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Comments and Proposals from Atlantis Healthcare Group of Puerto Rico

To the CMS Part C & D Advance Notice and Draft Call Letter 2019

March 5, 2018

The Honorable Alex Azar

Secretary of the US Department of Health and Human Services

200 Independence Avenue SW, Washington, DC 20201

cc/ Seema Verma, CMS Administrator

Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director

Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director of the Part C & D Actuarial Group, OACT

Re: A call for action on ESRD MA rates; the establishment of a minimum floor for ESRD MA payments.

Proposal: We request a minimum floor for ESRD MA payments of \$6,300.

Atlantis Healthcare Group of Puerto Rico, as one of the two main providers of dialysis services on the island, acknowledges the time and attention that the Centers for Medicare & Medicaid Services (CMS) staff and the U.S. Department of Health and Human Services (HHS) leadership have devoted to the unique issues of the Medicare program in Puerto Rico in past years. However, payment data reveals that the steps taken are still far from meaningfully mitigating increasing disparity between Medicare fee-for-service (FFS) and Medicare Advantage (MA) funding in Puerto Rico when compared to similar scenarios in the States. These disparities have been severely worsened by payment reductions in the Patient Protection and Affordable Care Act (ACA).

The End Stage Renal Disease (ESRD) Prospective Payment System in Puerto Rico is no different from the other Medicare funding disparities in relation to all other U.S. jurisdictions. In the **CY2017 Medicare ESRD Proposed Rule**, CMS presented the results of a study done on dialysis services in Puerto Rico. In the report, CMS acknowledged and explained the unique nature of the services provided in Puerto Rico when compared to the other U.S. jurisdictions. CMS was able to validate that the dialysis services in the island are more efficient when compared to any other place in the U.S. Moreover, CMS explicitly stated that:

“We believe that this information provides evidence that, in furnishing renal dialysis services, Puerto Rico could potentially have an economic disadvantage that the rest of the country may not be experiencing” (81 FR 42817).

The discrepancy in MA payment benchmarks is even pronounced for End Stage Renal Disease (ESRD) beneficiaries. **The most recent ESRD benchmark for Puerto Rico is \$4,314 in 2018, compared to a national average of \$6,753, and \$5,996 for the US Virgin Islands.** 3,500 ESRD patients are enrolled in the MA program in Puerto Rico and due to the high incidence of diabetes and other co-morbidities, these patients have a clinical profile even more complicated than ESRD patients on the mainland.

Consistent with the request to establish an Average Geographic Adjustment (AGA floor) in the development of the non-ESRD benchmark, by other Puerto Rico healthcare stakeholders, **we request that CMS establish a minimum ESRD benchmark that would reduce the disparity between the Puerto Rico benchmark and the actual cost of providing services to this vulnerable population.**

HHS and CMS have a significant and unique opportunity to enhance Medicare’s ESRD program in Puerto Rico in 2019 and to produce a positive case study that is particularly aligned with the policies supported and pursued by the new Administration. The comments and proposals herein for the ESRD Medicare benchmark for the 2019 Call Letter reiterate the urgent need to finalize meaningful policies to address these disparities in the Final Rule.

Sufficient data collection and analysis justifies CMS making a reasonable adjustment to Puerto Rico’s ESRD PPS Wage Index. Unfortunately, after considering all the public comments and facts presented by the community, CMS finalized the CY 2017 and CY 2018 ESRD PPS wage index based on the latest hospital wage data as proposed, and maintained a wage index floor of 0.4000. For CY 2018, CMS proposed to maintain the current wage index floor of 0.4000, and says they “will continue to monitor and analyze ESRD facility cost reports and projected impacts to guide future rulemaking with regard to the wage index floor.”

However, based on the empirical analysis presented by CMS on ESRD costs and wage index, we reiterate our request for urgent administrative action. This is yet another opportunity for CMS to use its authority to make legitimate policy corrections and adjustments to portions of the Medicare payments to Puerto Rico, and save access to care at the lowest cost. The CMS analysis published in 2017, along with several iterations of comments and responses within the regulatory cycle, provides more than enough background for CMS to make a determination in the Call Letter Final Rule on April 2nd, 2018.

As CMS recognizes in the CY 2018 Proposed Rule, **“Currently, all areas with wage index values that fall below the floor are located in Puerto Rico.”** This reflects Puerto Rico’s uniquely deficient wage index values. The disparity at the bottom is a significant outlier compared to every other jurisdiction in the U.S. This creates an immediate dislocation of the service, and puts the availability of dialysis providers at risk.

Scenario presented for the CY 2018 ESRD PPS PR Wage Index:

Specific comments and recommendations valid for Final Call Letter payment year 2019:

1. Key Fact: Data from Puerto Rico does not match with national data because of the differences in Composite Rate Costs and FTEs as mentioned by CMS on the CY 2017 Medicare ESRD Proposed Rule:

“Puerto Rican facilities employ a richer mix of staffing, as reflected in more than double the RNs per treatment in Puerto Rico than elsewhere. We believe that this information provides evidence that in furnishing renal dialysis services, Puerto Rico could potentially have an economic disadvantage that the rest of the country may not be experiencing”. (81 FR 42817 – CY 2017 Proposed Rule)

- Puerto Rico is required by law to provide the dialysis service with RNs, unlike the rest of the U.S. Puerto Rican dialysis facilities must provide a legally mandated complement of patient care providers. This is necessarily costlier, but our main observation here is that it is ***different*** than any other jurisdiction. This difference should be taken under consideration to support the use of a proxy or an adjustment to estimate the wage index as the geographic factor for the payment of dialysis services in Puerto Rico. **The standard relation that CMS assumes between the hospital cost report data and the dialysis service provision is not the same in the case of Puerto Rico. This is what the results of the CMS study reported in the CY2017 Proposed Rule reflect.**
- While patients receiving renal replacement therapy with dialysis are traditionally considered vulnerable, **those in Puerto Rico are even more vulnerable as evidenced by the fact that they suffer from a 50% higher mortality rate and 30% higher hospitalization rate than their mainland peers. This is likely due in part to the high rate (66%) of diabetes related ESRD (~50% higher than the mainland). This creates a subset of highly complex and costly patients to care for in the setting of a low wage index floor, providing fewer resources for quality care than on the mainland.**

- Of Puerto Rico's 78 municipalities, the Health Resources and Services Administration (HRSA) has categorized 72 (92%) as medically underserved areas. This reflects the adverse environment of social determinants of chronic disease that leads to more severe cases of ESRD and, especially, diabetes-related ESRD. Again, the low wage index floor provides fewer resources for quality care for these highly vulnerable patients than their mainland peers, against whom outcomes are judged and pay-for-performance penalties are decided.

2. Key Fact: Re-establishing a fair and meaningful wage index floor which considers data deficiencies and uniqueness of service delivery in Puerto Rico, as well as the risk of losing the only two providers of ambulatory dialysis available given the dramatically distinct and unviable FFS rates.

- Since CY 2010, the wage index floor has decreased from 0.65, when all the costs in Puerto Rico have risen. CMS should take into consideration the fact that Puerto Rico cannot bare another year with the current wage index floor.
- There are only two ambulatory dialysis service providers in Puerto Rico. The only reason they have not closed operations in the island is because they have contracted with Medicare Advantage and commercial plans at rates that are extremely higher than Medicare FFS rates.
- We are concerned that this scenario has created severe cost-shifting across programs and this implicit subsidy for Medicare FFS has not allowed for the appropriate costs of services to be reflected in the regular sources and methodology that CMS uses to establish payment rates in most jurisdictions.
- This is highly evident in regards to the higher drug costs with CMS dialysis bundling and the increasing number of medications added to the bundle over time, while the ESRD MA rate has dropped.
- Furthermore, the falling ESRD MA rate has prevented planned implementation of several key strategies for coordination of care and enhanced patient and family engagement (e.g. community health workers), which are sorely needed in the setting of complex patients and a fragmented health care system to reduce hospitalizations and potentially reduce the higher mortality rates for dialysis patients in Puerto Rico.

3. PROPOSAL: Use the USVI wage index for payment rate calculations in Puerto Rico, given the disadvantages recognized by CMS analysis and the inconsistencies with the indices used for other Territories.

- CY 2018 ESRD PPS Wage index in the Proposed Rule: Guam 0.96, Northern Marianas 0.96 (tied to Guam's), American Samoa 0.96 (tied to Guam's), U.S.V.I. 0.71 and **PR 0.40**.
- Hospital cost reports in Puerto Rico do not accurately represent the ESRD costs in the system or have the same relation to the delivery of dialysis services as they do in the States.
- Puerto Rico has a unique situation which can be resolved with a temporary proxy fix derived from past analysis and policy actions by CMS, as is the case with the Northern Marianas and American Samoa being tied to the wage index of Guam.
- Similar to the analysis and policy defined by CMS for other Territories, and similar to the CMS policy established in the CY2017 Physician Fee Schedule about the applicable GPCI factors, CMS can establish the use of the USVI wage index for dialysis payments in PR for CY2018. It would be a sensible policy to define this as a temporary measure derived from analysis and language presented in the CY2018 proposed rule, as well as in previous regulatory cycles.

4. PROPOSAL: Guarantee the corresponding adjustment in MA benchmarks for ESRD to secure the appropriate support for the Medicare program that serves more than 75% of all the Medicare A&B beneficiaries in Puerto Rico.

- Puerto Rico is an outlier at the bottom of costs for Medicare FFS and MA, but has suffered the worst funding cuts in Medicare history because of the implementation of the ACA mandated payment formulas.
- These cuts have not only led to an inability to recruit nurses, doctors, surgical specialists, and others but they have also led to a net migration of these providers out of Puerto Rico (this has been further accelerated following the 2017 hurricanes). This is creating a progressively negative impact that will likely be manifested by even higher rates of hospitalization and death that presently mirror outcomes in poorer countries. The negative impact of low reimbursement rate on providing optimal care, especially for poor patients, has been well documented in the Institute of Medicine report "Unequal Treatment."

5. MA ESRD Benchmarks disparity: The Medicare FFS ESRD costs and payments for Puerto Rico are impacted by significant changes in FFS pricing for Part A, Part B and dialysis payment anomalies identified in recent years by CMS, and documented in FFS regulation.

- We support CMS' intent to reprice the ESRD based on the process used to develop MA benchmarks, but are concerned that the adjustment would not be sufficient to address additional **Puerto Rico issues, including the difference in the coordination period with the local Medicaid agency (90 days coordination vs. the 30 months period CMS typically applies).**
- Puerto Rico's MA ESRD benchmark is still 25% below the lowest state (ND), 36% below the U.S. average, and 28% below U.S.V.I. If no action is taken by CMS on this matter, more providers will continue to migrate from the Commonwealth, further diminishing access for remaining patients. That will harm patients' health and impede efforts to improve the health of dialysis patients and healthcare landscape of Puerto Rico that is characterized by an already broken system.

Sincerely,



Dr. Ruby Harford
President and CEO, Atlantis Healthcare Group of Puerto Rico