AMERICA'S ESSENTIAL HOSPITALS

April 28, 2015

Ms. Vikki Wachino
Acting Deputy Administrator and
Director, Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
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Dear Ms. Wachino:

Thank you for taking the time recently to meet with me and my colleagues from America's Essential Hospitals to discuss a variety of Medicaid issues important to our members. We appreciated the rich and thoughtful discussion and your understanding of the critical role essential hospitals play in states' Medicaid delivery systems. Among the topics of discussion during the meeting was our shared desired to see states reduce their reliance on special supplemental payments to providers and instead rely on base rates that are sufficient to support the multiple roles essential hospitals fill in the health care delivery system. We also discussed the transformative work our members have engaged in through Medicaid-supported delivery system reform programs. You invited us to follow up with further thoughts on these topics. This letter is in response to that invitation.

In the wake of the recent Supreme Court decision in *Armstrong v. Exceptional Child Center,* the Centers for Medicare & Medicaid Services' (CMS') role in ensuring provider rates are sufficient to ensure equal access to care is more important than ever. We remain concerned that, even as state economies improve, Medicaid rate cuts adopted in the depth of the recession are not being restored, and in some states are deepening. CMS still has not finalized its proposed equal access rule released four years ago, and we have real concerns about the effectiveness of implementing the version proposed. Yet at the same time, the agency is adopting various administrative measures—seemingly unrelated but cumulatively burdensome—that are making it more difficult for states to supplement inadequate base rates with payments that

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bring them up to a sustainable level, particularly for their most committed Medicaid providers.

Something has to give. We urge CMS to take the following steps so that we may achieve our shared goals of ensuring access to quality care and supporting innovation and transformation in the Medicaid Program:

- Finalize an equal access rule that requires states to pay market-based rates that are truly sufficient to ensure Medicaid beneficiaries do, in fact, have the same access to providers as the general population.
- Allow providers a meaningful opportunity to offer input into CMS' review of proposed payment rates.
- To the extent that states are permitted to continue to pay far below the market, permit those shortfalls to be mitigated with targeted supplemental funding, regardless of whether the care is delivered through a fee-for-service or managed care delivery system.
- Through Medicaid waivers, permit states to provide support for the uncompensated care that is draining resources from their key providers.
- Preserve and build on CMS' investment in delivery system reform incentive payment (DSRIP) programs, which are enabling exciting and significant improvements in health care delivery and outcomes.

America's Essential Hospitals urges CMS to adopt a holistic view of how these various mechanisms work together to ensure the vitality, and often the very viability, of core Medicaid providers. It is these providers who in turn ensure Medicaid beneficiaries always have access to the highest quality, culturally sensitive, and openly welcoming care available, as they deserve. Insufficient payment rates force providers to accept fewer Medicaid patients or to cut services and programs low-income beneficiaries need. We offer our partnership to you in fulfilling your statutory responsibility to ensure equal access to care.

Background on America's Essential Hospitals

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our more than 250 members provide a disproportionate share of the nation's uncompensated care and devote roughly half of their inpatient and outpatient care to Medicaid or uninsured patients—32 percent of inpatient care and 27 percent of outpatient care at our member hospitals is provided to Medicaid beneficiaries, while 15 percent of inpatient and 24 percent of outpatient care is provided to the uninsured.[1] (This compares to

[1]Reid K, Roberson B, Landry C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential

only 23 percent of inpatient care and 21 percent of outpatient care to Medicare beneficiaries, significantly below the industry average.) Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an aggregate operating margin of negative 3.2 percent, compared to positive 5.7 percent for all hospitals nationwide.[2] And they do so with better cost efficiency than other hospitals nationwide, scoring slightly below the national median (0.97 versus 0.98 nationally) on the Medicare spending per beneficiary measure of efficiency.[3]

In addition, as essential hospitals, our members fill a vital role in their communities, providing specialized inpatient, outpatient, and emergency services such as trauma, burn care, and inpatient psychiatric care, which are not available elsewhere in their communities. In the 10 largest U.S. cities, our members operate 34 percent of all level I trauma centers, 69 percent of all burn-care beds, and 33 percent of psychiatric beds.[4] Members of America's Essential Hospitals also play a vital role in providing ambulatory care to their communities. The average member operates a network of 20 or more ambulatory care sites. And they deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Consistently, members of America's Essential Hospitals find increasingly innovative and efficient strategies for providing high-quality, complex care to their patients, all while facing high costs with limited resources.

CMS Must Enforce Payment Adequacy

Since 1989, the Medicaid statute (Section 1902(a)(30)(A)) has required states to adopt payment rates that

> are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[5]

On March 31, the Supreme Court ruled in *Armstrong v. Exceptional Child*, No. 14-15 (U.S.), that Medicaid providers cannot enforce this provision in federal courts, reasoning in part that Congress intended CMS to be the sole arbiter of

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Hospitals. March 2015. http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf. Accessed April 2015. (hereinafter, "Vital Data 2013")
[2]Ibid.
[3]Ibid.
[4]Ibid.
[5]42 U.S.C. §1396a(a)(30)(A).

state compliance through its authority to withhold federal funds to offending states. Historically, however, CMS has proved to be extremely reluctant to exercise that authority. Indeed, in *Armstrong* itself, the state had refused, for purely budgetary reasons, to implement the rate methodology that had actually been approved by CMS, and did so with impunity.

Over the years, CMS has devoted considerable attention to the "efficiency" and "economy" prongs of Section (a)(30)(A), implementing upper payment limit regulations, adopting nonregulatory policies that limit provider payments, and subjecting state plan amendments and other reimbursement proposals to close scrutiny to ensure providers are not overpaid. America's Essential Hospitals understands and supports the need for strong oversight in these areas to ensure the accountability and fiscal integrity of the program.

However, the agency has been much less vigilant when it comes to ensuring payments promote high-quality care and equal access to providers. In fact, after Section (a)(30)(A) was adopted, it took CMS more than two decades to issue any regulatory or other guidance on how these requirements impact the rates set by states. Finally, in 2011, CMS issued a proposed rule to establish a process for regular review of beneficiary access to Medicaid services, but the agency has never finalized the regulation. Moreover, in its proposed form, the rule provides such broad flexibility to states in demonstrating adequate access that we are concerned it would merely result in a paper exercise with little potential for real-world impact—other than unnecessarily draining Medicaid agency administrative resources.

In commenting on the proposed rule, America's Essential Hospitals urged CMS to make the regulation more robust.[6] We asked the agency to be faithful to the link Congress made in Section (a)(30)(A) between *payments* to providers and *equal access* for beneficiaries. Under the proposed rule, review of Medicaid payment rates compared to other payers' rates is subordinate to the three main prongs of the access analysis. Moreover, the preamble of the rule states specifically that payment comparisons may not be the primary indicator in meeting (a)(30)(A), despite the centrality that Congress placed on payment sufficiency. We urged CMS to require a market-based benchmark for rates—such as Medicare rates or average commercial rates—to ensure that care and services truly are available to Medicaid beneficiaries to the same extent they are available to the general population. Indeed, given CMS' desire to see the program operate more like other health care purchasing programs,

[6]Letter to Dr. Donald Berwick from Bruce Siegel. National Association of Public Hospitals and Health Systems. July 5, 2011. http://essentialhospitals.org/wp-content/uploads/2013/11/Association-Comments-on-Medicaid-Equal-Access-Proposed-Rule.pdf; Letter to Ms. Marilyn Tavenner from Bruce Siegel. America's Essential Hospitals. September 25, 2014. http://essentialhospitals.org/wp-content/uploads/2014/09/Equal-Access-letter-to-M.-Tavenner-FINAL.pdf.

paying providers rates that are below other insurers' rates is almost by definition unreasonable.

Now that judicial enforcement of payment adequacy has been definitively foreclosed, CMS has an even greater responsibility to devote much more attention than it has in the past to the "quality" and "equal access" prongs of Section (a)(30)(A). Moreover, to the extent that CMS disfavors widespread reliance on supplemental payments, it *must* exercise its agency enforcement powers to ensure adequate base rates. It is simply not enough to erect administrative obstacles for states wishing to use supplemental payments in the hope that the states will turn instead to increasing base rates. Providers, and more importantly, beneficiaries, are the losers in that scenario. Instead, CMS must require, as a key part of the state's end of the Medicaid bargain, payment rates to meet the statutory standard.

In addition, because judicial enforcement is no longer an option for providers (and presumably, beneficiaries), CMS must allow providers a meaningful opportunity to offer input into its review of proposed rates. Developing a process through which stakeholders can contest assertions made by states in justifying rates (particularly rate reductions) will be an important component of CMS' sole (a)(30)(A) enforcement authority.

CMS Must Remove Barriers to Support for Mission-Driven Essential Hospitals

In the absence of market-based rates, states have increasingly relied on various types of supplemental payments to support those providers that are the foundation of the Medicaid provider network. For members of America's Essential Hospitals, for whom Medicaid is such a crucial payer, these supplemental payments have made the critical difference between viability and bankruptcy. As noted above, our members' current operating margins are *negative* 3.2 percent—including supplemental payments. Reductions in supplemental payment sources push those negative margins even further into the red. For example, without Medicaid disproportionate share hospital (DSH) payments, which are scheduled for deep reductions in future years, those margins drop to an unsustainable negative 12.5 percent.[7]

Essential hospitals carry out multiple, critical missions. They care for vulnerable populations; train future physicians; provide unique and high-cost specialty and tertiary services; provide community-based access to comprehensive, integrated care; and advance public health. To do this, they rely on the funding provided through these various supplemental payment programs. Eliminating states' ability to provide such support comes with severe consequences to beneficiaries in need of these services.

[7]Vital Data 2013.

CMS Should Allow States to Supplement Managed Care Rates

States' increased use of managed care for Medicaid populations—recent data indicate that more than half of all Medicaid beneficiaries are enrolled in comprehensive risk contracts[8]—is having a direct impact on states' ability to support their essential Medicaid providers. Current Medicaid managed care regulations generally prohibit states from providing supplemental payments to providers for services delivered to managed care enrollees.[9] The premise for this prohibition is, presumably, that by using a private sector managed care delivery system, state Medicaid programs are acting more like purchasers. As such, they should allow the market to ensure the plans provide adequate payments to providers in their contracted networks. This premise can only work, however, if the base fee-for-service rates on which the capitation payments to plans are built are themselves adequate. But without the guarantee of adequate fee-for-service rates (as discussed above), managed care plans are going to be no more capable of paying adequate rates to their contracted providers than the Medicaid agency is. The need for supplemental payments does not disappear when managed care expands.

Moreover, this premise is based on an unnecessarily limited view of Medicaid's role and purpose. The Medicaid Program has always served as a payer for health care services. But it is more than that—"carr[ying] responsibilities borne by no other payer."[10] As described by the Medicaid and CHIP Payment and Access Commission:

> Medicaid's role in our health care delivery system is unique: the program covers the diverse health needs of enrollees; directly supports safety-net providers; covers long-term services and supports for low-income Medicare beneficiaries, and reduces uncompensated care. Incremental additions and changes have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and its costs.[11]

As noted above, states have become purchasers as well as payers with their increased reliance on Medicaid managed care. As such, they have to reconcile these marketplace roles with their long-standing public policy goals and

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[8]Kaiser Commission on Medicaid and the Uninsured. Medicaid Moving Forward. March 2015. http://files.kff.org/attachment/issue-brief-medicaid-moving-forward. Accessed April 2015.

[9]42 C.F.R. §438.60.

[10]Rosenbaum S, Frankford DM, Law SA, Rosenblatt RE. *Law and the American Health Care System, Second Edition.* St. Paul, Minnesota: Foundation Press; 2012. 204, citing MACPAC Report to Congress (March 2011).

[11]Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress. March 2011.

responsibilities. Like all payers and purchasers, they want to ensure their beneficiaries receive high-quality services at an efficient price. But as states, they have broader goals that they pursue in part through their Medicaid Program. These include population health goals, systemwide access and quality goals (particularly for the poor and vulnerable, including the uninsured), robust training for next generation health professionals, consumer protection, and reduction in disparities.[12]

CMS' direct pay prohibition in the managed care regulations has thwarted states' attempts to achieve these broader public policy goals, which are not necessarily shared by contracted health plans. In a letter to former CMS Administrator Marilyn Tavenner last fall, we detailed our concerns about the direct pay prohibition and its implementation. Since then, we have been pleased to learn, in meetings with CMS staff, that CMS's policy regarding states' ability to contractually require plans to make specific supplemental payments to specific providers is evolving, and that in certain (unspecified) circumstances, more prescriptive provisions are allowable. Direct supplemental payments from states to providers remain impermissible under the current regulations, but at least that prohibition appears less likely to also ban indirect payments through plans.

Nonetheless, it is still critical that the direct pay prohibition be repealed and states be allowed to make direct payments to providers to meet other state policy goals, beyond the current exceptions for graduate medical education payments, DSH payments and payments to federally qualified health centers.[13] While we support CMS' willingness to work with states on allowing supplemental funding to be provided through capitated rates to health plans, this approach does not fully resolve the challenge to ensuring providers receive adequate support. It could instead serve as an incentive for plans to direct patients away from the intended providers so that they may retain the enhanced funding, thereby undercutting the state's policy objectives. In our letter to Administrator Tavenner, we proposed specific regulatory language to replace the direct pay prohibition. We understand that the release of comprehensive proposed managed care regulations is imminent. We look forward to reviewing your proposals and hope they include a full repeal of the direct pay prohibition.

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[12]That states would use their Medicaid Program to achieve public policy goals, even those beyond the scope of the Medicaid Program, is not unremarkable, and has, in fact, been upheld by the Supreme Court. *See* Pharmaceutical Research and Mfrs. of America v. Walsh (01-188) 538 U.S. 644 (2003) (Stevens, J.) (Maine's interest in protecting the health of its uninsured residents provides a "plainly permissible justification" for a challenged Medicaid prior authorization requirement).

[13] These exceptions are specified by regulation (42 C.F.R. 438.60) and, in the case of DSH (42 U.S.C. §1396r-4(a)(2)(D)) and FQHCs (42 U.S.C. §1396a(bb)(4)) by statute as well.

CMS Should Allow States the Flexibility to Support Uncompensated Care

One way that several states, over the last 10 years or so, have maintained direct support for their essential providers is through uncompensated care payments authorized through a Section 1115 waiver. This mechanism offers a balance between ensuring adequate support for providers bearing the burden of large volumes of uncompensated care and allowing managed care plans to negotiate rates unfettered by state directives. It appears faithful to the dual roles of states as both prudent purchasers of Medicaid coverage and active interveners where the market does not adequately protect the public good. Waiver-based uncompensated care payments have been an effective means for states that contract out a large portion of their Medicaid Program to private plans. It helps them ensure privatization does not threaten the viability of their essential providers.

Recently, however, CMS has backed away from approving uncompensated care pools proposed by states, apparently on the assumption that these pools provide a disincentive to states to expand Medicaid coverage and that providers should be supported through adequate rates rather than uncompensated care payments. On the first point, America's Essential Hospitals agrees with CMS on the critical importance of Medicaid expansion. Our members have been at the forefront of advocacy efforts within states to convince policymakers to do so. But given the political reality in some states that expansion will not be authorized anytime soon, CMS is compounding the impact on low-income and otherwise vulnerable individuals by starving the hospitals they rely on for care. It is counterproductive to CMS' stated goal of moving Medicaid forward to improve care at lower costs. We should not allow vulnerable patients to be used as pawns in the expansion debate.

Similarly, as discussed above, we agree with CMS on the need for adequate base rates. But by insisting states can *only* invest in across-the-board rate increases and depriving them of the ability to target funding where it is needed (as they would be permitted to do in fee-for-service Medicaid), CMS ignores the historical role of Medicaid in achieving the public policy objective of ensuring vulnerable patients have access to a vibrant network of essential providers.

We therefore strongly recommend that CMS allow states to continue to provide support for uncompensated care through Section 1115 waivers. Such support can and should come with accountability for both states and participating providers. But at the same time, states' efforts to support uncompensated care should not be confused or conflated with programs to incentivize delivery system reform. To be effective, the latter typically require significant up-front investment of new resources, which essential providers cannot undertake if their operational support for ongoing care is being cut as states move to managed care.

CMS Should Not Disfavor Supplemental Payments Financed by Local Sources

States' reliance on supplemental payments to enhance low base rates is a function of tight state budgets already dominated by Medicaid Program expenditures. A shortage of state funds has meant that local governments and providers are increasingly being asked to shoulder the state share of the cost of the supplemental payments that have become a critical component of Medicaid reimbursement. Intergovernmental transfers, certified public expenditures, and provider taxes are all congressionally sanctioned and regulated sources of the nonfederal share of funding for the program, and they date back to Medicaid's inception. Indeed, prior to the enactment of Medicaid in 1965, local governments and providers were often funding 100 percent of the care for the populations that Medicaid eventually covered. By enacting Title XIX, Congress provided federal funding to share in those costs, with the proviso that state (as opposed to local) funds had to comprise at least 40 percent of the nonfederal share.

Today, some question the legitimacy of using local funding sources for the nonfederal share of supplemental payments, characterizing this as unfairly shifting costs to the federal government. But it was precisely Congress' intent in creating the Medicaid Program for the federal government to share in the costs of providing care to low-income populations. Supplemental payments are used to enhance below-cost rates that are simply unsustainable on their own (as demonstrated by our data on essential hospitals' negative margins, shared above). While it is not ideal that the nonfederal share of these payments must often come from local governments and providers themselves, there is nothing inappropriate about those funding sources.

CMS' treatment of supplemental payments should be based on clear policy objectives related to ensuring reasonable and adequate payments and not a sense of uneasiness that local financing somehow inappropriately shifts a greater funding burden to the federal government. If locally funded supplemental payments result in provider rates at the Medicare or commercial level—levels that cannot be considered unreasonable—then the federal government's share of those costs is neither excessive nor inappropriate. Indeed, to the extent that CMS policies result in the loss of such supplemental payments, the federal government is unfairly shifting the burden to local governments and providers to make up for inadequate Medicaid rates.

CMS Should Continue to Support Innovative Efforts to Incentivize High-Value Care

CMS has rightly devoted a significant amount of attention in recent years to "ensure that Medicaid reaches its fullest potential as a high performing health system and aligns with promising delivery system and payment reforms

underway in the private and public sectors."[14] Indeed, in the Medicare Program, CMS has set specific and ambitious goals to have 50 percent of fee-for-service payments be in alternative payment models and 90 percent be in value-based purchasing by 2018. Although no specific goals have been set for Medicaid, CMS clearly wants to see similar trends in the program.

Preparing the delivery system to accept alternative payment mechanisms and succeed under value-based purchasing is no small task, particularly when the delivery system comprises providers with resource constraints from routinely delivering half of their care to Medicaid and uninsured patients. Again, the negative operating margins under which these providers survive severely constrain their ability to make bold investments in delivery system transformation. Yet, with an increasing number of states expanding their Medicaid Program, such transformation is becoming more important than ever if the promise of the Affordable Care Act is to be realized.

For these reasons, America's Essential Hospitals has been pleased to see the evolution of innovative Section 1115 waiver programs that intensively promote such delivery system reform. DSRIP programs have been particularly important in jump-starting transformation in many of the states in which they are operating.

Through DSRIPs, essential hospitals are

- significantly expanding primary and preventive care capacity and access to specialty services (which is often particularly limited for low-income populations);
- building data analytics (data systems, disease registries, standardized quality reports, etc.) to facilitate quality improvement and advance population health;
- developing chronic and complex care management capacities;
- engaging patients and enhancing their experience;
- establishing cultures of improvement; and
- reducing harm and saving lives.

Many of our members are engaged in communitywide DSRIP planning and implementation, fostering collaboration and cooperation on an unprecedented scale. It is hard to overstate the enormous impact DSRIP programs have on our members' ability to transform themselves, and in turn, transform the care they provide to Medicaid patients and others.

It is important to note, however, the significant difference between the incentive payments available through DSRIPs and the various kinds of supplemental payments discussed earlier in this letter. DSRIPs are *not* payment for services; supplemental payments are. DSRIPs cannot be viewed

[14]State Medicaid Directors Letter SMDL #12-001. July 10, 2012.

as a replacement for historical funding for the care of Medicaid and uninsured patients. Those funds are needed for providing ongoing care, and CMS should not force DSRIPs on states as a replacement for or condition of continuing these supplemental payments. Meaningful delivery system change requires new up-front investments, which in the long run will reduce costs and improve care. But it is unrealistic to expect these providers to make such up-front investments without any new funding. Doing so undercuts the potential for DSRIPs to effect change and sets both the state and providers up for failure.

At our meeting, you indicated CMS is considering the future of DSRIPs. We urge you to preserve this important mechanism for states to invest in delivery system reform. Early results from the DSRIPs are very promising, but they are early. And with each new approved DSRIP, the programs are being refined and tailored in ways that not only meet the state's unique needs but also reflect CMS' continuous education about the effectiveness of various DSRIP approaches. New York's DSRIP, which is probably the most ambitious of those approved to date, is just now being implemented. It is far too soon to make any decisions about the future of DSRIPs as a whole.

We also believe that maintaining flexibility in the design and structure of DSRIPs from state to state will help ensure their ongoing success. Not every state's delivery system is currently at a point where they could take on a program as ambitious as New York's, yet that does not mean they could not benefit significantly from provider-level incentives to transform. CMS should recognize the varying starting points from which states are approaching delivery system reform and work with them to fashion programs that will challenge providers to undertake meaningful change while setting realistic expectations. State-by-state flexibility also allows states to better align their DSRIP with their overall state health policy goals, as CMS has been encouraging them to do.

With respect to CMS concerns about the administrative resources needed to implement and oversee DSRIPs, we agree that this kind of systemwide change is resource-intensive. But states are increasingly standardizing their DSRIP requirements across providers, offering menus of projects and measures providers can choose from, and developing rubrics for reviewing and approving plans. Many have contracted with independent evaluators to undertake the review of projects, reports, and milestone achievement. CMS can minimize the demand on its resources by directing its efforts to approving the framework for such review without having to review each plan and project itself.

DSRIPs are big and bold initiatives with the potential for big and bold results. They do require a time and resource investment from states and CMS, as well as the providers themselves. But without the funding available through DSRIPs, these providers would not have the resources to undertake the kind

of sweeping reform necessary in our health care system—even with value-based payment mechanisms and other reimbursement incentives in place. Indeed, the improvements realized through DSRIPs will provide a base for essential providers to more successfully participate in such payment reforms over the longer term.

The essential providers that are and should be at the center of DSRIP programs are the core of the Medicaid provider network. Medicaid's fate is necessarily tied to their fate. Investing time, resources, and funding in the transformation of these providers is an investment in the future of Medicaid and the beneficiaries it serves. We believe it is well worth CMS' continued support.

Conclusion: With CMS Support, Essential Hospitals Can Form the Backbone of a High-Performing Health Care Delivery System That Ensures Equal Access to All

We appreciate your ongoing willingness to engage in a dialogue with America's Essential Hospitals on these Medicaid issues, which are so critical to our members and their multiple missions. In particular, we ask CMS to do the following:

- Revise and finalize the proposed ***equal access rule*** in a manner that will enforce the requirement that states pay rates that provide Medicaid beneficiaries with access to care that is at least equal to that of the general population.

- Vigorously exercise its authority and responsibility—as the sole arbiter of the ***quality and access*** (as well as efficiency and economy) prongs of Section (a)(30)(A)—to review and disapprove rates that are insufficient to meet the statutory standard.

- Allow stakeholders to have ***meaningful and direct input*** into CMS' review of state rate proposals.

- Eliminate the ***regulatory prohibition on direct payments*** to providers for services provided through Medicaid managed care.

- Permit states to offer direct support for ***uncompensated care*** incurred by essential providers through Section 1115 waivers.

- Recognize the legitimacy and the historical basis for the use of ***local funding sources*** in the Medicaid Program and do not disfavor payments based on the source of the nonfederal share.

- Continue to support the development of ***DSRIPs*** through Section 1115 waivers.

- Reject attempts to use DSRIPs as a replacement for supplemental payments for services (including uncompensated care payments).

These issues do not arise in isolation, and we appreciate your willingness to consider them holistically. The need for continued reliance on supplemental payments is directly tied CMS' actions to enforce payment adequacy. Without the latter, the former will of necessity remain a feature of most states' Medicaid Program. And if CMS is unable to insist upon adequate base rates, it must remove the various administrative obstacles to supplemental payments that have been and are being erected.

Each state's Medicaid Program is much more than a simple purchaser of services. These programs can and do shape the entire health care delivery system on which low-income and otherwise vulnerable Americans rely. By ensuring adequate payment for services and providing opportunities, such as those offered through DSRIPs, for states to invest directly in system transformation, CMS can realize the vision embodied in the heart of the Medicaid statute—a program that provides Medicaid beneficiaries with truly equal access to care.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

cc: Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Kristin Fan, Acting Director, Financial Management Group
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