

January 7, 2011

President Barack Obama
The White House
Washington, DC 20500

The Honorable Kathleen Sebelius
Secretary of Health and
Human Services
Washington, D.C. 20201

The Honorable John Boehner
Speaker of the United States House of
Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
United States House of Representatives
Washington, D.C. 20515

The Honorable Harry M. Reid
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
United States Senate
Washington, D.C. 20510

Dear President Obama, Speaker Boehner, Senator Reid, Senator McConnell, Representative Pelosi and Secretary Sebelius:

As Governors preparing Executive Budget Recommendations for the upcoming fiscal year(s), we are writing to you regarding the excessive constraints placed on us by healthcare-related federal mandates. One of our biggest concerns continues to be the Maintenance of Effort (MOE) provisions of the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (PPACA), which prevent states from managing their Medicaid programs for their unique Medicaid populations. We ask for your immediate action to remove these MOE requirements so that states are once again granted the flexibility to control their program costs and make necessary budget decisions.

Every Governor, Republican and Democrat, will face unprecedented budget challenges in the coming months. Efforts by the United States Department of Health and Human Services (HHS) to regulate state operations impose greater uncertainty on our budgets for oncoming years and create a perfect storm when coupled with the current state of the economy. The National Governors Association (NGA) and National Association of State Budget Officers (NASBO) just last month released the annual Fiscal Survey of the States:

- “Since the recession began, states have had significant revenue declines and in order to balance their budgets, have made significant cuts and in some cases enacted tax and fee increases. ... Finally, the potential impact of health care reform in 2014 is a real unknown at this time.”

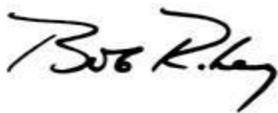
- “Finally, one of the clearest signs of state fiscal stress are mid-year budget cuts as they highlight the difference between budgeted levels of spending and forecasted revenue collections. For fiscal 2010, thirty-nine states made \$18.3 billion in mid-year budget cuts. Thus far for fiscal 2011, 14 states have made \$4 billion in cuts. In 2009, 43 states cut \$31.3 billion and in 2008, 13 states made \$3.6 billion in mid-year cuts.”

Health and education are the primary cost drivers for most state budgets. Medicaid enrollment is up. Revenues are down. States are unable to afford the current Medicaid program, yet our hands are tied by the MOE requirements included in ARRA and PPACA. The effect of the federal requirements is unconscionable; the federal requirements force Governors to cut other critical state programs, such as education, in order to fund a ‘one-size-fits-all’ approach to Medicaid. Again, we ask you to lift the MOE requirements so that states may make difficult budget decisions in ways that reflect the needs of their residents.

Attached is a fact sheet highlighting pending scenarios from many of our states as we cut services to meet the MOE requirements.

In these difficult fiscal times, we understand that the federal government cannot provide new sources of taxpayer dollars to assist the states. Therefore, our only option is to request flexibility and relief from MOE provisions so that we may responsibly manage our state budgets on behalf of our citizens.

Sincerely,



Governor Bob Riley
Alabama



Governor-elect Robert J. Bentley
Alabama



Governor Sean Parnell
Alaska



Governor Janice K. Brewer
Arizona



Governor Rick Scott
Florida



Governor Sonny Perdue
Georgia



Governor-elect Nathan Deal
Georgia



Governor C.L. "Butch" Otter
Idaho



Governor Mitch Daniels
Indiana



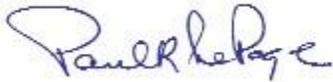
Governor-elect Terry E. Branstad
Iowa



Governor-elect Sam Brownback
Kansas



Governor Bobby Jindal
Louisiana



Governor Paul R. LePage
Maine



Governor Rick Snyder
Michigan



Governor Haley Barbour
Mississippi



Governor David Heineman
Nebraska



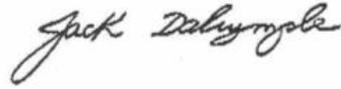
Governor Brian Sandoval
Nevada



Governor Chris Christie
New Jersey



Governor Susana Martinez
New Mexico



Governor Jack Dalrymple
North Dakota



Governor-elect John R. Kasich
Ohio



Governor-elect Mary Fallin
Oklahoma



Governor-elect Tom Corbett
Pennsylvania



Governor Mark Sanford
South Carolina



Governor-elect Nikki Haley
South Carolina



Governor-elect Dennis Daugaard
South Dakota



Governor M. Michael Rounds
South Dakota



Governor-elect Bill Haslam
Tennessee



Governor Rick Perry
Texas



Governor Gary R. Herbert
Utah



Governor Robert F. McDonnell
Virginia



Governor Scott Walker
Wisconsin



Governor Matthew H. Mead
Wyoming

Fast Facts:

Alabama:

In Alabama the cost of expanding Medicaid to 133 percent of the Federal Poverty Level will cost state and federal taxpayers close to \$1 billion per year to cover the new mandate beginning in 2014. Additionally the addition of nearly a half a million people to the Medicaid program will create substantial administrative cost.

Alaska:

MOE provisions limit Alaska's flexibility in managing the costs of its Medicaid program and may, when faced with the prospect of making reductions to anticipated Medicaid spending, ultimately force Alaska to place all of the burden on its providers. While Alaska is not currently experiencing the same short-term revenue shortfalls that many other states are struggling with, Alaska is faced with substantial growth in Medicaid caseloads and utilization. For FY2012 it is projected that Alaska will need an additional \$68 million in state general funds to cope with program growth and another \$123 million in state general funds to offset the loss of enhanced federal Medicaid funding under ARRA. In the absence of Congressional action to extend the ARRA funding, Alaska forecasts an over 40 percent increase in Medicaid state general fund expenditures. The State of Alaska has not yet developed an estimate for the total cost of the PPACA over the long term. However, a June 2010 preliminary analysis of the Medicaid impacts reflects that cumulative state general fund spending will increase by \$40.3 million, through 2020. Since spending in the early years is offset by increased federal match rates, spending in later years paints an even more concerning picture for Alaska's future.

Arizona:

The PPACA MOE requirements cost Arizona over \$800 million in the next fiscal year. Overall, it is anticipated that Arizona will have to spend \$11.6 billion in state General Fund monies from FY 2011 through FY 2020 to serve expansion populations, woodwork created by new mandates and to maintain previously optional groups that are now mandated through the MOE. Furthermore, because Arizona already expanded to 100% of the Federal Poverty Level, it receives a lower matching rate for those populations than other states that did not expand (who will initially receive full federal financing).

Over the past four years, while overall state spending has decreased, Medicaid spending has soared by 63 percent, and is now roughly 30 percent of the state general fund for FY 2011. During the current fiscal year, Arizona expects to collect \$7.6 billion in revenues - which would require an almost 15 percent

increase in our revenue simply to meet the state's mandated Medicaid expenditures. Put quite simply, Arizona has a Medicaid program that is not affordable or sustainable and the PPACA MOE prevents the state from making fiscal choices that reflect the priorities of its citizens.

Florida:

It is estimated that, in order to continue funding Medicaid at its current level next year, Florida will need to increase its state general revenue commitment by more than \$2 billion next fiscal year alone. And then, once the PPACA-mandated Medicaid expansion occurs and the state match requirement is initiated, Florida will have to increase its general revenue commitment by at least \$1.2 billion annually.

Idaho:

The MOE requirements imposed by the federal government require the State of Idaho to continue its pricing reductions, rate freezes and other benefit reductions to its Medicaid program. Hospitals, nursing homes, mental health providers, developmental disability providers, physicians and other Medicaid providers are facing the third year of budget reductions. In this current budget year, these providers saw reductions of \$36.2 million while still leaving the State to address another \$42 million. Without general funds available, the State will dip into the last of its rainy day funds to complete SFY 2011 within budget constraints. Projections show SFY 2012 Medicaid total costs at almost \$2 billion with a shortfall in general fund reaching 20 percent.

The overall cost to implement the PPACA Medicaid provisions in the State of Idaho is conservatively estimated to be \$228 million by 2020.

Indiana:

In Indiana, the Healthy Indiana Plan, a bi-partisan effort to provide a consumer driven health plan to uninsured Hoosiers, was never intended as an open entitlement. The plan has a dedicated but limited state funding stream and Medicaid dollars from the federal government were approved under a demonstration waiver, to study the results of this innovative insurance model. But under PPACA, the State is now required to open enrollment without regard to the state budget and state law that enabled HIP in the first place, costing as much as \$415 million per year. Indiana's actuary estimates that the state's cost to implement the mandates in PPACA will range from \$2.6 billion to \$3.1 billion.

Georgia:

Federal MOE requirements will force reductions in provider reimbursement that will undoubtedly lead to challenges for Medicaid patients to access care. Further, changes to covered optional Medicaid services combined with increased member cost sharing will be necessary to balance the Medicaid program budget. In the very short future, an estimated 700,000 additional lives will be added to our state Medicaid program as a direct result of PPACA. This will further exacerbate budgetary challenges we face with Medicaid alone.

The cost of the Medicaid expansion prescribed by PPACA will result in an additional \$1.2 billion of required state funding (FFY 2010 – FFY 2020).

Louisiana:

Louisiana's Medicaid program is under great financial strain with the current Medicaid eligible population. Louisiana's Medicaid program covers federally required populations, plus optional populations that constitute an additional \$352,997,222 in State General Funds to the Medicaid program. ACA and PPACA maintenance of effort language force Louisiana to maintain these otherwise optional populations, rather than allowing the state to make policy decisions for the Medicaid population covered.

As Medicaid enrollment continues to increase, the MOE requirements do not allow flexibility within the program, further tying Louisiana's hands in managing a balanced Medicaid program.

For example, in the current fiscal year, the state was forced to make over \$70 million in program reductions. After eliminating positions and non-priority programs, that state had limited options but to cut provider rates which could decrease access to care.

LA PPACA Impact Numbers:

1. The PPACA provisions are anticipated to cost Louisiana a total of \$7 billion in additional state general funds over the next 10 years.
2. Medicaid Expansion: PPACA will increase Medicaid rolls by 645,843 over the next 10 years at a cost of \$3.69 billion in state general funds.
3. Administrative Costs: high costs of the IT systems needed to implement the expansions and the link to the Exchange (whether state-run or federal) estimated at \$162 million in state general funds.

4. Increase payments to primary care providers, increased utilization for physicians and hospitals are estimated at \$2.6 billion in state general funds.

Background of \$2.6 billion:

- Over \$200 million for Medicaid administration
- Over \$464 million for Physician fee increase
- Over \$187 million for Physician utilization increase
- Over \$1.5 billion for Hospital rate increases
- Over \$280 million for Hospital utilization increase

Maine

- Maine's Medicaid program has experienced an increase in enrollment from the average in 2009 of 276,000 to more than 299,000 people by the end of 2010. Current enrollment in the program represents more than 23% of the state's population.
- Maine has a projected shortfall in the state's Medicaid program of over \$160 million for the next biennial budget beginning July 1, 2011.
- Since 1996, total spending in Maine's Medicaid program has increased by over 150%.
- Currently Maine's Medicaid program is projected to run out of money within the next 60 days in the absence of additional funding through an emergency supplemental budget request.
- Over the last several years, Medicaid rates for healthcare providers have been repeatedly cut to address the ongoing financial shortfalls in Medicaid as a result of increasing enrollment and utilization.
- As a result of these reductions, many Maine physicians have closed their practices to Medicaid patients significantly reducing access for Medicaid beneficiaries to primary care services.
- As Maine struggles to confront a shortfall of more than \$800 million in the next biennial budget and the requirement to adopt a balanced budget, it is imperative that the Governor and the Legislature have the necessary flexibility to comprehensively manage the Medicaid program and to make necessary changes to effectively reduce total spending in the program.

Mississippi:

The MOE requirements imposed by the federal government require Mississippi to make rate cuts to providers to address the budget shortfall in Medicaid.

Mississippi proposes to reduce Medicaid's budget by \$80 million by freezing provider rates. Both mandatory and optional services' rates will be frozen.

The overall cost to implement PPACA in the State of Mississippi is \$1.7 billion over ten years, including \$443 million in year 10 alone.

Nebraska:

An independent actuarial analysis completed for the State of Nebraska has determined that the Medicaid mandates contained in the federal healthcare reform law alone will cost Nebraska between \$458.2 and \$691.5 million over the first ten years of the law's implementation. It has also been determined that the state Medicaid program will now be responsible for between 108,000 to 145,000 newly-eligible participants as a result of the federal law's mandates.

New Jersey:

New Jersey Medicaid confronts a \$1.4 billion program deficit in state funding for the upcoming fiscal year (beginning July 2011). The federal MOE requirements imposed through the PPACA prevent the State from making program eligibility changes that could eliminate up to nearly \$530 million growth in state costs. If any of these eligibility changes are considered and implemented to manage the State's spending, New Jersey is at risk of losing up to \$6 billion in federal funds.

North Dakota:

Although North Dakota is not facing a budget shortfall, it very well could become problematic that the MOE provisions of ARRA and PPACA prevent states from managing their Medicaid programs and costs thereof. As such Governor Darlymple supports the removal of these MOE requirements out of principle and in light of their potential for future budgetary challenges.

Pennsylvania:

Pennsylvania's Medicaid program and current MOE requirements continue to place a heavy financial stress on the entire Commonwealth. Current estimates are that approximately \$824 million will be needed in additional state Medicaid funds in FY 2011-12 due to enrollment growth in the existing program and utilization increases. An additional \$1.4 billion will be needed to replace ARRA funding due to the expiration of the enhanced match, making the estimated increase in Pennsylvania direct funding for Medicaid at \$2.2 billion for FY2011-12.

Furthermore, it is estimated that Pennsylvania's Medicaid rolls may grow by as much as 800,000 with the expansion under the Affordable Care Act. As the Medicaid population continues to increase and state revenues continue to not keep

pace, the lack of any meaningful flexibility within the program will severely hamper virtually all other aspects of the state budget.

South Carolina:

Since December 2007, the South Carolina Department of Health and Human Services (SCDHHS) has seen its Medicaid rolls grow a net 100,000 people. The current Federal MOE requirements do not allow South Carolina the flexibility to fully manage the influx of new enrollees. This prohibition was originally tied to the acceptance of federal stimulus money and is now mandated in the new PPACA. SCDHHS is projected to run a \$228 million midyear deficit and needs as much of the previous flexibility to manage its program as possible.

South Dakota:

South Dakota estimates it will cost at least \$99.7 million in state funds through 2019 to comply with the Medicaid requirements of the PPACA.

This burden coupled with the inability to change other parts of the Medicaid program due to the MOE requirements will result in rate cuts to providers.

Providers that cannot absorb these cuts may stop taking people eligible for Medicaid, or may stop providing services altogether.

This would have a hugely detrimental effect on a very rural state, including citizens that rely on Medicaid for their health care and communities that may see their health care providers leave or quit. These unintended consequences of the MOE provisions in the PPACA are counter-productive of its larger goal to help Americans get access to the health care they need.

Texas:

3.3 million Texans are currently enrolled in Medicaid, costing Texas taxpayers \$7 billion per year from the state's general revenue fund alone. When accounting for the total cost of ARRA and FMAP changes as well as Medicaid caseload and cost growth for 2012-13, Texas is looking at a \$9.1 billion increase to retain current service levels. Because of the lack of flexibility in the Medicaid program, one of the few places states maintain the ability to make adjustments is in provider rate cuts. To fund for the full \$9.1 billion Texas would have to consider a 48% provider rate cut - an untenable option that would likely cause providers to leave the system altogether, resulting in severe shortages in access to care. States must have flexibility not only in regards to maintenance of effort, but in the overall administration of this program in order to best serve those with the highest needs

as well as continue to fund other budgetary priorities like education and public safety.

Tennessee:

Tennessee's Medicaid program is facing serious budgetary challenges in the coming fiscal year, as more than \$1 billion in one-time funding for TennCare runs out and revenue continues its slow climb back to pre-recession levels.

Unfortunately, MOE requirements take away the flexibility needed to make important changes to the program as we deal with such issues. For instance, TennCare could save \$16 million alone just by modifying nursing facility level of care requirements that would bring Tennessee in line with the criteria of other states and rebalance its long-term care system in order to serve more people with lesser levels of need in more cost-effective home and community-based settings while targeting the more expensive long-term care services to persons with higher acuity of need. However, MOE restrictions prohibit such changes.

At a time when Tennessee is already facing budget difficulties and the ACA is expected to cost the state up to an additional \$1.5 billion over five years, we must have the flexibility necessary to make common sense adjustments to the program.

Utah:

The MOE requirements imposed by the federal government require the State of Utah to restore funding to cover pregnant women with high assets on Medicaid. This will cost the State \$3.2 million annually.

The overall cost to implement the PPACA Medicaid provisions in the State of Utah is \$1.2 billion in state general funds over ten years.

Virginia:

The MOE requirements imposed by the federal government required Virginia to restore planned savings of almost \$460 million. This included increasing Medicaid eligibility level to 300 percent and requiring the state to lift a freeze on long term care waivers, in addition to other planned changes.

The MOE requirements prevent the state from changing the resource calculations for long term care as previously approved by the state legislature and Governor in an attempt to properly manage costs. The federal requirements have hindered the Commonwealth's ability to ensure that limited resources are directed to those most in need of public assistance.

Wyoming:

Wyoming is not presently suffering to the same extent as other states with regard to near term budgetary shortfalls; however, the costs of maintaining our Medicaid program are fast becoming a serious threat to our state general funds. Wyoming estimates its Medicaid costs for the next three years to be over 1.7 billion dollars. Because of the economic downturn, Wyoming's Medicaid program has seen an increase in enrollment and utilization of services. Wyoming needs to have flexibility at the state level to ensure the Medicaid program is operated efficiently and effectively.

Wyoming made a decision to accept the increased FMAP offered through the ARRA and thus agreed to the MOE provisions set out by ARRA.

Wyoming did not agree, however, to the continued MOE set out by the PPACA and strongly supports the removal of the PPACA MOE requirements.