



**State of North Carolina
Office of the Governor
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Michael F. Easley
Governor

Governor Mike Easley sent the following letter to the entire North Carolina Congressional Delegation.

March 9, 2005

Dear United States Senators and Representatives from North Carolina:

Last week, my fellow governors and I met in Washington to discuss issues of importance to all of us, including the proposed Medicaid cuts included in the President's 2005-06 budget. Under the President's plan, \$40 billion in costs would be shifted from the federal government to the states. We agreed that these proposals were not sustainable.

Like many states, the rapid growth in North Carolina's Medicaid enrollment – over 200,000 new enrollees in three years – has driven the increase in costs. As we have discussed before, our national trade policy has resulted in the loss of thousands of North Carolina jobs, and some of those families have been forced to seek Medicaid assistance to make ends meet.

Since 2001, North Carolina has taken many steps to control Medicaid costs. We have reduced provider rates and fees, denied some inflationary payments to providers, taken steps such as establishing a maximum allowable cost list and a shift to generic and over-the-counter (OTC) drugs to control costs, increased co-payments to maximum levels allowed by law, implemented technology to reduce fraud and abuse, and reduced the transitional Medicaid period by one year. Quite simply, we have exhausted many traditional cost-saving options.

Here are the precise ramifications of some of the President's proposals to North Carolina:

- The President proposes reducing the rate of targeted case management from 62% federal share to 50% federal share. This will eliminate Medicaid case management services to an estimated 3,500 individuals.
- The President recommends a cut in the provider tax rate from a maximum of 6% to 3%. The cut in the allowable provider tax rate would cut payments to nursing facilities by \$78 million and result in 600,000 fewer patient days of care provided during the year, the equivalent of 1,644 patients every day of the year.
- There is substantial discussion in Washington of controlling Medicaid costs through capping or cutting optional Medicaid services or populations. A cap or cut in optional services would require the elimination of adult dental care services that benefit 11,000 North Carolinians per month, adult optical services that benefit 3,650 North Carolinians per month, adult podiatry services that benefit 2,300 North Carolinians per month, and adult chiropractic services that benefit 1,600 recipients per month. I decided not to make these reductions in my budget recommendations this year, because these problems left untreated would result in the need for more costly medical care for these people in the future.

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- Approximately 90% of all “optional” service expenditures are for prescription drugs, mental health/substance abuse/developmental disabilities and home health/personal care services (PCS). Last fiscal year, over one million recipients benefited from prescription drug access, 155,000 received home health/PCS services, 4,500 individuals were served in an Intermediate Care Facility for the Mentally Retarded (ICF-MR), and tens of thousands of individuals received outpatient mental health and substance abuse services. Any cap on optional services will result in cuts to these people in these areas.
- The President also proposes shifting \$6 billion in administrative costs to state and local governments. Sufficient administration is needed to help the increased number of people that require Medicaid services and to ensure that the program integrity remains high. North Carolina’s share of this reduction would amount to \$12.4 million per year, and would necessitate: (a) eliminating one-tenth of the workforce responsible for making Medicaid eligibility determinations; or (b) eliminating all administrative funding for local health departments and area mental health agencies – two front-line agencies which serve as the health care “safety net” for many of North Carolina’s rural and medically-underserved areas.
- Similarly, if the President desires changes in the current intergovernmental transfer rules (IGTs), there must be fiscally sound mechanisms for states to draw down federal funds to fill the gap between the payment for Medicaid and charity care patients and the cost of providing these services, which was the original laudable intent of the entire Disproportionate Share Hospital (DSH) program. If the President’s proposal to eliminate IGTs occurs without a replacement mechanism, many North Carolina hospitals will be placed in serious financial jeopardy.

If the federal government wants to reduce the Medicaid budget, then it should be specific in which citizens will not be served and which services will not be provided. Calls for ‘flexibility for the states’ cannot simply mean making states choose between funding health care for the aged, disabled, or at-risk children. I want to be clear about the ramifications of these choices, because the state and the counties do not have the ability to replace the funds being cut in Washington.

I look forward to working with you to make meaningful reforms to Medicaid that address the fiscal sustainability of the program while assuring the availability of critical health care coverage this vital program provides for so many of our people.

With kindest regards, I remain

Very truly yours,



Michael F. Easley

MFE/dg