NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

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Oversight and Government Affairs

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Good morning Mr. Chairman and members of the Committee. My name is David Parrella. For the past 10 years, I have had the privilege of serving as Connecticut's Director of Medical Care Administration. I also am currently the Chair of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association. The National Association of State Medicaid Directors is a bipartisan, professional, nonprofit organization of representatives of state Medicaid. The primary purposes of NASMD are to serve as a focal point of communication between the states and the federal government, and to provide an information network among the states on issues pertinent to the Medicaid program.

Thank you for the opportunity to speak briefly with you today about the recent spate of regulations promulgated by my colleagues at the federal Centers for Medicare and Medicaid Services (CMS). Let me be clear that regardless of our differences on these issues, I do regard Dennis Smith and his staff at CMS to

be colleagues and I share their commitment to be good custodians of the public dollars that we spend on health care.

Let me begin by summarizing the broad mission of the Medicaid program, which is a state and federal partnership to provide health care to neediest and most vulnerable populations in our country. Medicaid currently provides comprehensive coverage to over 53 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest economic challenge that we face in health care as members of my generation approach retirement. But Medicaid is more than a long-term care program. It is generally the largest health care program, if not the largest program, period, in most state budgets. It provides supports and services for millions of Americans with a wide range of disabilities that enables them to live independent lives in the community. It is the single largest payer of mental health services; the largest purchaser in the nation of pharmaceuticals; and the source of health insurance coverage for most of the nation's working poor. As you debate the future of the State Children's Health Insurance Program (SCHIP), please remember that Medicaid is the largest source of care for children in low-income families and is the largest payer in most states for maternity and prenatal care.

Across this immense landscape of health care delivery that is literally from the cradle to the grave, Medicaid programs have been encouraged, and in many cases mandated by Congress to work in partnership with other state and federal programs that touch upon the same populations. Teaching hospitals and substance abuse programs, programs for children with special education requirements and developmental delays, programs for children in the child welfare system, residential placements for persons with developmental disabilities, community-based services

for persons with mental illness and HIV, child immunization programs and outreach programs through schools to reach needy and entitled children, all of these programs have all benefited from collaboration with Medicaid programs around the country as a source of federal matching funds to help states meet the mandates placed upon them by federal laws regarding the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), IDEA, etc.

And we have done so economically. National budget figures show a very low rate of growth of 2.9 percent in FY 2007. Providers will tell you that the rates we pay for health care services are far from exorbitant. Furthermore, we manage the program at an indirect cost rate that would be the envy of any CEO in the private market.

So despite the occasional messiness that ensues in a program of this size, we are not a run away train on spending. Yet in recent months we have experienced the stealthy release of regulation after regulation seeking to reduce the scope and breadth of Medicaid. We have seen regulations that would limit facilities that can be reimbursed as public facilities, eliminate payment for Graduate Medical Education (GME), regulations that would impose burdensome new accounting measures on the funding for community-based services, and limit the ability to partner with the schools where millions of Medicaid children can be enrolled and served. CMS is seeking to place new limits on how states are able to raise their required state share for the federal Medicaid match. And perhaps most disturbingly, CMS is attempting to redefine what services can be covered under Medicaid as part of the Rehabilitation State Plan option, likely the single greatest vehicle

for creativity in the design of programs for persons with lifelong needs.

Now, CMS officials will tell you that they do not seek to harm the Medicaid program, and I am sure they are sincere in this belief. Their rationale is based largely on a two-part premise that allowing federal matching funds under Medicaid for these purposes is inevitably too tempting for states and will lead them to create arcane schemes to draw down excess federal funds for services that were traditionally a state responsibility. And let me say here, as someone who has worked in Medicaid for the past 20 years, that they have a legitimate concern regarding program integrity, especially when times are tight in state budgets.

But the other part of their premise is simply wrong. They maintain that the elimination of $20 billion in federal Medicaid funding for Medicaid administrative activities in the schools, or rehabilitation services for children with developmental delays, or graduate medical education is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved state plan amendments across the nation. CMS's argument continues that "*If states want to fund these activities they can simply appropriate more money. Special Education is purely the responsibility of the Education Department, services for persons with mental illness should be under the purview of SAMHSA, disease prevention under public health, and medical education is limited to funds appropriated in the budgets of the state teaching hospitals.*" Although there is no new appropriation on the horizon to replace Medicaid funding for these service through federal IDEA legislation or other areas where it might well belong, Medicaid is simply supposed to reduce the scope of its activities.

It is surprising that this philosophy should come at a time when most experts in the field would say that the nation's health care system is in a state of crisis. The emergency rooms of our teaching hospitals are bursting at the seams as they try to provide both emergency and non-emergency care to the 47 million Americans who have no health insurance. A greater awareness of autism spectrum disorders and mental illness among very young children has placed a strain on the entire mental health system. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. A retrenchment by Medicaid will only make those struggles more difficult for millions of Americans at a time when no comprehensive reform of the health care system is even on the horizon. We are apparently unable to agree on what income level should qualify a child to receive assistance with health care under SCHIP, much less comprehensive health reform.

As chair of the National Association of State Medicaid Directors, I applaud your efforts to review some of the changes that CMS officials have placed on states. I further appeal to you to continue your efforts to expand the moratoriums that you have already placed on some of these regulatory initiatives. It is the belief of the National Association of State Medicaid Directors that these issues need to be part of a broader debate on the future of health care here in these chambers. On many of these issues you did debate them during the discussion that led to the Deficit Reduction Act and chose not to act.

Please do not allow CMS to further limit the ability of the states to derive their share of Medicaid from taxes imposed on medical providers. Please do not allow CMS to eliminate the option for states to use Medicaid funding to pay for graduate medical

education. Please do not permit CMS officials to jeopardize the future for children with development disabilities by subjecting the services they receive to an artificial distinction between having lost their cognitive abilities or never having had them at all. Please do not force persons with disabilities back into institutional settings because states cannot match cost report standards for the community-based services that they receive to a Medicare institutional standard. Please do not cut off information gathered by school personnel from helping states determine eligibility for their programs. Please do not dictate to states what facilities can be designated units of government for reimbursement purposes. Please do not take hospital reimbursement back to the future by mandating retro cost-based methodologies.

Absent any new sources of funding, to restrict the state option to use Medicaid to fund any of these activities will only make life harder for the millions of poor Americans who look to you for answers on health care. When we finally have that conversation all of these issues will be on the table, along with a host of others. But let's have that discussion as part of a more comprehensive debate, one that is focused on outcomes as well as costs, and that is mindful of the needs of our most vulnerable citizens and medical institutions.

Thank you. I'd be happy to try and answer any questions that you may have.

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