August 15, 2006

The Honorable Michael O. Leavitt
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Leavitt:

On behalf of the Medicaid directors in the fifty states, the District of Columbia, and the U.S. territories, the American Public Human Services Association (APHSA), and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully request that you not implement the proposed Medicaid regulatory changes included in President Bush's fiscal year 2007 budget proposal. We have appreciated the opportunity to work with your staff within the Medicaid division of the Centers for Medicare and Medicaid Services (CMS) on the numerous changes made to the Medicaid program by the Deficit Reduction Act of 2005 (DRA). However, as we discuss in more detail below, we believe the administrative proposals contained in the fiscal year 2007 budget proposal would constitute a noteworthy cost shift to states at a time when states are striving to implement the many reform opportunities contained in the DRA and to exercise new options to deliver innovative, appropriate, high quality, and cost effective care.

Specifically, the changes impacting Medicaid include a decrease in the allowable provider tax rate; limits to payments for government providers; and changes to reimbursement policies for rehabilitation, transportation, and school-based health services. These proposals would overturn current reimbursement systems and result in an inappropriate and unsustainable shift in costs to states.

First, we urge you not to proceed with the Administration's proposal to lower the allowable rate at which a state could use provider tax revenues to count towards the state share of Medicaid dollars from the current level of 6 percent to 3 percent. This proposal conflicts with previous law and policy upon which states have based their existing statutes and regulatory policy. Specifically, in passing the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 101-234), Congress amended the federal Medicaid statute to include detailed criteria for when a state could

use provider tax revenues to count towards the state share of Medicaid dollars. Further, subsequent formal regulations at (42 CFR 433.68(f)(3)(i)) already regulate and limit states' ability to implement provider taxes.

The Administration also proposes to cap payments to government-owned providers to no more than the cost of providing services to Medicaid enrollees. APHSA and NASMD urge you not to proceed with this proposal as it threatens the ability of states to pay their share of Medicaid costs. Although this proposal is expected to lower the federal share of Medicaid costs in the short term, it does little to address the underlying cost drivers in the overall Medicaid program. Moreover, it is reasonable to expect that the ensuing funding instability for states and for safety net providers could trigger shifts in the health care system that would lead to long-term cost increases.

In addition, the states' Medicaid administrators are concerned with the Administration's proposal to limit the scope of reimbursable services under the Medicaid rehabilitation services option. As you know, Medicaid is an increasingly important source of coverage for the delivery of behavioral health services and states use the Medicaid rehabilitation option to deliver a variety of community-based behavioral health services. The Medicaid rehabilitation option has been an integral benefit that has enabled states to ensure that beneficiaries receive services and supports to help them rely less on restrictive levels of service. Services that states cover under the option are those that restore basic life skills necessary to function independently in the community; redevelopment of communication and socialization skills; and family education and other family services exclusively related to the treatment or rehabilitation of the eligible individual. Limiting these services and the funding available to support them could have profoundly detrimental effects on the access, quality, and delivery of necessary services for Medicaid beneficiaries with complex mental and behavioral health needs.

Finally, states also believe that interagency efforts are vital to the goal of coordinating care, particularly in the early identification of child health needs. As a result, states Medicaid directors wish to work with you to ensure that any reform of school-based administration or transportation services does not prohibit appropriate reimbursement to states for health care services provided in the educational setting.

APHSA and NASMD shares the Administration's goal of ensuring the integrity of the Medicaid program. However, as currently presented, these proposals would result in a disproportionately negative impact to states. Instead, we are prepared to work with you to achieve meaningful reform that will strengthen the delivery of services and achieve program efficiencies for the federal government and states.

If we can be of further assistance please do not hesitate to contact Martha Roherty, Director of the National Association of State Medicaid Directors, at (202) 682-0100.

Sincerely,

Jerry W. Friedman
Executive Director
American Public Human Services Association

Nancy V. Atkins
Chair
National Association of State Medicaid Directors

Cc: Dennis Smith
NASMD Executive Committee