June 16, 2015

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-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

Comments for the FY2016 Medicare IPPS Proposed Rule
Federal Register / Vol. 80, No. 83 / Thursday, April 30, 2015 / 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 Acting Administrator Slavitt:

We request the following specific proposals for inclusion in the FY 2016 Medicare IPPS Proposed Rule (the 2016 Proposed Rule), which move Puerto Rico closer to fair payment rates, but still at the very lowest level funded by CMS. These proposals have been personally discussed with CMS/HHS and the President's Task Force on Puerto Rico issues on several occasions, most recently in the February 13th, 2015 Puerto Rico Healthcare Roundtable meeting at the White House with participation by Mr. Marc Hartstein, Director, Hospital and Ambulatory Policy Group, Center for Medicare, CMS, and other leaders from the agency. (See attached agenda). These proposals, within the administrative authority of CMS, will allow Puerto Rico to sustain the access and quality of care for our beneficiaries in 2016.

We write to you on behalf of the Medicaid and Medicare Advantage Association of Puerto Rico, Inc. (MMAPA), which is composed of the main health plans in the island that combined serve over 550,000 Medicare Advantage (MA) beneficiaries, as well as the Puerto Rico Hospital Association, which members provide services to the over 3.6 million residents of the island of Puerto Rico, as representatives of the local healthcare community.[1] As we have consistently been pointing out, there are particular impacts and implications in the year to year Proposed Rules for the Medicare IPPS that will continue to significantly reduce funding for our hospitals and for the Medicare program in general in 2016.

Given recent technical fixes defined by CMS regulation to rationalize the implementation of the Affordable Care Act (ACA), we understand that CMS can make the following adjustments, which are rational, legitimate, and within the scope of authority of the agency, to generate a fairer scenario for Part A payments to Puerto Rico:

[1] For more information about MMAPA and the PRHA, please visit www.mmapapr.org and www.hospitalespr.org.

(1) **Inequities in the Payment Adjustment for Medicare Disproportionate Share Hospitals in Puerto Rico (DHSs), §412.106 - A rational and legitimate adjustment is needed.** CMS can make technical adjustments in Part A payment formulas to appropriately reflect the inapplicability of the Supplemental Security Income (SSI). CMS can use Medicaid days for dual eligible beneficiaries or an alternative method to estimate low income days.

- Use new proxy in the 25% of the "Old DSH" formula
- Use new proxy to calculate the DPP (DSH Patient Percent)
- Use new proxy for the calculation of the uncompensated care amount

(2) **Wage Index, Labor: Non-Labor Ratio – The Hospital IPPS unfairly reduces payment only for hospitals providing services to Medicare beneficiaries in Puerto Rico.** CMS can take action to correct the Puerto Rico amount (25%) by defining a regulatory alternative to reflect more appropriate assessment of NON-Labor costs for PR in IPPS formula.

- Work with Puerto Rico hospitals to gather any empirical data needed to demonstrate the non-labor costs in Puerto Rico.
- Define regulatory interpretation that does not lower non-labor and capital portions of the rate for Puerto Rico just to meet the current interpretation of the legislative language about labor/no-labor ratios**. (e.g. capital standard used 51% lower than US Average)**

(3) **Make simultaneous corresponding adjustments in the Medicare Advantage (MA) rates given the high penetration in Puerto Rico - Part A reductions are added to other significant cuts to Puerto Rico.** The lack of legitimate administrative and regulatory corrections in part A payments is exacerbating the increasing funding cuts and disparities in the entire Medicare and Medicare Advantage program in Puerto Rico.

(1) Inequities in the Payment Adjustment for Medicare Disproportionate Share Hospitals in Puerto Rico (DHSs) (§412.106). – A rational and legitimate adjustment is needed.

Last year CMS responded to commenters from Puerto Rico about the issue related to the fact that the DSH and Uncompensated Care formulas still use Medicare SSI days as an important component, while the SSI program is statutorily exclude for citizens residing in the Territories.[2] CMS explained that they still believe (even in the case of the Territories) "that SSI data combined with Medicaid data are the best data currently available for estimating hospitals' uncompensated care burdens".

We respectfully request CMS to re-evaluate this conclusion and use Medicare+Medicaid days (or "Dual Days") as the proxy to identify the indicator of the hospital utilization of the Medicare beneficiaries that are poor in the Territories. This is an appropriate substitute in any place of the formula where the Medicaid SSI days are used given that citizens that are residents in the Territories are not eligible to Supplemental Security Income

[2] **Pages 50006 and 50007 of the Federal Register** *(Vol. 79, No. 163, Friday Aug 22, 2014)*

by Statute. This data is available and could be submitted to CMS regularly by hospitals and by the local Government agency that administers Medicaid.

The use of the SSI for Territories in this formula has been discussed for several years. We understand that there is merit to our request and there is precedent of similar CMS determinations within the regulatory process.

Given the current situation of Federal programs in Puerto Rico, we urge CMS to work with us in discussing these alternatives for policy adjustments during this regulatory process. Resolving the problem of the SSI indicator in the DSH and Uncompensated Care formulas for the Territories will be a fair and legitimate adjustment CMS can make beginning October 2015.

The ACA added the new SSA 1886(r) modifying the methodology for computing the Medicare DHS payment adjustment beginning in FY2014. The prior DSH formula used through FY2013 relied upon care provided to SSI enrollees to calculate payments to hospitals. Because the prior formula relied so heavily on SSI and because SSI is statutorily excluded for citizens residing on Puerto Rico, DSH payments to Puerto Rico hospitals were disproportionately depressed in comparison to payments to hospitals in the 50 states. Since DSH payments are counted as Medicare FFS expenditures which are used to calculate county benchmarks used in setting payment rates for Medicare Advantage plans, the payment policy also disproportionately lowered payments to Puerto Rico MA plans as well.

Because the U.S. citizens residing in Puerto Rico are not entitled to SSI benefits, CMS' interpretation and application of current law to date has resulted in the inaccurate conclusion that hospitals on the Island do not treat any low-income Medicare beneficiaries when, as a matter of fact, over 40% of Medicare beneficiaries in Puerto Rico are Medicaid eligible while the National average is about half of the proportion. This contrast is even more significant when considering that in Puerto Rico Medicaid eligibility is currently at 87% FPL, lower than in most states.

The new DSH payment formula implemented in FY2014 is an improvement because it significantly reduces the value of SSI enrollment in calculating DSH payments. However, the fact that the new formula relies at all upon SSI enrollment means that payments are unintentionally and unfairly lowered for hospitals and MA plans in Puerto Rico. The new formula consists of 25% of an "empirically justified payment" and 75% determined as a product of three factors. One of those three factors is intended to account for a hospital's specific portion of uncompensated care as a percent of uncompensated care by all hospitals. CMS determines uncompensated care as the sum of insured low-income Medicaid patient days and SSI days.

CMS is not required by statute to use SSI in determining uncompensated care. Rather SSA 1886(r)(2)(C) states only that the Secretary determines uncompensated care "as estimated by the Secretary, based on appropriate data." Therefore CMS has the discretion to consider other data in place of SSI to indicate uncompensated care. In fact, SSA 1886(d)(9)(D) requires the Secretary to ensure that Medicare DSH payments made to Puerto Rico hospitals are made "in the same manner and to the extent as they apply" to PPS hospitals in the United States. The revised DSH formula fails to apply payments to Puerto Rico hospitals "in the same manner" because it factors in and is based upon an indicator that is not even available to Puerto Rico. Therefore, DSH payments are applied in a disproportionately reduced manner to Puerto Rico hospitals based upon the inclusion of SSI data.

This interpretation by CMS of §1395ww(d)(9)(D) has disallowed Island hospitals from counting any days of service attributable to low-income Medicare beneficiaries residing in Puerto Rico. This outcome is illogical as the main purpose of the DSH payment is to compensate hospitals for the higher costs of treating low-income Medicare patients.

We believe CMS clearly has exercised such discretion previously in the interest of fulfilling the intent of a statute. (For example: in estimating uncompensated care provided by hospitals, in using a proxy for GPCIs in the Virgin Island FFS payment due to lack of data, by delaying implementation of certain ACA exchange programs as appropriate, etc.) We strongly urge CMS to use its discretionary authority to adjust the formula for purposes of Puerto Rico only to substitute another data source for SSI. Alternatively, CMS could use data to determine those patients of Puerto Rico hospitals who would be eligible for SSI and count them under the formula.

While it is true that most Puerto Rico hospitals are benefiting since 2014 from the proposed new Medicare DSH calculation methodology, the fact is that significant vestiges of inequality still remain in its implementation, particularly as it pertains to the 25 percent empirically justified payment, which is based on current formula, and the calculation of factor three, which uses Medicare SSI days – not applicable in Puerto Rico – as a component of its formula.

The health care providers of Puerto Rico welcome the opportunity to work with CMS to determine the appropriate substitute measure of SSI to provide a more realistic quantitative description of the amount of low income Medicare beneficiaries receiving care in the island's hospitals. We respectfully request that CMS carefully review the SSI-related components in the proposed Medicare DSH and uncompensated care calculation methodology for Puerto Rico.

- **An Alternative: using the Medicaid days for all beneficiaries with Medicare Part A** considering that Medicaid in Puerto Rico is only 87% FPL and therefore the dual eligible numbers are an adequate representation of the "low income insured days" for the Medicare beneficiaries on the island.

We urge CMS to take this into account and define an alternative methodology to correct payment deficiencies for Puerto Rico before the Final Rule and data is released. We also urge them to engage the PRHA and MMAPA in the analysis of the scenario and the potential alternatives to find a fair solution to this problem.

(2) Wage Index, Labor: Non-Labor Ratio – The Hospital IPPS unfairly reduces payment only for hospitals providing services to Medicare beneficiaries in Puerto Rico. – CMS can take action to correct the Puerto Rico amount (25%).

In the response for the 2015 IPPS final rule CMS acknowledged the comment and proposal from Puerto Rico in relation to the impact of the application of the current labor / non-labor ratio to the payment for Puerto Rico hospitals.[3] We continue to believe that forcing the 62% labor ratio for Puerto Rico is creating an undue reduction in the non-labor and the capital payment for the Puerto Rico formula. Moreover, we still understand that the statutory language in section 1886(d)(3)(E) of the Social Security Act opens the possibility of an adjustment to the ratio in cases like this one. The language explains that the Secretary must employ 62% as a labor related share unless this "would result in lower payments to a hospital than would otherwise

[3] **Page 49990 and 49991, and Page 49996 of the Federal Register** *(Vol. 79, No. 163, Friday Aug 22, 2014)*

be made". CMS has concluded in the past that this allows them to increase the labor share to accommodate hospitals that spend more on labor. We understand that a similar conclusion should be reached to lower the 62% for hospitals in Puerto Rico that have a significantly lower labor costs compared to non-labor. Based on the CMS response for last year, we respectfully request a process for the analysis of the proposed and needed adjustments for Puerto Rico to include the following:

A. **CMS does not have empirical data that demonstrates "why a lower labor-related share is justified".** – As community associations, we do not necessarily have all the information that CMS has to make some of these evaluations with the complete and the appropriate data. The assessment of the Labor / No-Labor share for the hospitals in Puerto Rico would need to use the information submitted in the CMS cost reports. We propose that CMS can gather its cost report data for hospitals in Puerto Rico and share the pertinent data and analysis with MMAPA and the Puerto Rico Hospital Association representatives as part of this regulatory process for the 2016 Final Rule.

B. **Non-Labor costs in Puerto Rico are higher** – The Puerto Rico Institute of Statistics has inserted Puerto Rico in the COLI – Cost of Living Index program of the Council for Community and Economic Research. https://www.coli.org/ Based on this ongoing study, the composite index result for the MSA of San Juan, Puerto Rico, is 112.9 where 100.0 is the average composite index of over 200 MSAs compared by this tool. Examples of the Puerto Rico index for some non-labor items include utilities at 185.1 and supermarket items at 122.7. We could provide more price index data as needed by CMS to support the fact that non-labor costs in the island are actually higher than the US average.

C. **Legal Assessment** – Given the different understanding of the language in the law in relation to how strict is the use of the 62% for the case of Puerto Rico, we request the opportunity to have a discussion with the pertinent staff at CMS and our legal and technical team to present our justification.

Puerto Rico has suffered unprecedented and extremely high reductions Medicare funding in general in recent years. Historic technical issues in Part A payments should be addressed now to avoid more cuts and mitigate harmful effects. We are available to discuss and work with CMS on these matters in the next 6 weeks before the Final Rule is released. Otherwise, we are very concerned if the result of this effort is that we have to wait another year and another cycle for these issues to be addressed.

As discussed in the proposed rule, Medicare reimburses hospitals in Puerto Rico through the IPPS, the same system that is used to pay hospitals in the fifty states. The IPPS reimburses hospitals for their costs according to a national formula that includes labor, non-labor, operating and capital payments. Hospitals in Puerto Rico, however, were initially reimbursed under a special formula that provided them with a blended rate for their inpatient operating costs based on 25% of the national standardized amount and 75% of the Puerto Rico-specific standardized amount (compared to the 100% national standardized amount for hospitals located in the 50 states).

While Puerto Rico's reimbursement rate has been increased by the U.S. Congress to a 25%-75% blend of the Puerto Rico/National standardized rate since 2004, hospitals continue to endure a disproportionate financial hardship when compared to hospitals located in the 50 states and the other territories.

This unequal treatment to hospitals on the island has been maintained, despite the fact that the U.S. citizens of Puerto Rico pay the same Medicare payroll taxes and deductibles as their fellow citizens in the 50 states, and hospitals on the Island are required to comply with the same Medicare standards of participation as hospitals on the mainland.

A careful examination of the proposed rule evidences that basic differences in compensation and funding to hospitals in Puerto Rico under IPPS still remain.

For example:

- **a)** The hourly wage figures used for Puerto Rico are 53% lower than National amount;
- **b)** The proposed adjusted operating standardized amount for **NON-Labor is also 53% less than half the National average**; and,
- **c)** The proposed Capital Standard Federal Payment Rate for Puerto Rico ($230.93) **is 51% less than half the National average ($468.51)**.

The disparity in Non-Labor and Capital Rates is not consistent with the basic reality of Puerto Rico.

As defined by statute, CMS calculates a Puerto Rico proportion of the regular IPPS formula. Even when labor costs levels still seem very low, there is some factual data that does reflect lower labor costs in Puerto Rico relative to National average. However, the fact that the NON-Labor portion and the Capital standard payment rates are also approximately 53%-52% lower than the National rates unequivocally mandates careful review.

We are concerned that Labor/Non-Labor ratios - adjustable under the authority of the Secretary - may be generating an undue additional reduction in hospital payments to Puerto Rico by unintentionally and artificially lowering the cost estimates for the hospitals operating on the island. It is well known that the compensation and wage disparities for healthcare and other professionals in Puerto Rico in comparison to the U.S. mainland are not related to a similar comparison of other operational costs. In the healthcare context, the costs for property, rent, electricity, potable water, ground transportation, gasoline, equipment, materials, prescription drugs, hardware, and related expenses is very similar, if not higher, in Puerto Rico compared to the National averages. (See Puerto Rico's Cost of Living Index program of the Council for Community and Economic Research – https://www.coli.org/)

From the regulatory and statutory language related to the definition of the labor proportion of the operating standardized amount, we understand that current applicable regulation allows CMS to define an alternative Labor proportion percentage if the application of 62% could generate a reduction in hospital payments. Accordingly, CMS applies a higher percentage of the labor portion for hospitals with wage indexes higher than 1. Contrastingly, there is no apparent adjustment in the case where labor costs reported are enormously lower than the National average. Instead, there seems to be an extension of the labor costs disparity to Non-Labor and Capital rates for the Puerto Rico formula. We understand that this is a technical unintended consequence of the formula, which CMS can adjust under its current scope of authority and in line with the intent of the statute to avoid lowering payments to hospitals.

If Non-Labor costs in Puerto Rico are similar to those in the U.S. mainland, and the payment formula is 53% lower, then it is not realistic to expect that the compensation of physicians and health professionals in the hospital is ever going to gain ground relative to the national average. The lack of appropriate non-labor estimates, commensurate with real costs in Puerto Rico, is further incentivizing the ongoing exodus of professionals. We live in an open labor market, and such a significant gap created by geographical factors

could hinder the possibilities to have access to specialist and higher quality of care in the poorest areas of the Nation.

We urge CMS to review this carefully and to define in the regulation a methodology that does not limit the Non-Labor and Capital amounts of the payment due to the significantly lower labor costs reported for Puerto Rico. These amounts should not differ so significantly from the National average because non-labor and capital costs are simply not cheaper in Puerto Rico.

The historic disparity in Part A payments for Puerto Rico has delayed important infrastructural, technological and professional development progress in the hospitals of the island that serve Medicare beneficiaries. It is also noteworthy that these hospitals have to follow the same quality and operational standards for Medicare contracting as all the other hospitals in the Nation, albeit at a lower level of funding. The effect of current Puerto Rico funding disparity is endangering, accelerating and perpetuating a spiral towards the bottom for low cost geographical areas.

The historic underfunding has also aggravated the increasing exodus of technical and specialized medical professionals, who are well trained and bilingual, who, for economic reasons, feel the pressure to leave for the mainland. Such professionals receive significantly higher compensation under the Medicare program in the states. Puerto Rico is one of the most severe examples of low cost areas that may be caught in a spiral towards the bottom through the applicability of geographically adjusted wage indexes and cost factors. Increasing labor mobility, information technology, telecommunications, and economic recession are simply driving the best professionals to higher compensated areas, at the risk of exacerbating disparities in access to and the quality of healthcare between high and low cost geographical regions. This scenario is different today, compared to what it was when the geographical factors were first implemented.

We encourage CMS to continue evaluating the use of methods that protect low cost areas and low income populations, like the homogeneous use of national averages and compensation floors.

(3) Make simultaneous corresponding adjustments in the Medicare Advantage (MA) rates given the high penetration in Puerto Rico – Part A reductions are added to other significant cuts to Puerto Rico.

The lack of legitimate administrative and regulatory corrections in Part A payments is exacerbating the increasing funding cuts and disparities in the entire Medicare and Medicare Advantage program in Puerto Rico. If a reasonable amount of funding is secured and assigned for beneficiaries residing on the island, the Medicare program in Puerto Rico could become a very valuable case study of the development of the most cost-effective quality healthcare in the Nation. With over 565,000 MA members and approximately 75% MA penetration, Medicare beneficiaries have additional benefits and care coordination services to a greater extent than anywhere in the US. Unfortunately, unintended consequences of the ACA have exacerbated historic funding inequities that threaten to alter a clear path to higher quality at the absolutely lowest cost levels in Medicare. Puerto Rico MA benchmarks have suffered net reductions since 2012 that take them to 38% below the national average in 2016. Moreover, the Medicare program in Puerto Rico does not include the extra help of the Part D Low Income Subsidy, while also managing the same sequestration cut and health insurance fee cut as everywhere in the Nation. If CMS does not implement administrative fixes for Part A in line with those proposed here, the resulting difficulties and potential harm for Medicare Advantage beneficiaries in Puerto Rico will worsen.

Our proposals and requests primarily seek fairness for over 740,000 Medicare beneficiaries on the island. It is noteworthy that even by granting all the adjustments proposed by herein, the Medicare Program in Puerto Rico will still be by far the lowest cost program 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.

Best Regards,

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

Lcdo. Jaime Plá-Cortés
President, PR Hospital Association

Cc/
Senator Orrin G. Hatch, Chairman of the US Senate Finance Committee
Representative Paul Ryan, Chairman of the US House of Representatives Ways and Means Committee
Hon. Alejandro García Padilla, Governor of Puerto Rico
Representative Pedro R. Pierluisi
Senator Charles Schumer, US Senate
Senator Kirsten Gillibrand, US Senate
Senator Marco Rubio, US Senate
Senator Bill Nelson, US Senate
Senator Robert Menendez, US Senate
Senator Cory Booker, US Senate
Representative Charles B. Rangel, US House of Representatives
Representative Luis Gutierrez, US House of Representatives
Representative Jose E. Serrano, US House of Representatives
Representative Nydia M. Velazquez, US House of Representatives
Mr. Juan E. Hernández-Mayoral, Executive Director, PRFAA
Mr. Paul Dioguardi, Member of the White House Task Force on Puerto Rico and Director of Intergovernmental Affairs, U.S. Department of Health and Human Services
Mr. James Albino, Puerto Rico Affairs, the White House
Mr. Jim Kerr, CMS Regional Administrator, NYRO
Mr. Reginald Slaten, Associate Regional Administrator, New York Division of Medicare Health Plans Operations
Michael Meléndez, Associate Regional Administrator, Medicaid and CHIP

Addendum 1

THE WHITE HOUSE
WASHINGTON

Puerto Rico Healthcare Roundtable

February 13, 2015, 8:15 am – 3:00 pm EST
Eisenhower Executive Office Building, Room 430

8:15am	**Participant Registration – Participants should arrive at this time**
8:30am - 8:50am	Welcome and Presentation of Participants
8:50am - 9:10am	Overview of President's Task Force Process and Report Recommendations
9:10am - 10:00am	Roundtable- Action Needed for Healthcare in Puerto Rico
10:00am - 10:20am	**Break**
10:20am - 11:20am	Medicare FFS – Part A and Part B
11:20am - 12:30pm	Medicare Part C and Part D
12:30pm - 1:30pm	**Lunch Break**
1:30pm - 2:30pm	Medicaid
2:30pm - 3:00pm	Conclusions and Next Steps