



North Carolina Department of Health and Human Services
Division of Medical Assistance

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February 28, 2008

Henry A. Waxman
Congress of the United States
House of Representatives
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

Thank you for the opportunity to provide feedback to the Committee on Oversight and Government Reform. Attached is North Carolina's response to your letter dated January 16, 2008, regarding the Administration's proposed regulatory action on Medicaid. The State's response addresses the estimated fiscal and service delivery impact on Medicaid beneficiaries.

If you should have any questions regarding this response, please contact me at (919) 855-4100.

Sincerely,

William W. Lawrence, Jr., M.D.

Attachment

cc: T. H. Galligan
Sharnese Ransome
Tom Davis



bcc: Pat Jeter
Venessa Hodges
Gregorio Hunt

CMS Proposed Regulations Impact for North Carolina

CMS 2258-FC Cost limits for public providers

- For the current year, 42 NC public hospitals (other than the University affiliated hospitals) certify public expenditures, approximately \$651,855,002, related to Medicaid recipients and another \$248,283,455 in expenditures related to indigent care costs. These certified public expenditures are used as non-federal shares to support Disproportionate Share Hospital (DSH) payments made to public and private hospitals that treat Medicaid recipients and indigent recipients in North Carolina.
- This proposed rule defines a “governmental unit” such that almost all public hospitals in the state would be excluded. As a result, this proposed rule would destroy North Carolina’s DSH program because the state’s public hospitals would no longer be able to certify public expenditures as matching state dollars against which federal monies would be drawn to fund the DSH program. The resultant loss of support for the state’s public and private hospitals would adversely impact the North Carolina Medicaid program and diminish the ability of the State to provide basic health care and services provided in the hospital setting to Medicaid and indigent recipients.
- Elimination of the DSH program would have a profound impact on the State and its Medicaid and indigent population. The cost of this impact cannot be calculated. However, a financial analysis estimating the loss in federal funds to support the DSH program over the next five years is attached.

CMS 2279- P Graduate Medical Education

- North Carolina has 14 non-state and two state hospitals identified as teaching hospitals. These 16 hospitals account for more than 48% of all hospital Medicaid discharges. The intent behind North Carolina’s Medicaid Graduate Medical Education is to partially defray teaching costs associated with providing medical care to Medicaid recipients.
- Elimination of payment for graduate medical education will result in a cut to the North Carolina Medicaid program of \$84 million per year in federal funds. It is estimated that over a five year period, this will amount to a loss of \$420 million dollars to support these hospitals.
- If this rule is finalized, the financial stability of our safety-net teaching hospitals will be jeopardized, affecting many of the state’s most vulnerable citizens covered by the Medicaid program and served by these hospitals.

- Implementation of this rule also would negatively impact non-teaching hospitals in the State since many non-teaching hospitals participate in resident training programs at the community level. As a result, the reduction in funding would reduce the number of residents in the community programs, negatively impacting the quality and access to care for Medicaid recipients.

CMS-2213-P Payment of hospital outpatient services

- This regulation would not impact the North Carolina Medicaid Program. The State’s Medicaid Program definition of outpatient services and reimbursement is clearly defined in the State Plan and would be compliant with CMS-2213-P if the rule were to be finalized.

CMS-2275-P Provider Taxes

- North Carolina utilizes assessments imposed on its Medicaid providers in two programs, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). These assessments have been used to draw federal funds and allowed the state to more appropriately reimburse providers. A reduction or elimination of these assessments would impede access to care by Medicaid recipients in these facilities.
- The fiscal impact per the HCFA-179 Federal Budget Impact Form which accompanied the submission of the State Plan Amendment estimated the fiscal impact (federal share only) as follows:

FFY 2004	\$148,753,400/Nursing Care Facilities
FFY 2005	\$152,884,668/Nursing Care Facilities
FFY 2005	\$3,205,240/ICF-MR Facilities
FFY 2006	\$3,301,397/ICF-MR Facilities

CMS-2261-P Coverage of Rehabilitative Services

- North Carolina Medicaid State Plan amendment (NC SPA 05-005) already approved by CMS regarding service definitions and the process of evaluating clients for services needed as well as the methodology for reimbursing providers is consistent with this rule. The State already ensures that Medicaid recipients receive the appropriate level of care and that services are not duplicated. We are unable to adequately project the fiscal impact at this time because of remaining questions about how this regulation will be applied; however, we anticipate a negative impact.
- The proposed rule suggests that a person’s rehabilitation from mental illness or substance use disorder follows a straight-line trajectory of continued improvement and that recovery can be achieved relatively quickly and permanently. Although individuals progress, they may experience relapse. Mental illness and addictive diseases are chronic conditions; many people do achieve recovery with effective rehabilitation treatment, but they are never “cured” of the illness. Further,

rehabilitation services should not be custodial. These services should represent active clinical treatment and interventions and the proposed rule does not recognize this reality.

- The proposed rule assumes that the changes will reduce cost to the Medicaid Program for Rehabilitation Option services by \$2.2 billion dollars over a four year period. However, the elimination of these services contradicts the Administration's New Freedom Commission Report, which provides a course of action on how services to individuals with mental illness and substance abuse disorders should be improved in the United States. North Carolina's efforts over the last six years to improve its public system of service to Medicaid recipients with mental illness and substance abuse disorders will be negatively impacted by the implementation of this rule.

CMS 2287-P School Based Administrative Claiming and Transportation

- The elimination of School Based Administrative Claiming as contemplated by this rule would mean the State's school districts would no longer be able to receive reimbursement for school based personnel who identify Medicaid-eligible children and arrange for their needed medical care. North Carolina Public Schools utilize funds from School Based Administrative Claiming to ensure vital services and equipment for students with disabilities are available. Medicaid Administrative Claiming (MAC) reimbursements are also used to help pay for direct services related to children with special needs. Some school districts choose to use MAC funds, supplemented by local and state funds, to support school-based nurses.
- North Carolina's estimated Medicaid eligible student population for the July to September 2007 quarter is 511,356 and it is estimated that implementation of this rule would result in a loss of \$56 million in federal funding to the State over the next five years.

DHHS Division of Medical Assistance

Estimated Impact Resulting from Enactment of CMS 2258-FC

Assumes Worst Case Scenario: No Current Public Hospitals Qualify as Government Hospitals (pending completion of Governmental Status

of Health Care Provider Surveys)

	FFY2009	FFY2010	FFY2011	FFY2012	FFY2013
Lost Federal Funds:					
Medicaid Deficit	249,586,035	250,210,000	250,835,525	251,462,614	252,091,271
Uninsured	181,089,352	183,733,326	186,448,031	189,234,828	192,095,103
Total	430,675,387	433,943,326	437,283,556	440,697,442	444,186,373

Note: Assumes 64.05% FFP all years