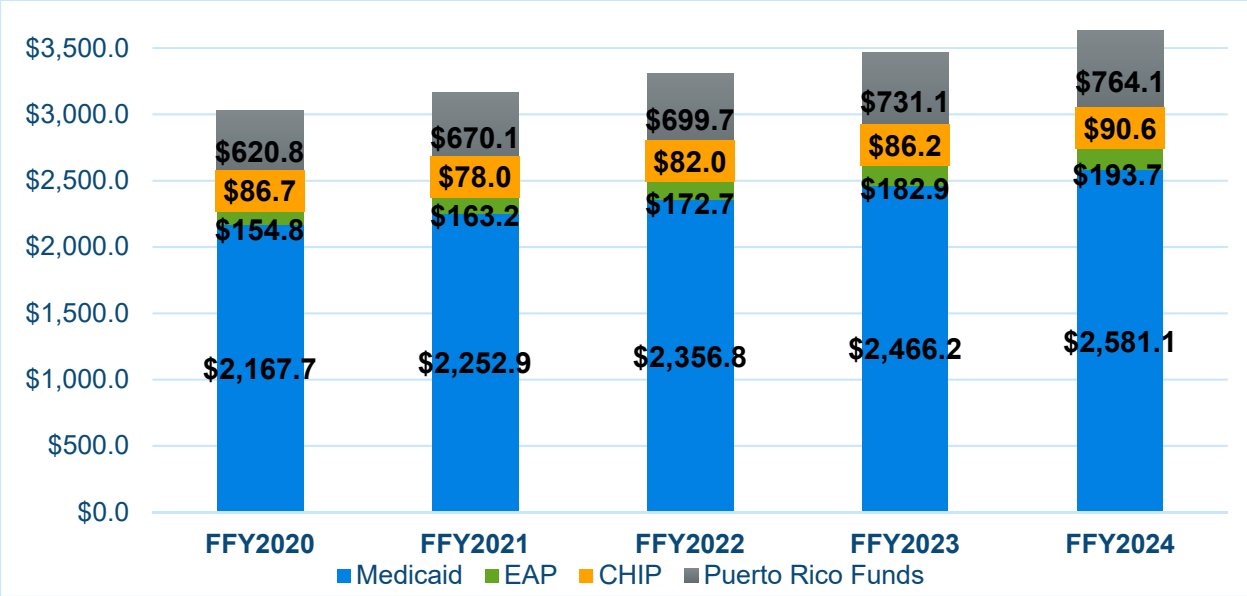
In anticipation of the Medicaid cliff, ASES requested that Milliman project expenditures for the GHP from FFY2020 to FFY2024 at an 83% FMAP. The estimate was included in Governor Ricardo Rosello's letter to Congress dated May 1, 2019,[5] requesting $15,100 million for five years at an 83% FMAP. The projection is composed of two main components: 1) five-year program costs for the program as it is currently structured, and 2) projections for the critical sustainability measures that the government identified to stabilize, strengthen, and improve the Medicaid program and the island's healthcare system. ASES requested that we assume an increase from the statutory 55% FMAP to 83%. This increased FMAP is based on the need to leverage federal matching to implement the critical sustainability measures.

Since the initial request, we have updated our projection, which resulted in an increase for the projected federal funds over the five-year period from the initial request of $15,100 million to $15,630.9 million. The updates in the latest projection are:

1. Updated Part B premium increase assumption each calendar year.
2. Updated average program FMAP applied to the critical sustainability measures.
3. Updated EAP funds increase assumption.
4. Enrollment data as of June 2019.

Figure 2 below shows the projected GHP program expenditures by source of funding assuming an 83% FMAP.

FIGURE 2: PROJECTED GHP PROGRAM EXPENDITURES BY FUNDING SOURCE AT 83% FMAP (MILLIONS)



The government of Puerto Rico has identified several critical sustainability measures that need to be implemented in the near term and are aimed to stabilize, strengthen, and improve the healthcare system. Given the historical underfunding of the Medicaid program Puerto Rico has had to limit program benefits and provider reimbursement rates. Consequently, this has led to an unsustainable healthcare system that is lacking infrastructure investment and faces provider shortages.[6] These measures can only be enacted if sufficient federal funding is appropriated to Puerto Rico,

[5] Governor Rossello, Ricardo (May 1, 2019). Puerto Rico Medicaid Funding Request Letter to Congress.
[6] MACPAC (June 2019). Chapter 5: Mandated Report – Medicaid in Puerto Rico.

given current budgetary constraints. Figure 3 shows the estimated cost of the critical sustainability measures as well as the estimate federal and Puerto Rico share of the critical sustainability measures.

FIGURE 3: PUERTO RICO MEDICAID REQUEST (MILLIONS)

Critical Sustainability Measures	FFY2020	FFY2021	FFY2022	FFY2023	FFY2024
Projected Federal Funds	$540.6	$593.2	$591.0	$598.3	$615.9
Projected Puerto Rico Funds	($101.7)	($111.5)	($120.4)	($128.0)	($134.0)

The projected negative Puerto Rico funds amount is due to the increase Puerto Rico poverty level initiative. The initiative would increase the income level thresholds used to qualify members into the program so that the Commonwealth population becomes Medicaid eligible. This population is already covered by the GHP with 100% state funds. Under the initiative Puerto Rico would receive federal matching for expenditures that they already incur.

Figure 14 shows the development of the critical sustainability measures estimate.

The table in Figure 4 contains the updated projected federal funds for the Medicaid costs and critical sustainability measures assuming an 83% FMAP for the period from FFY2020 to FFY2024. The projection does not include the amounts for CHIP or Commonwealth expenditures and does not include supplemental prescription drug rebates. In addition, we do not include amounts for expenditures that are not subject to the Medicaid cap such as establishment of a Medicaid Fraud Control Unit (MFCU) and establishment of operational and eligibility systems.

FIGURE 4: PUERTO RICO MEDICAID REQUEST (MILLIONS)

Projected Medicaid Federal Funds	FFY2020	FFY2021	FFY2022	FFY2023	FFY2024	Total
Medicaid Federal Share Assuming 83% FMAP	$2,322.4	$2,416.1	$2,529.5	$2,649.1	$2,774.8	$12,691.9
Critical Sustainability Measures Federal Share	$540.6	$593.2	$591.0	$598.3	$615.9	$2,939.0
Total	$2,863.0	$3,009.3	$3,120.5	$3,247.4	$3,390.7	$15,630.9

Note: The projection is developed on an incurred basis; therefore, there could be a lag in the drawdown of federal funds.

Appendix 1 of this report shows the development of the Medicaid expenditure estimate assuming an 83% FMAP.

Methodology and assumptions

We developed the five-year projections using a monthly pro forma model that incorporates expenditures for all populations in the GHP. The five-year projection of total costs for the program as it is currently structured, assuming an 83% FMAP, does not include any additional benefits or enhancements. The projection does not include amounts for the following items:

1. Supplemental pharmacy rebates received by the GHP.
2. Expenditures that are not subject to the Medicaid cap, such as establishment of a Medicaid Fraud Control Unit (MFCU) and establishment of operational and eligibility systems.
3. Third-party liabilities and recoveries.

Our projection was developed on an incurred basis, approximating the month that expenditures will be claimed for federal matching. However, there could be a lag in the timing of when the expenditure is incurred and when the actual federal fund request occurs.

We developed the model based on the data provided to Milliman from the participating managed care organizations (MCOs) and ASES. The remainder of this section discusses the assumptions and methodology used to calculate each expenditure item. Appendix 1 provides a summary of the expenditures by federal fiscal year.

PMPM PREMIUM EXPENDITURES

The GHP is a 100% managed care program where participating MCOs are paid a per member per month (PMPM) premium for enrolled members. The premium varies by eligibility category. The premium also varies by age, gender, and certain health conditions for the Medicaid, CHIP, and Commonwealth eligibility categories. The premium expenditures are calculated as the PMPM premium multiplied by membership for each month and eligibility category. These expenditures account for approximately 92% of all program costs.

In our projection we used the actual contracted premiums for the period from November 2018 to October 31, 2019, shown in the table in Figure 5. For each subsequent contract year, we assumed a 5.1% annual trend increase in the PMPM premium paid to the contracted MCOs. We assumed a 0% trend for the dual eligible Medicare Platino wraparound premium in the projection.[7]

FIGURE 5: NOVEMBER 2018 TO OCTOBER 2019 PREMIUM BY ELIGIBILITY CATEGORY

Eligibility Category	Premium
Medicaid and Medicaid Newly Eligible	$178.07
CHIP	$97.84
Commonwealth	$107.36
Foster Children and Domestic Abuse Victims	$302.22
Dual Eligible, Medicaid	$371.85
Dual Eligible, Platino	$10.00

[7] In 2006, Puerto Rico implemented the Medicare Platino program. Under this program, dual eligible GHP beneficiaries were allowed to enroll in qualified Medicare Advantage Special Needs Programs, or SNPs. The SNP programs provided additional benefits, primarily related to prescription drug and dental benefits, so that the Medicare Advantage benefit package included benefits that were at least equal to the benefits to which the beneficiaries had been entitled under GHP. ASES pays a "wraparound premium" or "capitation" for these additional benefits. Since at least 2014, the wraparound premium has remained at $10.

Appendix 1 contains the estimated MCO premium expenditures during the projection.

MATERNITY KICK PAYMENT

The MCOs are paid a maternity kick payment for each delivery, as the cost of deliveries is not included in the premiums. This payment covers the cost of an inpatient stay for a normal or cesarean delivery and will be paid upon the reporting of a delivery claim to ASES. The projection includes these costs in the month of birth; however, there could be a reporting lag between the date of birth and when ASES receives the delivery claim.

The maternity kick payment costs are calculated as the projected births for the enrollees in the GHP during each contract year, times the kick payment for each birth. The kick payment for the period from November 2018 to October 31, 2019, is $4,641.59; we have assumed a 5.1% annual trend increase each subsequent contract year, corresponding to the premium increase for nondelivery premiums. The projected costs for the payments are included in the MCO premium expenditures in Appendix 1.

The annual birth projection is based on data compiled from the University of Puerto Rico Medical Sciences Campus Demography Program.[8] The data shows total births on the island by source of insurance from 2013 to 2016. The data is publicly available from the Puerto Rico demographic registry. During this period, births in the GHP decreased 27.9%, from 27,594 in 2013 to 19,905 in 2016. In addition, we estimated 17,335 births in the GHP during the period from July 2016 to June 2017 based on GHP claims data. The table in Figure 6 contains our assumption of average monthly births in the GHP based on the observed data points.

FIGURE 6: PROJECTED GHP AVERAGE MONTHLY BIRTHS

Period	Average Monthly Births
November 2018 – October 2019	1,120
November 2019 – October 2020	1,010
November 2020 – October 2024	900

TREND DEVELOPMENT

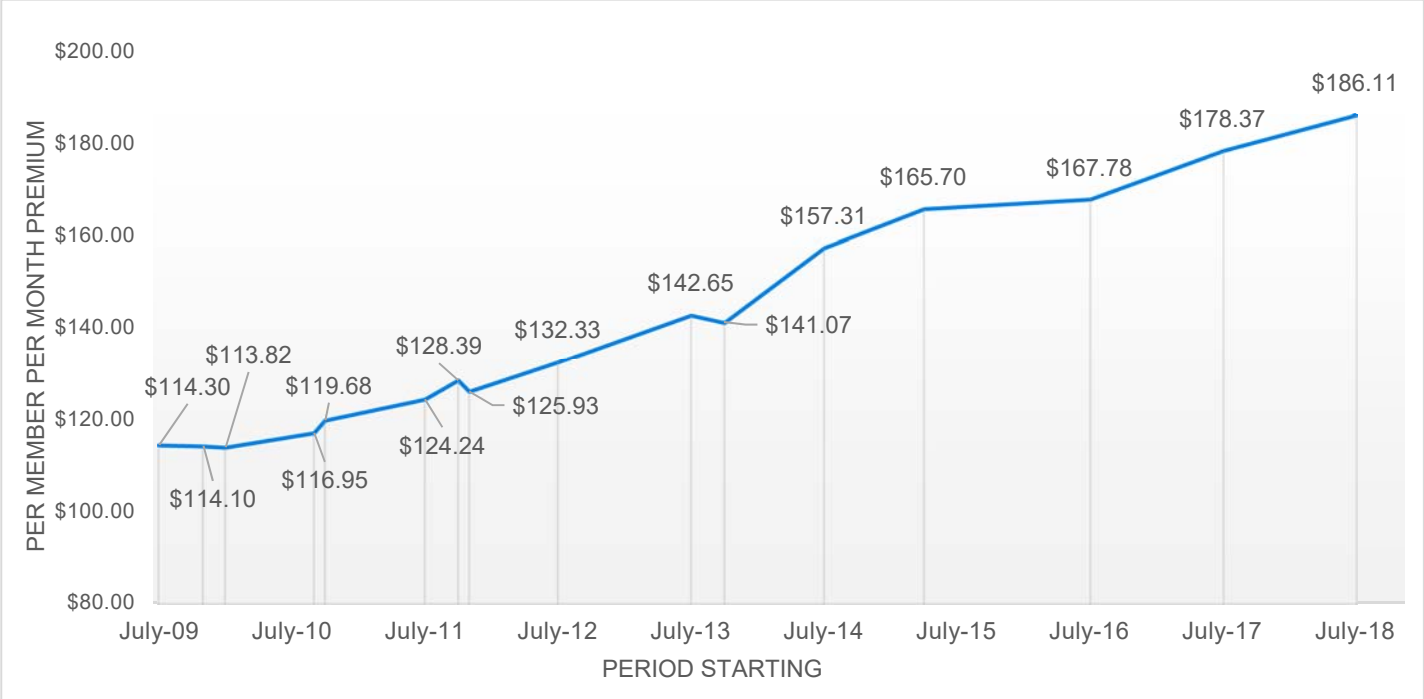
The 5.1% trend increase assumption is based on our expertise and knowledge of the GHP, supplemented by historical program data, selected actuarial literature, and public reports. Milliman has assisted ASES with financial projections, premium rate development, and production of the actuarial certification for the program for the past 20 years.

Premium rates are developed based on historical program experience trended forward, in 12-month periods. Changes to the program such as fee schedules, copay changes, and additional benefits are also included in the projection. The actuarial certification documents the methodology, data, program changes, and other assumptions that are relied upon in order to develop premium rates. The certification is reviewed by the Centers for Medicare and Medicaid Services (CMS) and is required to receive federal matching funds for the program. The documentation must be sufficient and in compliance with the Medicaid Managed Care Rule to support that premium rates are adequate, not excessive, and in compliance with federal regulations. The documentation also includes a statement signed by the actuary stating that the premium rates are actuarially sound.

Given that the rates are based on actual historical experience and observed trends, the change in premium over time is a reliable indicator of trend. Figure 7 shows the historical premium for the GHP. For the period from July 2009 to November 2018, the annualized premium increase was 5.4%.[9] Our experience is that, if premium rates result in a budget that exceeds available funding, then program changes are incorporated in order to meet budgetary needs. Therefore, previous premium increases may have been depressed to comply with this constraint. In periods where sufficient federal funding is available program changes are implemented, such as adding benefits mandated by the ACA, and consequently increasing premium.

[8] University of Puerto Rico Medical Sciences Campus Graduate Demographic Program (February 2018). Puerto Rico Live Births 2013-2016. Retrieved September 9, 2019, from http://demografia.rcm.upr.edu/index.php/sabias-que/nacimientos-e-indicadores.
[9] Historical premiums exclude Platino wraparound premium and Health Insurance Provider Fee.

FIGURE 7: HISTORICAL GHP PREMIUM FROM JULY 2009 TO NOVEMBER 2018



Notes:
1. From October 2013 to March 2015 the GHP was managed completely through a third-party administrator arrangement. These amounts are estimated. The program returned to 100% managed care in April 2015.
2. Premiums do not include amounts due for the Health Insurance Providers Fee.

We also reviewed the 2016 National Health Expenditure (NHE) Projections released in December 2017, which estimated NHE amounts, by type of expenditure, e.g., hospital expenditure, and by source of funds, e.g., Medicaid, for calendar years 2017 through 2026 on a nationwide basis. The NHE Projections also estimated enrollment by source of funds. Using this information, we calculated per capita claim costs by type of expenditure under Medicaid for 2019 through 2026. We developed annual trends by service category by observing year-over-year changes in estimated per capita claim cost by type of expenditure. We then calculated a composite annual trend using weights based on PMPM claim costs by service category under GHP in state fiscal year 2018. The calculated composite annual trend is 5.1%, as shown in the table in Figure 8.

We reviewed the reasonableness of our estimate by reviewing projected trends in the 2016 Actuarial Report on the Financial Outlook for Medicaid prepared by CMS. We found that the year-over-year changes in estimated per capita claim costs in the 2016 Actuarial Report were similar to our projected composite annual trend.

We also reviewed the impact of the difference in eligibility mix between the GHP and nationwide Medicaid using information in the 2016 Actuarial Report. We found the impact to be negligible and did not incorporate the impact of eligibility mix difference in our 5.1% estimate.

FIGURE 8: COMPOSITE ANNUAL TREND

Service Category	Weight	NHE Per Capita Trend
Hospital Expenditures	35.60%	4.9%
Physician and Clinical Expenditures	12.54%	5.5%
Other Professional Services Expenditures	13.02%	4.6%
Prescription Drug Expenditures	32.02%	5.5%
Dental Services Expenditures	2.90%	5.5%
Home Health Care Expenditures	0.93%	5.2%
Other Health, Residential, and Personal Care Expenditures	1.38%	4.3%
Durable Medical Equipment Expenditures	1.61%	6.3%
	100.00%	**5.1%**

FEDERAL HEALTH INSURANCE PROVIDERS FEE

Section 9010 of the ACA imposes a Health Insurance Providers (HIP) fee on each covered entity engaged in the business of providing health insurance for U.S. health risks.[10] The fee applies to all premiums paid except the dual eligible Platino wraparound payment. There is a moratorium of the fee for 2019; therefore, no fee is due in 2019 based on the 2018 data year. The fee is variable and calculated each year by the federal government; therefore, this percentage is only an estimate, and will most likely be different from the actual fee paid. We have estimated that the fee will be approximately 1.8% of premium for all periods after the moratorium. Our estimate is based on the HIP fee data provided to ASES by the MCOs as evidence of payment for the HIP fee. The estimated percentage of premium is calculated as the total fee due by contracted MCOs divided by the total capitation paid to MCOS for the GHP program. The percentage of premium considers that one of the participating MCOs is a nonprofit organization and therefore will not have to pay the fee. We do not include a federal tax gross up because the participating MCOs do not pay federal taxes on Puerto Rico income.

Each year the fee is due ASES will reimburse the MCOs, after the MCOs provide documentation of the amount owed to the Internal Revenue Service (IRS). We estimate that the reimbursement of the fee will occur on September of the year the fee is due.

Appendix 1 contains the estimated amount for the fee during the projection.

PROJECTED MEMBERSHIP

The GHP provides benefits to enrollees in Medicaid, CHIP, and the state-funded Commonwealth population. Each member is enrolled into a managed care plan once eligibility requirements have been verified. ASES only pays premiums for those enrollees who have been fully enrolled into an MCO. ASES provides the enrollment data to Milliman each month, including members that had retroactive eligibility in prior months. Figure 9 contains the enrollment by eligibility category assumed in our projection for all periods.

[10] See the full text of the Affordable Care Act Provision 9010 - Health Insurance Providers Fee at https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

FIGURE 9: ASSUMED MEMBERSHIP BY ELIGIBILITY CATEGORY

Eligibility Category	Assumed Membership
Medicaid	542,678
Medicaid, Newly Eligible	365,231
CHIP	88,195
Commonwealth	119,037
Foster Children and Domestic Abuse Victims	3,182
Dual Eligible, Medicaid	73,443
Dual Eligible, Platino	263,000

The membership used in all periods for the projection is based on the actual enrollment in June 2019. We assumed that all eligibility categories will remain at the same level for future periods. The 0% enrollment trend assumption is our best estimate given the population fluctuations and recent policy decision as a result of the hurricanes discussed below.

ASES notified Milliman that the Platino population is not being calculated correctly, due to a mismatch of the dual eligible flag in the enrollment file. ASES estimates that the correct number of Platino members is approximately 263,000. We have assumed 263,000 Platino members starting on July 1, 2018, throughout the projection.

During the emergency period following Hurricanes Irma and Maria in September 2017, the process for current enrollees to recertify into Medicaid was suspended and enrollment extended automatically for a year to all enrollees. The automatic recertification ended on June 30, 2018. During this period, only new enrollees entered the program. Beginning on January 2019, eligibility was extended an additional three months to allow enrollees to be recertified into the program.

Since our initial estimate, included in the governor's Medicaid request, we have updated the assumed membership. Previously we had used membership as of February 2019; this projection uses membership as of June 2019. In both estimates, the Medicaid Platino population remained unchanged at 263,000. The remaining population increased from 1,190,291 to 1,191,766 from February 2019 to June 2019. The update in population assumption is not material to the cost projection or the Medicaid request.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

The FMAP varies by eligibility category and time period according to the Social Security Act (SSA), ACA, and Bipartisan Budget Act of 2018 (BBA). The BBA approved a 100% FMAP for all Medicaid expenditures, including administrative costs, for the period from January 1, 2018, through September 30, 2019. For our projections, we have assumed an 83% FMAP, the maximum allowable by statute, for the period after September 30, 2019.[11] If the per capita income formula were applied to Puerto Rico, its FMAP would be higher than the 83% limit. In 2014, CMS calculated that Puerto Rico's FMAP, based on the per capita income formula, would have been 91%.[12] A higher FMAP would permit Puerto Rico to implement the critical sustainability measures while maintaining a sustainable level of local funds. Finally, a higher FMAP would avoid having to implement the program cuts that are mandated by the Financial Oversight and Management Board (FOMB) if savings targets outlined in the fiscal plan are not met.[13]

[11] Section 1905(b) of the Social Security Act.
[12] U.S. Government Accountability Office (March 2014). Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources. Report no. GAO-14-31. Retrieved September 9, 2019, from https://www.gao.gov/assets/670/661334.pdf.
[13] FOMB (May 9, 2019). 2019 Fiscal Plan for Puerto Rico, p. 118.

In the cases where there are population cohorts that have a mix of applicable FMAPs (e.g., Foster Children and Domestic Abuse Victims and Dual Eligibles) the federal share is determined by the weighted average of each eligibility category in the cohort. The Commonwealth population receives no FMAP and therefore is fully funded by local funds.

The table in Figure 10 shows the FMAP assumed in our projections and the FMAP according to current statute. The table does not include the FMAP applicable to other expenditures such as health information technology (HIT), Medicaid Management Information Systems (MMIS) implementation, and enrollment systems because these expenditures are not subject to the cap.

FIGURE 10: FMAP BY ELIGIBILITY CATEGORY

ELIGIBILITY CATEGORY	PERIOD	ASSUMED FMAP	STATUTORY FMAP
Medicaid	January 2018 to September 2019	100%	100%
	Subsequent periods	83%	55%
Medicaid, Newly Eligible	January 2018 to September 2019	100%	100%
	CY 2019 Q4	93%	93%
	CY 2020 and subsequent periods	90%	90%
CHIP	FFY 2019	91.5%	91.5%
	FFY 2020	80%	80%
	FFY2021+	68.5%	68.5%
Administration	January 2018 to September 2019	100%	100%
	Subsequent periods	50%	50%

Sources:
1.U.S. Department of Health and Human Services, Federal Register notices for FYs 2019–2020.
2. MACPAC Federal Match Rates for Medicaid Administrative Activities. See https://www.macpac.gov/federal-match-rates-for-medicaid-administrative-activities/.
3. Congressional Research Service (CRO). 2018. Federal Financing for the State Children's Health Insurance Program (CHIP). Report R43949. See https://fas.org/sgp/crs/misc/R43847.pdf.

Note: The FMAP for Puerto Rico will be lower than what is statutorily available in periods when federal funding is exhausted and no additional appropriations are available.

Appendix 1 contains the estimated effective federal share for the Medicaid and CHIP expenditures during the projection.

NON-PREMIUM EXPENDITURES

Non-premium expenditures are program costs for carved-out medical services and operational and administrative activities that are not included in the MCO capitation rates.

1. **PBM administration:** The pharmacy benefit manager (PBM) charges a per claim cost to ASES to cover the costs of adjudicating pharmacy claims, which includes reviewing prior authorization and other clinical services. ASES provided the paid amount for this contract for the period from July 2017 to June 2018. The total amount paid was $13,662,798. We converted this amount into a PMPM figure by dividing it by member months for the same period. We projected the estimated expenditures for subsequent periods by multiplying the PMPM by the projected membership each month. We do not expect that the per claim cost under this contract to change materially during the period of the projection, based on guidance provided by ASES.

We have assumed that this expenditure is matched at the applicable FMAP rate by eligibility category shown in Figure 10 above, excluding administrative FMAP. The average FMAP rate varies by month depending on the proportion of members from each eligibility category in a given month.

2. **HIV program:** The costs of covered medications for the treatment of HIV has been carved out from the capitation rates and are administered through the Puerto Rico Department of Health AIDS Drug Assistance Program (ADAP). ASES provided the paid amount for this contract for the period from July 2017 to June 2018. The total amount paid was $52,068,927.

   To develop our estimate we have relied upon the ADAP enrollment and spending data provided by ASES and the PBM, and enrollment and cost information for currently covered and non-covered antiretrovirals as provided by the PBM. The costs provided are before supplemental rebates. We converted this amount into a PMPM figure by dividing it by member months for the same period. We projected the estimated baseline expenditures for subsequent periods by multiplying the PMPM by the projected membership each month.

   To estimate the cost for the new drugs, we relied upon the 2018 Milliman Commercial Health Cost Guidelines™ Prescription Drug Rating Model (RxRM) to estimate the impact of expanding the formulary. From this, we estimate the ASES formulary for antiretrovirals currently includes approximately 94.8% of the total cost of a comprehensive formulary. This estimate does not include the current coverage of Juluca, Biktarvy, or Trogarzo. We have estimated that these drugs will increase the program costs by approximately $1.36 PMPM or $21 million annually, before supplemental rebates. We projected the estimated expenditures for subsequent periods by multiplying the PMPM by the projected membership each month.

   We do not expect the per unit costs for these drugs to change materially during the projection period. For this reason we have not applied cost trend to the PMPM. We have assumed that this expenditure is matched at the applicable FMAP rate by eligibility category shown in Figure 10 above, excluding administrative FMAP. The average FMAP rate varies by month depending on the proportion of members from each eligibility category in a given month.

3. **Synthroid dispensing:** Synthroid is a prescription drug that treats hypothyroidism, and, in some cases, enlarged thyroid gland and thyroid cancer. ASES has entered an agreement with the participating MCOs that they will dispense brand-name Synthroid but will only be liable for the generic alternative cost. ASES will reimburse the difference between the generic and brand-name cost to the MCO. We have estimated that the difference between the generic and brand-name Synthroid ranges between $0.53 and $1.08 PMPM, based on drug trends and pricing fluctuations. We have projected the PMPM cost utilizing the Milliman prescription trend tool. We have assumed a 2.2% annualized cost trend for the projection period.

   We have assumed that this expenditure is matched at the applicable FMAP rate for the eligibility category shown in Figure 10 above, excluding administrative FMAP. The average FMAP rate varies by month depending on the proportion of members from each eligibility category in a given month.

4. **FQHC wraparound:** Federally Qualified Health Centers (FQHCs) are health providers that receive additional federal funding. These centers provide services to GHP enrollees at the contracted rate by the MCOs, which is included in the capitation rates. However, federal regulations establish that these centers must receive payment equal to the cost of services provided. The wraparound payment is a direct payment to the FQHCs to compensate for the difference between the MCO contracted rate and the actual cost of providing services. We have relied upon the projections provided by the Puerto Rico Medicaid Department for this expenditure. Historically the payment has not varied significantly from projected amounts. For this reason we have not applied a cost or utilization trend to this expenditure. In FFY2020, ASES estimates the amount for this payment to be $55.2 million. For subsequent periods, we expect the payment to be approximately the same based on guidance provided by ASES.

We assumed that this expenditure is matched at the applicable FMAP rate by eligibility category shown in Figure 10 above, excluding administrative FMAP. The average FMAP rate varies by month depending on the proportion of members from each eligibility category in a given month.

5. **ASES payroll and overhead:** These are the costs borne by ASES for administration, payroll, contractors, rent, and other costs related to the operation of the agency. We have relied upon the projections from ASES for this item. For FFY2020, ASES estimates this amount to be $36.7 million. Given budgetary constraints, ASES does not expect costs to increase significantly from current levels; therefore, we have assumed that the amount will remain the same.

   This expenditure is matched at the 50% administrative FMAP rate.

6. **Enrollment counselor:** The enrollment counselor is a federally required service made available to enrollees to provide advice and counseling when choosing an MCO. This expenditure began with the new managed care model on November 1, 2018. For FFY2020, ASES estimates this amount to be $7.5 million. Given budgetary constraints, ASES does not expect the contracted costs to increase significantly; therefore, we have assumed that the amount will remain the same.

   This expenditure is matched at the 50% administrative FMAP rate.

7. **Medicaid administration:** The Puerto Rico Medicaid agency is responsible for the certification and enrollment of members into the GHP. These are costs related to the operation of this agency, including but not limited to payroll, overhead, contractors, and rent. We have relied upon the projections provided by the Puerto Rico Medicaid Department for this item. For FFY2020 the estimated cost for this item is projected to be $40.8 million. This expenditure does not include costs for MMIS implementation or enrollment systems because these expenditures are funded through separate grants that are not subject to the cap.

   This expenditure is matched at the 50% administrative FMAP rate.

APPROPRIATED FEDERAL FUNDS

Puerto Rico Medicaid expenditures are financed through several funding streams with different amounts and effective periods. The main grant is known as the recurring Section 1108 block grant. In fiscal year 2019 the amount awarded is $366.7 million. This amount increases each fiscal year by the medical care component of the consumer price index (CPI) for all urban consumers as published by the U.S. Bureau of Labor Statistics (BLI) for the 12-month period ending in March. We estimate the grant amount for fiscal year 2020 to be $372.9 million based on a 2019 12-month CPI of 1.7%. For subsequent years, we have increased the grant amount by the same percentage.

The Enhanced Allotment Plan (EAP) funds is a recurring grant for Medicaid programs in the territories that provides assistance in covering dual eligible Part D expenditures.[14] In fiscal year 2019, the awarded amount is $56.5 million. This amount increases each fiscal year by the percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D-eligible individuals, for the 12-month period ending in July of the previous year. We assumed a Part D per capita expenditure increase of 5.25%, based on the CMS estimate of Part D spending growth.[15] For subsequent years, we estimated that EAP funds will increase by this amount.

Since our initial estimate, which was included in the governor's Medicaid request, we have updated the projected EAP funds by increasing each year according to the CMS Part D per capita increase projection of 5.25%. Previously we had

[14] Per the Medicare Prescription Drug Benefit Manual, "Part D-eligible individuals who are not residents of the 50 States or the District of Columbia are not eligible for the low-income subsidy program, but may be eligible for additional financial assistance with their prescription drug expenses under Section 1935(e) of the Act. Territories receive an enhanced allotment to their Medicaid grants that must be used to provide coverage of Part D drugs for their full benefit dual eligible populations." See https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/Chapter13.pdf.

[15] CMS (April 1,2019). Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved September 9, 2019, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

assumed that the EAP funds would increase by the average increase in the previous two fiscal years. The update in assumption increased the five-year projected EAP funds by $21.4 million. The assumption update does not change the costs projection or the Medicaid request.

CHIP funds are awarded to each state based on the previous year's spend increased by a growth factor. For our projection, we have estimated the grant amount in each fiscal year is equal to the projected CHIP expenditures.

Over the last decade the ACA, the Consolidated Appropriations Act of 2017, and the Bipartisan Budget Act of 2018 have appropriated sufficient federal funds to receive the full FMAP for the period July 1, 2011, through December 31, 2019. The table in Figure 11 shows the currently appropriated grants by authorizing statute. Figure 11 does not include the grants applicable to other expenditures such as HIT, MMIS vendor costs, and enrollment systems because these expenditures are funded through separate grants that are not included in the projection.

FIGURE 11: PUERTO RICO MEDICAID FEDERAL GRANTS

GRANT NAME	AMOUNT GRANTED	AUTHORIZING STATUTE	EFFECTIVE PERIOD
Medicaid MAP	Variable. Increases by the medical care component of the CPI in the previous year.	Section 1108(a) of the Social Security Act	No time limit
Enhanced Allotment Plan (EAP)	Variable. Increases by Part D per capita increase in the previous year.	Section 1935(e) of the Social Security Act	No time limit
CHIP	Provided to states annually based on each state's previous year's spend increased by a growth factor	Section 2104(a) of the Social Security Act	Subject to periodic reauthorization
Medicaid ACA Section 2005(a)	$5.4 billion	Section 2005(a) of the ACA	July 1, 2011, through September 30, 2019
Medicaid ACA Section 1323 (Exchange Funds)	$925 million	Section 1323 of the ACA	December 31, 2019
Medicaid Omnibus Bill	$295 million	Section 202 of the Consolidated Appropriations Act of 2017	Expires September 30, 2019
Bipartisan Budget Act of 2018	$4.8 billion	Section 20301 of the Bipartisan Budget Act of 2018	Expires September 30, 2019

In FFY2020, CMS approved the use of the Medicaid MAP funds after the exhaustion of the ACA Section 1323 funds in December 31, 2019.[16] The table in Figure 12 shows the projected available amount of each federal grant for the period from FFY2020 to FFY2024.

FIGURE 12: PROJECTED PUERTO RICO MEDICAID FEDERAL GRANTS (MILLIONS)

Appropriated Federal Funds	FFY2020	FFY2021	FFY2022	FFY2023	FFY2024
Medicaid MAP	$372.9	$379.2	$385.6	$392.2	$398.9
Medicaid ACA Section 1323	$586.4	$0.0	$0.0	$0.0	$0.0
CHIP	$86.7	$78.0	$82.0	$86.2	$90.6
EAP	$59.4	$62.5	$65.8	$69.3	$72.9
Total	$1,105.4	$519.7	$533.4	$547.7	$562.4

Note:
1. The amount projected to be leftover in FFY 2020 is due to the expiry of the Section 1323 funds on December 31, 2019.
2. The CHIP grant amount in each fiscal year is equal to the projected CHIP expenditures.

[16] Per email from Ricardo Holligan, CMS New York Division of Children's Health: ASES (May 22, 2019). Re: ACA 1323 – FMAP.

CRITICAL SUSTAINABILITY MEASURES

The government of Puerto Rico has identified several critical sustainability measures that need to be implemented in the near term and are aimed to stabilize, strengthen, and improve the healthcare system. Given the historical underfunding of the Medicaid program Puerto Rico has had to limit program benefits and provider reimbursement rates. Consequently, this has led to an unsustainable healthcare system that is lacking infrastructure investment and faces provider shortages.[17] These measures can only be enacted if sufficient federal funding is appropriated to Puerto Rico, given current budgetary constraints.

We have projected the net added cost to the program for the measures assuming that they will all be implemented. There are interdependencies between the measures, therefore removing a single measure may have implications on the estimates of the other measures. Since our initial estimate, included in the governor's Medicaid request, we updated the FMAP assumption for all measures. Previously we calculated the federal share of the measures not taking into account that the average FMAP for the program will increase when the Commonwealth population becomes Medicaid-eligible. This update increased the average FMAP used to calculate the federal share, consequently increasing the federal funds for the measures over a five-year period by approximately $467 million. We have also assumed that, under the Part B initiative, Medicaid dual eligibles will be moved to a Platino plan, and therefore we have excluded these members from the provider increase calculation. The reduction resulting from this update was not material to the five-year projection.

We also assumed that the effective date for each measure will be contract year 2020, starting November 1, 2019. The following is a description of each measure and the methodology used to project their associated costs.

1. Increasing provider reimbursement rates

Reimbursement rates for GHP providers are particularly low compared to other Medicaid programs in the states and territories. In addition, increases in reimbursement rates have been limited due to budgetary constraints. For example, from July 2016 to July 2017 primary care services were reimbursed at 19% of the Puerto Rico Medicare fee, while these services are reimbursed at 66% of the Medicare fee nationally. Also maternity services were reimbursed at 50% of the Puerto Rico Medicare fee while these services are reimbursed at 81% of Medicare fee nationally.[22] Appendix 2 shows the percentage of Medicare reimbursement by specialty for the GHP. The low reimbursement rates have caused provider shortages, lack of access to certain specialty services, and lengthy wait times. To address this issue the Puerto Rico government has outlined the following measures:

- Establish a 70% of Medicare reimbursement floor for all outpatient physician services

As indicated above the reimbursement for physicians in the GHP as a percentage of Medicare is lower on average compared to other Medicaid programs in the states and territories. ASES wants to establish a 70% of Puerto Rico Medicare fee schedule reimbursement floor for all physician services. The floor will be implemented through a directed payment arrangement that will be submitted for approval by CMS. The costs associated with the measure will be included in the MCO PMPM capitation rate. In turn, the MCOs will be contractually obligated to reimburse all contracted providers at the rate of at least 70% of the Puerto Rico Medicare fee schedule, which will ensure that the increase will be transferred to providers. The directed payment arrangement will not apply to services that MCOs sub-capitated.

We have calculated the impact of increasing provider reimbursement by repricing the incurred claims during state fiscal year 2017 to at least 70% of the 2018 Puerto Rico Medicare fee schedule. All procedures that were reimbursed at lower levels were increased to the fee schedule and all procedures that were reimbursed higher than the fee schedule remained unchanged. The total impact is the sum of the difference between the total paid amount during the experience period and the total paid amount utilizing the fee schedule floor. We then calculated the PMPM impact by dividing the difference by the membership during the same period. The resulting PMPM was then trended to the contract period utilizing a 2% cost trend. We did not make any adjustments for potential increase in utilization as a result of increased access. We estimate that the total increase is $8.57 PMPM or approximately

[17] MACPAC (June 2019). Chapter 5: Mandated Report – Medicaid in Puerto Rico.

$123 million annually. For subsequent periods, the fee schedule will increase when MCO premiums are revised each contract year. This increase is embedded within the 5.1% PMPM trend already assumed for MCO premiums.

- Increase sub-capitation payment to primary care physician (PCP) services

Almost all primary care services are paid through sub-capitation arrangements where MCOs delegate the risk for these services to Primary Medical Groups (PMGs). The PMGs are reimbursed through a fixed PMPM payment. In order to improve access to primary and preventive services ASES asked Milliman to estimate a 10% increase in PMPM sub-capitation paid to PMGs for contract year 2020. We estimate that a 10% increase in the sub-capitation will be $1.50 PMPM or $20 million annually. We consider this a one-time increase and therefore no trend is applied to subsequent periods. However, we do expect that the sub-capitation will increase when MCO premiums are revised each contract year. This increase is imbedded within the 5.1% PMPM trend already assumed for MCO premiums.

- Increase dental reimbursement rates

The GHP currently covers child and adult dental services. The dentist have historically not received reimbursement rate increases for their services. ASES asked Milliman to evaluate and create a Medicaid dental fee schedule in order to assess the reasonability of the current reimbursement rates. The result of the analysis is that dental services on the island are being reimbursed at a much lower level compared to other Medicaid programs. ASES then asked Milliman to estimate the impact of increasing reimbursement rates for dental providers to a rate comparable to other Medicaid programs. ASES has already submitted a directed payment arrangement to CMS that will ensure that the increase will be transferred to dental providers. ASES is awaiting for approval of the directed payment arrangement from CMS to implement the increase.

For each dental procedure code, we calculated a billed cost per service, area-adjusted for Puerto Rico, based on the Milliman Dental Cost Guidelines. The Puerto Rico-billed cost per service was then adjusted by the allowed-to-billed reimbursement relativity observed in the states of Alabama, Mississippi, and West Virginia. We computed the reimbursement ratio as the Medicaid reimbursement divided by the area-adjusted billed charge per service. The allowed-to-billed reimbursement ratio observed in those states ranges from 50% to 70% of the commercial billed charge per service. We used this relativity benchmark to establish a dental fee schedule for the GHP and estimate the impact of the reimbursement increase.

The PMPM increase was calculated to reflect base period experience data for state fiscal year 2017. The utilization by procedure code in the base period was repriced utilizing the fee schedule. Then each procedure code was mapped to a dental service category in order to calculate the fee schedule adjustment factor. The factor is calculated as the total paid amount based on the new fee schedule divided by the total paid amount contained in the base period experience for each service category.

The base period experience data is trended to contract year 2020, assuming a 1% trend factor. The resulting PMPM increase is estimated to be $1.75 or approximately $25 million. We did not make any adjustments for potential increases in utilization as a result of increased access. For subsequent periods, we assume that the dental reimbursement rate will increase by a 1% trend factor when MCO premiums are revised.

- Increase hospital reimbursement rates

According to CMS hospital cost reports, over 50% of Puerto Rico hospitals reported net losses.[18] Medicaid, as is the case in most other states, is the payer with the lowest reimbursement rates for hospitals. Puerto Rico hospitals are disproportionately affected by the low reimbursement rates because Medicaid covers almost half of the island's population. These conditions jeopardize the ability of hospitals to operate and reinvest in infrastructure. To support the sustainability of hospital services and increase access, an estimated $46 million is needed to compensate for losses attributable to providing services to GHP beneficiaries during contract year 2020. The increase will be tied to the new diagnosis-related group (DRG) payment system that is currently being designed for the GHP. The

[18] Based on fiscal year 2016 hospital cost reports, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year.html.

payment system will allow reimbursement rates to be tied to acuity, quality, and value of services offered by each facility. ASES will ensure that the increase will be transferred to providers by mandating all MCOs to increase the base rate payment to hospitals by this amount. Subsequent increases to hospital reimbursement rates will be reflected in increases in the DRG base rate. This increase is embedded within the 5.1% PMPM trend already assumed for MCO premiums.

2. Provide coverage for hepatitis C drugs

The GHP currently does not provide coverage for drugs that cure the hepatitis C virus (HCV). Approximately 14,000[19] Puerto Ricans are eligible for treatment and could be cured by making these drugs available to them. While the up-front cost is high, in the long term program savings can be achieved due to the avoidance of costs related to the treatment of HCV such as decompensated cirrhosis and liver transplants. We have assumed that the benefit will also be made available to all dual eligibles.

We have estimated the five-year net additional cost of providing hepatitis C drug coverage and incorporated this estimate into our projection. We identified the potential GHP members with an HCV diagnosis in fiscal year 2018, and used existing projections for GHP membership and demographic makeup. In addition, ASES would provide coverage for HCV drugs for members who are coinfected with HIV and HCV and currently receive drugs through the Puerto Rico Department of Health ADAP Program. In order to develop the cost projection, we further relied upon certain assumptions provided by AbbVie, the pharmaceutical firm that produces Mavyret, an HCV drug. We reviewed these assumptions and their sources, and believe them to be reasonable. They are summarized in the table in Figure 13.

FIGURE 13: HEPATITIS C PROJECTION ASSUMPTIONS

HCV Prevalence	2.3%
HCV Incidence	0.01%
Disease Rate	6%
Self HCV Resolution Rate (15%-25%)	15%
SVR (sustained viral response)	97.5%
Additional annual expenditures for HCV–related liver complications:	
Decompensated Cirrhosis (DC)	$29,818
Hepatocellular Carcinoma	$47,562
Liver Transplant (LT), first year	$188,818
Liver Transplant (LT), second and following years	$41,123
Stages F0 through F3 (METAVIR scores fibrosis)	$452
Stage F4 (METAVIR scores fibrosis)	$2,518
PR vs, USA medical cost adjustment	60%
HCV Treatment Cost (oral drug)	$21,394
HCV Treatment Cost (labs)	$345

We note that the liver transplant costs shown in Figure 13 do not include the cost of the surgery itself, estimated to be $210,000 in Puerto Rico, but only the post-transplant care.[20,21]

[19] ASES estimate.
[20] Estimate provided by ASES via Hospital Auxilio Mutuo organ transplant program.
[21] The GHP does not cover organ transplants.

The diagnosis rate for HCV-positive members is estimated to be 25%. For the utilization rate of treatment, we relied upon AbbVie's estimated utilization rate adjusted for the diagnosis rate observed in the data.

Our assumptions include post-transplant costs of care for liver transplants. Without intervention, we assumed five transplants per year. With intervention, this number is reduced proportionately to the untreated population. Our estimate assumes that the program will achieve savings in the out years by avoiding these costs. Therefore the costs related to this initiative decrease as more enrollees are cured.

All cost estimates for both the medication and medical treatment associated with HCV are not trended in this analysis, and no discount rate is applied. The costs associated with providing HCV drug coverage will be tied directly to the utilization of the drug by enrolled members.

3. Payment of Medicaid Part B premium for dual eligibles

There are approximately 282,000 Medicaid and Medicare dual eligibles in Puerto Rico who pay the Medicare Part B premium out of pocket. In all states, the premium is required to be paid by Medicaid for dual eligibles—however, this does not apply in Puerto Rico. ASES wants to assume the payment of the Part B premium for all dual eligibles and have these members choose from a Medicare Platino plan. Currently, there are approximately 53,000 Medicare Part A only dual eligible members that are not eligible to choose a Platino plan because Part B enrollment is a requirement to enroll in a Medicare Platino plan. Presumably these members would choose a Medicare Platino plan if allowed given that in general these plans offer a wider range of services and benefits above Medicaid benefits. Our estimate for this measure assumes that the currently structured Platino plan will not change and that there will not be any significant changes in policy.

We have estimated the net additional cost of paying for the Part B premium by multiplying the estimated Platino and non-Platino dual eligible members, of approximately 336,000, by the estimated Part B premium plus the $10 wraparound payment for each calendar year in the projection. We then calculated the difference of these costs from baseline projected costs for dual eligible members in the currently structured program. We have assumed that ASES will assume payment of the Part B premium of $135.50 and the $10 wraparound payment for all dual eligibles enrolled into a Platino plan in calendar year (CY) 2020. Each subsequent calendar year we have assumed an increase for Part B premiums according to estimates released by CMS. The table in Figure 14 contains the assumed Part B premium and wraparound payment for each calendar year.

FIGURE 14: ASSUMED PART B PREMIUM AND WRAPAROUND PAYMENT

Calendar Year	Part B Standard Premium	Wraparound Payment	Total
2019	$135.50	$10	$145.50
2020	$144.30	$10	$154.30
2021	$150.00	$10	$160.00
2022	$156.60	$10	$166.60
2023	$165.50	$10	$175.50
2024	$175.80	$10	$185.80

Source: 2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, D.C. (April 22, 2019).

In our initial estimate, that was included in the governor's Medicaid request, we did not assume an increase in the Part B standard premium. The update in this assumption increased the five-year projected net additional cost of

this measure by $372.3 million. The costs associated with this initiative will be paid directly to CMS for payment of the Part B premium for dual eligible members.

4. **Puerto Rico poverty level adjustment**

   ASES and the Medicaid Department are currently analyzing an increase to the Puerto Rico poverty level (PRPL) to mitigate the loss of eligibility for members who do not qualify into the GHP due to the implementation of the modified adjusted gross income (MAGI) methodology. The goal is to increase PRPL to a level that would qualify most of the Commonwealth population for Medicaid or CHIP. In addition, the government is also analyzing the potential increase in enrollment for members who are currently uninsured; however, this analysis is not yet finalized and therefore not included in our projection.

   We have assumed that the current Commonwealth population will qualify for Medicaid and receive an 83% FMAP. This also will increase the average population FMAP and increase federal matching for non-premium expenditures. We assume that the cost for this population will remain the same, with the exception of lower copay levels for services and utilization increases caused by the lower copay levels, specifically in pharmacy and emergency room (ER) services. In order to comply with federal requirements, copays will have to decrease to a level that does not exceed 5% of monthly family income. We have estimated that the PMPM increase in premiums for this population will be approximately $6.44 PMPM due to lower copays, $0.74 PMPM due to ER utilization increases, and $2.12 PMPM due to pharmacy utilization increases. We have estimated that for contract year 2020 the PMPM for this population will increase from $108.20 to $117.56 and for contract year 2021 the PMPM will increase from $115.86 to $125.15. These amounts are not trended in subsequent contract years because we assume the induced utilization increase will dampen over time.

For each of the above measures we have estimated the projected federal share by multiplying the projected net additional cost for each measure by the FMAP for each eligibility category. The table in Figure 15 contains our estimate of each measure by fiscal year and the corresponding federal and state share.

FIGURE 15: ESTIMATED COST FOR THE CRITICAL SUSTAINABILITY MEASURES (MILLIONS)

Critical Sustainability Measures	FFY2020	FFY2021	FFY2022	FFY2023	FFY2024
Projected Net Additional Cost					
Provider Reimbursement Increase	$184.7	$201.7	$201.9	$202.1	$202.4
HCV Drug Coverage	$38.3	$42.0	$23.6	$9.1	$1.0
Payment of Part B Premium for Dual Eligibles	$214.0	$235.9	$242.9	$256.9	$276.4
Puerto Rico Poverty Level Adjustment	$12.4	$13.5	$13.5	$13.5	$13.5
Total	$449.4	$493.1	$482.0	$481.7	$493.3
Projected Federal Funds					
Provider Reimbursement Increase	$157.4	$169.7	$169.9	$170.1	$170.3
HCV Drug Coverage	$32.7	$35.3	$19.9	$7.7	$0.8
Payment of Part B Premium for Dual Eligibles	$183.3	$202.0	$207.5	$218.8	$234.6
Puerto Rico Poverty Level Adjustment	$155.8	$173.7	$181.2	$189.3	$197.7
Total	$529.1	$580.7	$578.6	$585.8	$603.4
Projected Puerto Rico Funds					
Provider Reimbursement Increase	$27.3	$32.0	$32.0	$32.0	$32.1
HCV Drug Coverage	$5.7	$6.7	$3.7	$1.4	$0.2
Payment of Part B Premium for Dual Eligibles	$30.7	$33.9	$35.4	$38.1	$41.8
Puerto Rico Poverty Level Adjustment	($165.4)	($184.0)	($191.6)	($199.6)	($208.0)
Total	($101.7)	($111.5)	($120.4)	($128.0)	($134.0)

Caveats and limitations of use

In preparation of our analysis, we relied upon the accuracy of data or information provided to us. Each month participating MCOs provide encounter data to ASES, which is then loaded into the Milliman Medinsight® data warehouse. We have not audited this information, although we have reviewed it for reasonableness. Milliman does validate the data against financial summaries provided by the MCOs for reasonableness. In addition, several data quality checks are performed to verify completeness. If a data submission does not meet the requirements then a data correction is requested from the MCO. If the underlying data or information is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

Each of the policy options analyzed has been provided by ASES, Milliman does not have a position on the policy options.

Differences between projected reimbursement rates/utilization and actual experience will depend on the extent that future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions made. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

This information is intended for the use of ASES. It should not be provided to other parties without our written consent. Milliman makes no warranties or representations regarding the contents of this letter to third parties. Likewise, third parties are instructed to place no reliance upon this information prepared for ASES by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. One of the authors of this communication, Susan Pantely, is a member of the American Academy of Actuaries, and meets the qualification standards for performing this analysis. The terms of Milliman's consulting service agreement with ASES, signed on August 2, 2019, apply to this letter and its use.

Appendix 1: Puerto Rico GHP Expenditures (millions) at 83% FMAP

This table summarizes the projected expenditures for the program, not including the critical sustainability measures, assuming an 83% FMAP. The expenditures are shown by major expenditure line and population. We also calculated the effective FMAP for Medicaid and CHIP expenditures.

Expenditure Category	FFY2020	FFY2021	FFY2022	FFY2023	FFY2024
Premiums					
Medicaid	$2,096.0	$2,196.8	$2,308.4	$2,426.1	$2,549.8
CHIP	$108.4	$113.9	$119.7	$125.8	$132.2
Dual Eligibles	$374.6	$392.1	$410.5	$429.8	$450.1
Commonwealth	$166.8	$174.6	$183.5	$192.9	$202.7
Federal Health Insurance Provider Fee	$47.2	$49.4	$51.9	$54.5	$57.3
Other					
Healthcare-Related Programs	$151.9	$152.2	$152.2	$152.2	$152.2
Administrative and Operating Costs	$85.1	$85.1	$85.1	$85.1	$85.1
Total	$3,030.0	$3,164.2	$3,311.2	$3,466.4	$3,629.5
Effective FMAP					
Medicaid	84.3%	84.0%	84.1%	84.2%	84.2%
CHIP	80.0%	68.5%	68.5%	68.5%	68.5%
Estimated Federal Funds					
Medicaid (83% FMAP)	$2,322.4	$2,416.1	$2,529.5	$2,649.1	$2,774.8
CHIP	$86.7	$78.0	$82.0	$86.2	$90.6
Total	$2,409.1	$2,494.2	$2,611.5	$2,735.3	$2,865.4
Estimated Puerto Rico Funds					
Medicaid	$432.3	$459.5	$478.5	$498.6	$519.8
CHIP	$21.7	$35.9	$37.7	$39.6	$41.7
Commonwealth	$166.8	$174.6	$183.5	$192.9	$202.7
Total	$620.8	$670.1	$699.7	$731.1	$764.1

Notes:
1. Expenditure projections are not net of pharmacy rebates or third-party liability.
2. Administrative costs do not include amounts for expenditures that are not subject to the Medicaid cap such as establishment of a Medicaid Fraud Control Unit (MFCU) and establishment of operational and eligibility systems.

Appendix 2: GHP SFY 2017 Professional Reimbursement as a Percentage of Medicare

This table shows the GHP professional reimbursement as a percentage of the 2018 Puerto Rico Medicare physician fee schedule. The table is based on state fiscal year 2017 paid claims data for professional non-facility services.

Specialty	Percentage of 2018 Puerto Rico Medicare
Anesthesiology	41%
Cardiology	102%
Clinical laboratory (billing independently)	108%
Dermatology	47%
Diagnostic radiology	114%
Emergency medicine	38%
Family practice	26%
Gastroenterology	86%
General practice	24%
General surgery	71%
Geriatric medicine	27%
Hematology/oncology	57%
Internal medicine	62%
Nephrology	56%
Nuclear medicine	98%
Obstetrics/gynecology	50%
Ophthalmology	83%
Orthopedic surgery	78%
Otolaryngology	67%
Pediatric medicine	56%
Rheumatology	37%
Speech Language Pathologists	47%

Notes:
1. The data represents state fiscal year (SFY) 2017 paid claims for which a Medicare fee was available to reprice the GHP allowed amount.
2. Repricing is based on the 2018 Puerto Rico Adjusted Medicare Physician Fee Schedule.
3. Data does not include claims for services rendered under sub-capitated arrangements.
4. Specialties listed are those coded onto the claim data and do not represent the entirety of specialist rendering services for the GHP.
5. Data does not include Platino paid claim experience.

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