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July 12, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2367-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

Dear Ms Tavenner:

On behalf of the Office of Medicaid of the Executive Office of Health and Human Services (EOHHS), we appreciate the opportunity to respond to the request for comments on the State Disproportionate Share Hospital (DSH) Allotment Reductions, Centers for Medicare & Medicaid Services Agency (CMS), published in the Federal Register on May 15, 2013.

Massachusetts health reform, as enacted in Chapter 58 of the Acts of 2006 and implemented by the Commonwealth with the support and partnership of CMS, has been an unparalleled success. Over 97 percent of Massachusetts residents now have health insurance, the highest rate in the country. More than 408,000 people in Massachusetts are newly insured since the implementation of Chapter 58. Private group and individual purchase make up more than 32 percent of the newly insured, with enrollment in group insurance increasing by 83,000 lives and individual purchase more than doubling.¹

Hospitals that serve a disproportionate share of Medicaid and uninsured patients have played an important role in the success of Massachusetts' health insurance expansion by providing care for a large number of the newly insured population. Safety net hospitals experienced a significant increase in Medicaid patient care volume in the years following Massachusetts' health care reform. In addition, disproportionate share hospitals have

¹ Health Care in Massachusetts: Key Indicators, a report released by the Massachusetts Division of Health Care Finance and Policy, November 2009. (Available on line at www.mass.gov/dhcfp)



contributed to the success of health care reform by assisting many uninsured individuals to access Medicaid benefits and other subsidized coverage through their outreach and enrollment efforts.

Due to Massachusetts' success in reducing the number of uninsured, major provisions in the Affordable Care Act were modeled on our reforms. Following implementation of Chapter 58, the Commonwealth in recent years has focused intensive efforts on addressing the rising costs of health care for families, businesses and taxpayers. In 2012, Massachusetts enacted comprehensive health care cost containment legislation known as Chapter 224. The Patrick Administration, the legislature, and a broad-based group of health care business partners and consumer advocates are jointly committed to the continued success of Massachusetts health reform and the cost containment and payment reform strategies necessary to make the entire system fiscally sustainable, while ensuring access and quality.

It is critical that Massachusetts sustain these accomplishments in increasing health care access as we pursue the next set of milestones addressing cost containment. Many states will learn from Massachusetts' experience as they forge their own paths toward decreasing the uninsured rate and increasing health care access and quality while decreasing costs. From this unique perspective, we offer the following comments on the proposed rule.

1115 Budget Neutrality Factor

The 1115 Budget Neutrality Factor (BNF) implements the statutory provision requiring that the methodology for DSH reductions take into account whether a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion under section 1115 as of July 31, 2009. The proposed rule would exclude the amount of the DSH allotment used specifically for coverage expansion from the DSH allotment reduction for the High Volume of Medicaid Inpatients Factor (HMF) and High Level of Uncompensated Care Factor (HUF). However, the amount of the state's DSH allotment used for non-coverage expansion purposes would still be subject to reduction. According to the preamble, uncompensated care pools and safety net care pools are considered non-coverage expansion purposes, and therefore subject to reductions under the HMF and HUF criteria.

Massachusetts respectfully recommends that the full amount of a state's DSH allotment that was included in the budget neutrality calculation for an 1115 Demonstration in effect on July 31, 2009, be excluded from reduction, provided that the primary purpose of the 1115 Demonstration was for coverage expansion. This interpretation is consistent with the statute and recognizes that safety net care pools and uncompensated care pools can serve to support comprehensive coverage expansions. In Massachusetts, for example, use of the state's DSH allotment in its safety net care pool to support the provision of essential services is a feature of the Demonstration that is inseparable from its primary purpose of enabling coverage expansion. Massachusetts' safety net care pool is an example of one that should be eligible for the reduction exemption.

The Commonwealth created its Safety Net Care Pool (SNCP) in 2006 as part of the framework for Chapter 58, Massachusetts' landmark health care reform and coverage expansion. This legislation consisted of a series of interdependent activities and programs, each necessary for the other to be successful and to achieve the overall goal of drastically reducing the rate of uninsurance in Massachusetts. The SNCP has been used to fund Commonwealth Care, a coverage expansion program that today provides affordable health insurance to over 200,000 Massachusetts residents, and thus is an integral component of the initiative to reduce the rate of uninsurance. SNCP funding for payments to providers also supports coverage expansion by funding care for a large portion of the newly insured, as well as the residually uninsured population. The use of the DSH allotment to support major safety net providers has allowed the Commonwealth to commit funding to support programs that enable coverage expansion.

The Centers for Medicare and Medicaid Services (CMS) specifically recognized the importance of Massachusetts' SNCP for coverage expansion, as written in a letter to the Massachusetts Secretary of Health and Human Services on December 20, 2011: "...The Commonwealth proposes to use the Demonstration to strengthen its health care reform efforts...to advance children's health care coverage and parents' access to health care coverage. Restructuring the current SNCP...will enhance the Commonwealth's efforts to support the health care safety net and the Commonwealth Care program that provides sliding scale premium subsidies for the purchase of private health plan coverage for uninsured individuals."

While the proposed rule would exclude safety net care pools from coverage expansion consideration, it is apparent that safety net care pools can be crucial to providing health care coverage to the previously uninsured. We believe it is contrary to the statutory intent to automatically designate all safety net care pools and uncompensated care pools as not contributing to coverage expansion purposes. CMS should re-examine the definition of "coverage expansion purposes" as it applies to the BNF to include safety net care pools and uncompensated care pools that are established as part of broader efforts to expand coverage.

Furthermore, Massachusetts recommends that CMS change the way in which the BNF is applied. CMS' proposed methodology would exclude from the DSH allotment reduction, for the HMF and HUF, the amount of DSH allotment that each state uses for coverage expansion in the budget neutrality calculation. Massachusetts proposes that this amount instead be excluded from the reduction associated with the Uninsured Percentage Factor (UPF). This approach better aligns with the fact that coverage expansion is directly related to the level of uninsurance in the state; it logically follows that the benefit of applying the BNF should mitigate reductions due to the UPF.

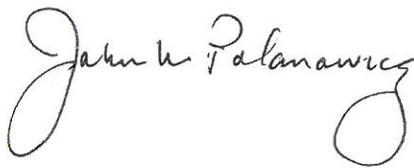
Weighting of Factors

Massachusetts respectfully recommends that CMS reconsider the weighting of the UPF. In the proposed rule, 33 percent of the weight is placed on the percentage uninsured within the state, and the remaining 67 percent is distributed between the HMF and HUF. Under the proposed rule, states that have made reducing the rate of uninsured a priority will receive the harshest penalties. Disproportionate share hospitals that have participated actively in supporting health care reform also would be penalized. We recommend that the UPF be weighted to a lesser degree to avoid disproportionately penalizing states that expanded health care coverage early. Weighting the UPF equally with the other factors will be more appropriate once other states implement national health care reform.

The Affordable Care Act (ACA) required that DSH reductions be largest for those states with the lowest rate of uninsured. However, this provision was included in anticipation of a then-mandatory Medicaid expansion and other provisions to expand coverage, which would place states on relatively equal footing. Since then, the Medicaid expansion has become voluntary. CMS has proposed a two-year DSH rule that uses data that reflects the uninsured rate prior to implementation of the ACA and does not take into account whether a state opts to implement the Medicaid expansion, in part due to the lack of more timely reliable data. While the data constraints are unavoidable, placing such a significant weight on the UPF unduly penalizes states that were early innovators and achieved a low uninsured rate prior to the implementation of national health care reform. Therefore we urge CMS to reduce the weight placed on the UPF at this time.

We thank you for consideration of our comments and look forward to continuing to work with the federal government on successful implementation of the Affordable Care Act.

Sincerely,

A handwritten signature in cursive script that reads "John Polanowicz". The signature is written in black ink and is positioned above the printed name and title.

John Polanowicz
Secretary, Executive Office of Health and Human Services