June 17, 2016

SUBMITTED ELECTRONICALLY VIA WWW.REGULATIONS.GOV

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

Comments for the FY2017 Medicare IPPS Proposed Rule

Federal Register / Vol. 81, No. 81 / April 27, 2016 / Proposed Rules

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2016 Rates…

Dear Administrator Slavitt:

We write on behalf of the healthcare community of Puerto Rico. The comments included here are the results of contributions or support from the following organizations:

- the Medicaid and Medicare Advantage Association of Puerto Rico, Inc. (MMAPA)
- the Puerto Rico Hospital Association
- the Puerto Rico Healthcare Crisis Coalition
- the Puerto Rico IPA Association (Primary Care Groups)

The **FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule** includes adjustments related to important policy actions taken by Congress and by the Centers for Medicare & Medicaid Services (CMS) to address the increasing disparities in Part A payments, and Medicare in general, for inpatient services provided to Medicare beneficiaries in Puerto Rico. Specifically, we appreciate the change enacted by Congress in the 2016 Omnibus Appropriations bill, which applied the national IPPS formula to Puerto Rico hospitals at 100 percent for the first time ever, commencing in January 2016. In addition, we also recognize that CMS is including a proposal to use a proxy in lieu of the Supplemental Security Income (SSI) days used nationally to estimate low income days of Medicare beneficiaries with regards to the current formula used to allocate uncompensated care funding.[1]

As a community, we are thankful and appreciative of the increasing effort and attention of CMS officials to the uniqueness of Medicare FFS program payments and operations in Puerto Rico, which are mainly result of historically differential treatment in statute. Nevertheless, even with these adjustments our hospitals remain in a significantly detrimental position, in which average payments in Puerto Rico are still approximately **half the level of the national average**. These depressed payment levels result from the remaining, unaddressed anomalies in the program's unique historic development. Therefore, a

[1] The need for a proxy for SSI days in Part A payment formulas had also been included in our proposals and Comment letters to CMS in 2014 and 2015, for payments occurring in 2015 and 2016.

meaningful solution to the Part A payment disparity in Puerto Rico is still needed, to tackle issues such as the wage index death spiral, as well as Medicare's continued use of indicators not applicable to the context of Puerto Rico.

Specifically, we urge CMS to consider and implement our proposals for the following:

1. The use of an alternate proxy for SSI days in payment formulas for both the Disproportionate Share Hospital (DSH) and uncompensated care payments.

2. Exclude or delay the use of the S-10 form for hospitals in Puerto Rico to estimate the burden of uncompensated care, given the potential significant impact, as well as the distinct statutory and economic context of healthcare in the island.

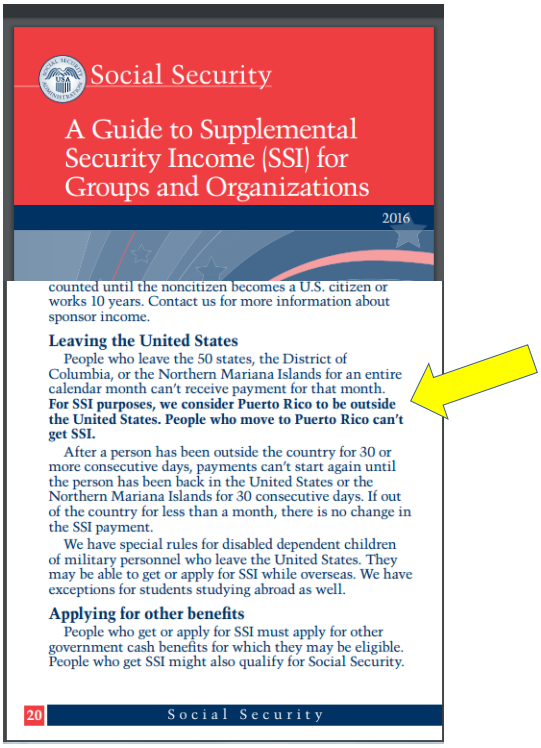
3. The use of an alternate wage index that would result in more reasonable payments and stop the current "death spiral" that results from the application of the standard formulas to the unique character of the Puerto Rico health economy.

4. Making a simultaneous adjustment in Medicare Advantage (MA) rates to avoid underpayment in the MA program for 2017.

Below we provide a more detailed description and explanation of these proposals.

1. The use of an alternate proxy for SSI days in payment formulas for both the DSH and uncompensated care payments.

We appreciate the attention and effort of CMS to develop a fair and appropriate method to estimate SSI days for Puerto Rico, as the SSI program is statutorily unavailable to U.S. citizens residing in Territories. We also support the use of the "Medicaid days to SSI ratios" to estimate the SSI days in Puerto Rico, given that the data of beneficiaries with both Medicare and Medicaid in the cost reports may be deficient.


Social Security

A Guide to Supplemental Security Income (SSI) for Groups and Organizations

2016

counted until the noncitizen becomes a U.S. citizen or works 10 years. Contact us for more information about sponsor income.

Leaving the United States

People who leave the 50 states, the District of Columbia, or the Northern Mariana Islands for an entire calendar month can't receive payment for that month. **For SSI purposes, we consider Puerto Rico to be outside the United States. People who move to Puerto Rico can't get SSI.**

After a person has been outside the country for 30 or more consecutive days, payments can't start again until the person has been back in the United States or the Northern Mariana Islands for 30 consecutive days. If out of the country for less than a month, there is no change in the SSI payment.

We have special rules for disabled dependent children of military personnel who leave the United States. They may be able to get or apply for SSI while overseas. We have exceptions for students studying abroad as well.

Applying for other benefits

People who get or apply for SSI must apply for other government cash benefits for which they may be eligible. People who get SSI might also qualify for Social Security.

20 Social Security

While recognizing this positive step taken by CMS, we have to reiterate that Medicare DSH payments to hospitals located in Puerto Rico have been undercompensated since the beginning of the program in 1986, for 30 years. [2] The use of SSI eligibility as an indicator of low income Medicare patients effectively extends the statutory exclusion of this program to other Federal programs which are clearly **not** excluded by statute for US citizens residing in the Territories, or for services in the Territories, like the Disproportionate Share Hospital (DSH) program.

Examining Data to Evaluate Future Alternatives

[2] The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986.

In regards to the objective of using data for Medicare beneficiaries with Medicaid eligibility (duals), we propose that CMS initiate in the final rule a plan to work with hospitals in Puerto Rico to formally review, define and resubmit cost-report data of recent years in relation to the documentation of hospital days for dual beneficiaries. Based on this process, CMS may have the needed assessment to make the determination to use cost report data, while hospitals in Puerto Rico would also have a better understanding of the payment implications related to this. As a second step, we propose that CMS allows hospitals in Puerto Rico to re-submit the pertinent worksheets of the cost reports of past years, to appropriately document the hospital days for duals ("dual days"), including those in the integrated Medicare Platino program that works through membership in Medicare Advantage (MA).

Use Proxy for the 25 Percent "Old DSH" Factor as Well

As part of our comment letters and meetings with CMS staff over the last three years, we have explained our understanding of CMS' authority to use an alternate indicator for SSI days in the case of Territories. We include as Appendix (1) a legal memorandum from Epstein, Becker and Green (EBG), which provides the legal rationale in support of this needed policy changes. The statutory language defining the methods to be used by CMS in implementing the uncompensated care payments, and the "Old DSH" is certainly different. However, we understand that CMS has used proxies in cases when data is not available, or in other particular circumstances, guided by the intent and objectives of the law. The use of a proxy in the old DSH formula, is logical and naturally derived from the proposal included by CMS to use the ratio of SSI days to Medicaid days for the uncompensated care formula.

As the EBG Memorandum explains, we believe there is sufficient precedent and legal support for CMS to use the SSI proxy for the 25 percent DSH factor. The law requires CMS to apply the formula "in the same manner and to the same extent" in each jurisdiction. By not addressing the exclusion from SSI of beneficiaries in the Territories, the old DSH payment formula and its resulting payments are not consistent in "the same manner and same extent". The result is that the jurisdiction with a highest proportion of low income beneficiaries gets the lowest disproportionate share payment, within the context of the old DSH.

We urge CMS to reconsider and evaluate again its authority to use a proxy for SSI days in the "Old DSH" formula.

2. Exclude or delay the use of the S-10 form for hospitals in Puerto Rico to estimate the burden of uncompensated care, given the potential significant impact, as well as the distinct statutory and economic context of healthcare in the island.

CMS is proposing a three year phase-in period, starting FY2018, to use the S-10 form as the source for the estimation of the uncompensated care provided by a hospital. The data and documentation issues with the S-10 form have occurred at a national level, but CMS understands that progress has been made and the transition from low-income days to S-10 can start in 2018.

However, as we have shared directly with CMS, the anomalous statutory treatment of Puerto Rico, combined with a particular socio-economic reality, creates another dimension of this problem for hospitals. The Island is underfunded with regards to Medicaid and Medicare payment levels (at 40% to 60% of the national average), but has an uninsured percentage of only eight percent, one of the lowest in the nation. This context provokes a potential significant cliff in Medicare Part A uncompensated care payments to hospitals in Puerto Rico if the S-10 form is used. Moreover, we understand that the

unintended result of the change in the methodology may be to increase payments for Medicare hospitals in the highest cost areas, like in Florida and Texas, which typically also exhibit the highest levels of uninsured population. Conversely, the reality of providing more access to care, BUT at sub-standard payment levels, may result in an unintended penalty for hospitals located in Puerto Rico. In parallel, the new methodology would reward those jurisdictions that tend to have the highest healthcare inflation, and the lowest access to care.

Apart from the national discussion about the reasons to delay the use of the S-10 form, we understand that the unique situation in Puerto Rico merits further study. The history and distinct operations of our Medicaid program, may require evaluating particular data elements or data collection processes to adequately fill out a form related to low income care or uncompensated care. Standard forms, data collections or categories may not be appropriate in Puerto Rico. Based on the analysis of our hospitals, the problem with the reliability of FFS data is not only about the discipline to fill out the forms, but, most importantly about the definition of the data elements, and about their interpretation. Accordingly, we propose CMS to exclude Puerto Rico from the use of the S-10 form, considering the unique statutory treatment under Medicaid and Medicare Part A. In the alternative, CMS should delay the implementation of the S-10 Form until policy disparities are corrected. We also propose that CMS work with the hospitals on the island to conduct a specific study of uncompensated versus under-compensated care, before moving away from the levels of funding under the current uncompensated care formula. The study should also allow hospitals to clearly define what "uncompensated care" means in the unique context of Puerto Rico, the opportunity to restate past years S-10 forms, and to understand the real dollar impact of the change.

3. The need to use an alternate wage index that would result in more reasonable payments to hospitals in Puerto Rico, and stop the current "death spiral" that is resulting from applying the standard formulas to the unique Medicare FFS program of Puerto Rico.

Puerto Rico's Medicare program is unfortunately becoming the icon of the "chicken-and-the-egg" relation of cost and pricing factors, in a spiral that is going in the wrong direction fueled by decreasing MA funding, historic FFS disparities, and resulting in unsustainable inequities within the US healthcare programs. There is an evident miss-conception created by abysmal differences in the labor and non-labor positioning of costs in Puerto Rico within the Medicare program as a whole. Non-labor costs are not less in Puerto Rico, but **depressed wages**, and potential technical problems with labor cost estimates, may be reflecting an erroneous perception that providing services in Puerto Rico is cheaper or that the costs of living for a health professional are cheaper.

Cost of Living Relative to 296 Metropolitan Statistical Areas in the States

Cost of Living Index (San Juan MSA)

Category	Index Avg = 100
Grocery Items	121.4
Housing	101.8
Utilities	182.1
Transportation	122.4
Miscellaneous Goods and Services	108.9
Overall Cost of Living Index	**115.4**

As evidenced in the data from the Cost of Living Index (COLI) performed by the Council for Community and Economic Research, Puerto Rico is not cheaper.[3] In fact, out of 296 MSAs, the data reported for first quarter 2015 places Puerto Rico as the 35th costliest area, and averaging 15% higher prices than the US average.

In regards to key healthcare inputs, we should note the following for the case of Puerto Rico:

- Prescription drugs are purchased in the national market at the same US average prices.
- Housing, office and construction costs are similar to US averages.
- Equipment and medical supplies are acquired in the national market at the same US average prices.
- Diagnostic machines, computers and electronics are acquired from the US national market at the same US average prices.
- For all the above materials, equipment, and goods, transportation costs have an effect that increases final purchasing price in Puerto Rico.

The only geographic factor that lowers costs in Puerto Rico is wages, which for health care have been significantly influenced by the statutory and programmatic uniqueness of the island, as detailed in previous sections. Moreover, if wage indexes or any geographic index in Medicare tends to be understated for Puerto Rico, the inevitable effect is to increase the pressures to decrease compensation or to avoid any increases for multiple years. With increasing Medicare cuts and non-labor costs increasing, our system is submerged in a race towards the bottom with regards to geographic cost indexes, and a death spiral is becoming evident in the funding of Medicare programs. How can the market generate wage increases when non-labor costs are increasing *via* national market prices, while geographic indexes seem to perpetuate a depressed level of payment rates in the poorest areas of the US?

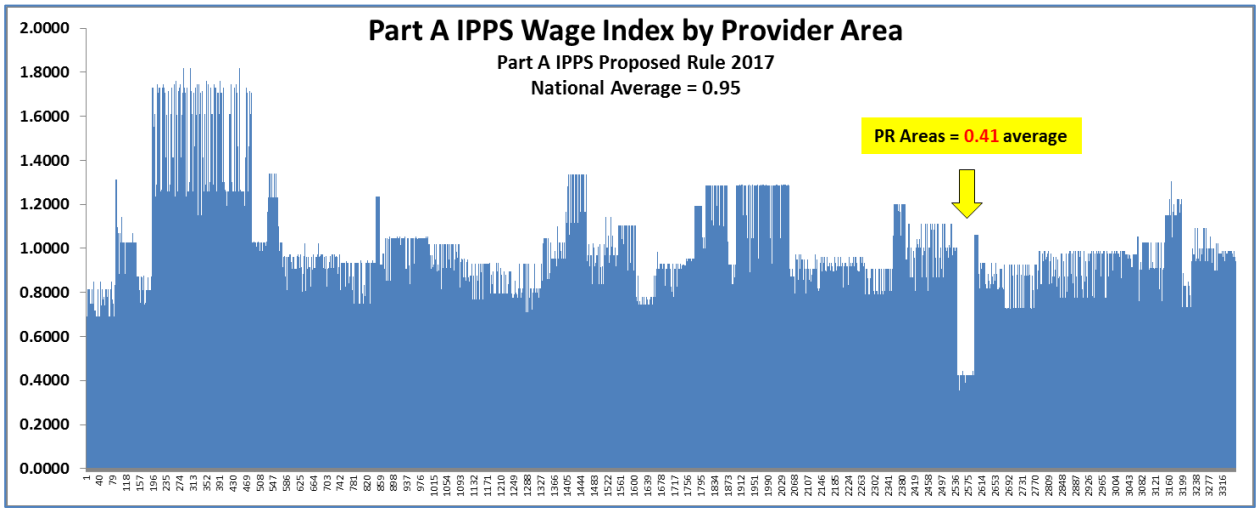
The magnitude of the funding differential in Medicare for Puerto Rico is so large, that it is a case of *unfair competition*, where the *different version* of the Medicare FFS program existing in the mainland increasingly pulls the most qualified human resources out of the island. Since health professionals and physicians are US-educated and bilingual there is a natural escape valve for many. It is estimated that one physician leaves Puerto Rico every day, and most likely our highest quality professionals are the ones leaving. Inevitably, Puerto Rico is part of the US labor market of health professionals. Modern communications, transportation, 5 million Puerto Ricans, and over 50 million Hispanics in the US just makes the decision to move to the mainland much easier than ever for the US citizens residing in Puerto Rico.

Medicare Part A IPPS - Wage Index in Puerto Rico vs US mainland

A critical increasing issue for the Medicare program in Puerto Rico is the evident disparity in the Part A wage index. For FY2016, Part A wage indices in the CMS Final Rule for hospitals in Puerto Rico were basically at the 0.4 floor. Moreover, this wage index is also applied to the outpatient ESRD payment formulas, extending the issue beyond the hospitals. There are several reasons why this disparity could exist; however, the extraordinary distance at the bottom is in itself cause for concern. At the more macro level, as explained in previous sections, the local health care market has evolved in a statutory and programmatic context that is unique within the US. This unequal and incongruent context has

[3] http://www.estadisticas.gobierno.pr/iepr/

maintained health care compensation at increasingly lower and disparate levels of payment relative to the rest of the US. On the other hand, at the time it is not clear if Medicare Cost Reports for Puerto Rico hospitals could have information gaps or particular market-based issues which may be understating costs. The chart below illustrates how impressive the funding disparity is, for hospitals that have to meet the same contracting, credentialing and quality standards as those everywhere else in the states.



In order to understand how the Puerto Rico Medicare (Part A) wage index could relate to the general situation of Puerto Rico, we reviewed the most recent data available in the ***Occupational Employment Statistics of the Federal Bureau of Labor Statistics (BLS)***. Not surprisingly, wages for Puerto Rico in general, are reported to be significantly lower than national averages. However, the revealing observation is that the average annual wage is approximately **59%** of the US average, which is significantly higher than the relative position of the Medicare Part A wage index for Puerto Rico (**0.41 of a 0.95 US average**). As commented in the **2016 Final Rule for ESRD payments**, CMS has the authority to consider all the factors described herein to maintain or establish a temporary floor that protects the reimbursements from falling further.

We urge CMS to consider a common sense, temporary rationale for a minimum wage index level, to avoid further harm or increases in disparities while more analysis is done:

- **PROPOSAL: Puerto Rico wage indices in Medicare FFS should not be lower than the average ratio of Puerto Rico non-healthcare wages to US non-healthcare wages, using the data from the Occupational Employment Statistics (OES).**

It is evident that addressing and correcting this long-standing and aggravating issue will require further study. However, the fact that the wage index perpetuates a level of inequality in health care (vs mainland), to a significantly larger extent than the disparity of wages in the general economy (based on the **OES**) is extremely concerning.

We understand that the statute, as well as the use of proxies for other cases in the proposed rule, provide CMS with the opportunity to implement a temporary wage index floor for hospitals in Puerto Rico, derived from the "***Puerto Rico : All US"*** ratio of wages for non-health occupations as reported by the ***BLS***. This alternative would result in a wage index of approximately **0.56**, which would still keep Puerto Rico as an outlier at the bottom, but provide much needed temporary relief and stop the ***rate-cost*** spiral that continues to increase funding disparities unless measures like this are taken.

Related Provisions in SSA

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

4. The need to make a simultaneous adjustment in Medicare Advantage (MA) rates 2017 to avoid the underpayment in the MA program for 2017.

The use of the SSI proxy will generate legitimate increases in FFS payment rates starting in October 2016. However, MA rates for 2017 did not contemplate this incremental expense in the estimate of the FFS cost to develop said rates. We request CMS to evaluate this problem and develop a payment factor for MA rates in 2017 to account for this change.

In General

We urge CMS to take the unique opportunities of these proposals to take additional positive steps, and mitigate the increasing disparities in Medicare FFS and MA in Puerto Rico. Our proposals and requests primarily seek fairness for over 700,000 Medicare beneficiaries on the island. It is noteworthy that even by granting all the adjustments proposed by the community of stakeholders, these programs will still be by far the lowest cost programs in the nation. Conversely, the system could have a fairer and more legitimate chance to meet the standards and excel in the achievement of adequate access and quality of care for our citizens.

Sincerely,

James P. O'Drobinak
President, Medicaid and Medicare Advantage
Products Association of Puerto Rico (MMAPA)

Lcdo. Jaime Plá-Cortés
President, PR Hospital Association

Dennis Rivera
Chairman, PR Healthcare Crisis Coalition

Dr. José J. Vargas
President of PR IPA Association

Cc/

Silvia M. Burwell, Secretary of Health and Human Services