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Building on ACA's Success Would Help Millions with Substance Use Disorders

By Peggy Bailey

The need for substance use disorder treatment is acute. A record 52,000 people died of drug overdoses in 2015, with 33,000 due to opioid use.[1] Drug overdose deaths rose by statistically significant amounts in 19 states between 2014 and 2015, according to the Centers for Disease Control and Prevention.[2] Millions of Americans have gained access to treatment through the Affordable Care Act (ACA) — coverage that must be maintained and expanded despite Republicans' efforts to repeal the ACA.

President Trump recently charged a new commission with studying the "scope and effectiveness of the Federal response to drug addiction and the opioid crisis."[3] There's no need, however, to wait for the commission to complete its work to continue to make treatment available and accessible to those who need it.

The ACA's expansion of Medicaid to low-income adults has allowed millions of people with substance use disorders (SUDs) to get health coverage and access to SUD treatment services, according to a comprehensive report last year from the U.S. Surgeon General.[4] The report also showed how millions of people who buy coverage in the individual and small-group markets, including those getting coverage through the ACA's marketplaces, have gained coverage for SUD treatment, because the ACA deemed it an essential health benefit.

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[1] Rose A. Rudd *et al.,* "Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015," Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report 2016;65:1445–1452, DOI, http://dx.doi.org/10.15585/mmwr.mm655051e1.

[2] Centers for Disease Control and Prevention, "Drug Overdose Death Data: 2014-2015 Death Increases," https://www.cdc.gov/drugoverdose/data/statedeaths.html. The 19 states were Connecticut, Florida, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Washington, and West Virginia.

[3] "Presidential Executive Order Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis," March 29, 2017, https://www.whitehouse.gov/the-press-office/2017/03/30/presidential-executive-order-establishing-presidents-commission.

[4] Department of Health and Human Services, Office of the Surgeon General, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," Executive Summary, November 2016, https://addiction.surgeongeneral.gov/executive-summary.pdf.

The House Republicans' failed ACA repeal bill, the American Health Care Act, would threaten these gains by effectively ending the Medicaid expansion and capping and cutting Medicaid funding, in addition to other provisions that would weaken individual and small-group-market coverage and affordability. The bill would leave 24 million more people uninsured and shift hundreds of billions in costs to states, including those that have been hit disproportionately by the opioid epidemic.

Rather than cutting access to SUD treatment, Congress and the Administration can follow the path set forth in the Surgeon General's report to build on the success of the ACA to increase insurance eligibility and coverage for people with SUDs. Key steps include:

- Expanding Medicaid in the 19 remaining states that have yet to adopt the ACA expansion for low-income adults.
- Maintaining Medicaid's current financing structure, which ensures that states can provide adequate coverage to all eligible people.
- Rejecting state Medicaid proposals that would restrict eligibility or benefits for people with SUDs, such as drug testing beneficiaries, instituting work requirements, or requiring excessive cost-sharing.
- Keeping the essential health benefit requirements for plans in the individual and small-group markets to ensure that substance use treatment is covered.
- Promoting state flexibility and innovation by approving Medicaid pilot programs designed to strengthen SUD treatment, and continuing peer learning and pilot projects through the Centers for Medicare and Medicaid Services (CMS).

Extend Medicaid Expansion to Remaining States

Hundreds of thousands of people with SUDs have gained coverage through the expansion of Medicaid to adults with incomes up to 138 percent of the poverty line. But 19 states have not yet expanded, despite the federal government picking up at least 90 percent of the cost. In states that didn't initially adopt the Medicaid expansion, 28 percent of uninsured non-elderly adults with incomes below 138 percent of the poverty line have a mental illness or substance use disorder, the Department of Health and Human Services (HHS) estimated in 2014.[5]

In states that haven't expanded, many adults are not eligible for Medicaid, because they do not meet strict disability criteria, or are not 65 or older, pregnant, or caring for a child in their home. SUD alone is not considered a disabling condition, so people with SUDs must *also* have a serious mental or physical health condition to qualify for Medicaid on the basis of a disability. Most people with SUDs don't meet this requirement and are therefore largely left uninsured.

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[5] Judith Dey *et al.*, "Benefits of Medicaid Expansion for Behavioral Health," Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, March 2016, https://aspe.hhs.gov/system/files/pdf/190506/BHMedicaidExpansion.pdf. Six states included in this analysis expanded Medicaid after 2014: Alaska, Indiana, Louisiana, Montana, New Hampshire, and Pennsylvania.

States that have expanded Medicaid have seen dramatic results for people with SUDs. The share of people with substance use or mental health disorders who were hospitalized but uninsured fell from about 20 percent in 2013 to 5 percent by mid-2015.[6] The Medicaid expansion has been particularly beneficial in states hit hardest by the opioid epidemic. In West Virginia, the state with the highest drug overdose death rate in 2015, the share of people with substance use or mental health disorders who were hospitalized but uninsured fell from 23 percent in 2013 to 5 percent in 2014.[7] After expanding Medicaid in 2014, Kentucky saw a 700 percent increase in Medicaid beneficiaries using substance use treatment services.[8] Use of these services rose nationally as well; one study found that expanding Medicaid reduced the unmet need for substance use treatment by 18.3 percent.[9]

Maintain Medicaid's Current Financing Structure

Under Medicaid's current funding structure, the federal government pays a fixed share of states' Medicaid costs, varying by state but averaging about 64 percent. As an entitlement program, Medicaid expands to meet need, which ensures that states receive federal support to meet increasing demand for health care services, including public health challenges such as opioid addiction.

The House Republicans' failed ACA repeal bill proposed radically restructuring Medicaid's financing system by converting it to a per capita cap or a block grant. This conversion coupled with rolling back Medicaid expansion would cut federal Medicaid spending by $839 billion over ten years, according to the Congressional Budget Office. It would eliminate the automatic response to need and shift costs to states, likely forcing them to cut services, reduce eligibility, and stop testing new models of treatment or recovery supports.[10]

By making it more difficult for people to obtain treatment, these cuts would be particularly damaging to states with high incidence of drug-related deaths. (See Table 1 and Appendix Table 1.) In West Virginia and New Hampshire, the states with the two highest rates of deaths due to drug overdoses in 2015, the House Republicans' bill would have cut 9.8 percent and 15.1 percent, respectively, from their total federal and state Medicaid budgets over ten years.

States could not afford to fill gaps of that magnitude. Medicaid's role in providing comprehensive SUD treatment has grown as a result of the ACA, but the trend had started earlier, as state and local governments' share of SUD treatment spending fell from 35 percent to 29 percent between 2007

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[6] Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, "Continuing progress on the opioid epidemic: The role of the Affordable Care Act," January 11, 2017, https://aspe.hhs.gov/pdf-report/continuing-progress-opioid-epidemic-role-affordable-care-act.

[7] Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *op cit.*

[8] Foundation for a Healthy Kentucky: "Substance Use and the ACA in Kentucky," December 2016, https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf.

[9] Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *op cit.*

[10] Edwin Park, Judith Solomon, and Hannah Katch, "Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families," Center on Budget and Policy Priorities, March 21, 2017, http://www.cbpp.org/research/health/updated-house-aca-repeal-—bill-deepens-damaging-medicaid-cuts-for-low-income.

and 2014.[11] The end result would be millions more people uninsured, and many fewer people with SUDs having access to the treatment they need.

TABLE 1

Medicaid Cuts Would Jeopardize Needed Coverage for Substance Use Disorder Treatment

States with highest drug-related deaths and potential Medicaid cuts under the American Health Care Act

State	Drug-Related Death Rate (per 100,000 in 2015)[a]	Projected Accumulated Federal and State Cuts from 2019 – 2028[b]	Percent Change in Current Funding
West Virginia*	41.5	$5 billion	-9.8
New Hampshire*	34.3	$4 billion	-15.1
Kentucky*	29.9	$20 billion	-14
Ohio*	29.9	$32 billion	-10
Rhode Island*	28.2	$6 billion	-14.8
Pennsylvania*	26.3	$31 billion	-10.2
Massachusetts*	25.7	$23 billion	-11.1
New Mexico*	25.3	$13 billion	-15.2
Utah	23.4	$2 billion	-4.5
Tennessee	22.2	$7 billion	-4.6

*Denotes states that expanded Medicaid.

[a] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Continuing progress on the opioid epidemic: The role of the Affordable Care Act," January 11, 2017, https://aspe.hhs.gov/pdf-report/continuing-progress-opioid-epidemic-role-affordable-care-act.

[b] John Holahan *et al*., "The Impact of Per Capita Caps on Federal and State Medicaid Spending," Urban Institute, U.S. Health Reform – Monitoring and Impact, March 2017, http://www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_1.pdf. These estimates are based on the bill as reported by the House Budget Committee and assume that states would reduce their spending proportionately in response to federal Medicaid funding cuts.

Reject Medicaid Proposals that Impose Barriers to Coverage

Some states are seeking federal permission to impose conditions on Medicaid coverage, including work requirements, premiums and co-pays, and drug testing.[12] These conditions would erect barriers to eligibility and coverage and would result in fewer low-income people being covered and receiving the health care they need.

- While **work requirements** have never been allowed in Medicaid, HHS Secretary Tom Price and CMS Administrator Seema Verma have indicated that they are willing to reconsider past

[11] Tami L. Mark *et al.*, "Insurance financing increased for mental health conditions but not for substance use disorders," *Health Affairs*, 35(6), June 2016, http://content.healthaffairs.org/content/35/6/958.full.pdf+html.

[12] Hannah Katch *et al.*, "Are Medicaid Incentives an Effective Way to Improve Health Outcomes?," Center on Budget and Policy Priorities, January 24, 2017, http://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes.

decisions.[13] Work requirements instituted as part of the Temporary Assistance for Needy Families (TANF) program did not reduce poverty and were particularly ineffective for people with significant barriers to employment, research shows.[14]

- Indiana and other states have imposed **premiums and cost-sharing** in their Medicaid programs, despite a robust body of research that shows premiums decrease eligible beneficiaries' participation and cost-sharing keeps people from obtaining necessary health care services.[15]
- Wisconsin Governor Scott Walker wants to conduct **drug tests** of Medicaid beneficiaries who are suspected of using drugs, with a failed test resulting in mandated treatment.[16] Medicaid law does not permit random or broad-based, suspicion-less drug testing, but at least eight states (Arizona, Maine, Mississippi, Missouri, North Carolina, Oklahoma, Tennessee, and Utah) have instituted drug testing programs under TANF. Evidence has shown that drug testing is often inaccurate due to certain medical conditions (such as kidney disease) or legitimate prescription drug use.[17] In addition, these programs often cost more to administer than any savings from denying TANF benefits to those who test positive for drug use.[18]

These restrictive policies would be particularly harmful for people who need SUD treatment. Working is difficult for people enrolled in a treatment program, and people who aren't working would have trouble paying premiums, co-pays, or deductibles. Drug testing Medicaid beneficiaries is likely to deter people from seeking coverage and keep them from getting the treatment they need. Moreover, SUD is a long-term disease and people sometimes relapse. People need to keep their coverage regardless of their drug use, ability to pay, or job status.

Maintain Coverage of SUD Treatment

Insurance *eligibility* is only part of the equation — insurance must also include the right benefits so people can obtain needed health care. Before the 2008 Mental Health Parity and Addition Equity

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[13] HHS Secretary Tom Price and CMS Administrator Seema Verma letter to governors, March 14, 2017, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

[14] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016, http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.

[15] Kaiser Family Foundation, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," February 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf.

[16] Paige Winfield Cunningham, "Want Medicaid coverage? A drug test should come first, Wisconsin governor says," *Washington Post,* April 2, 2017, https://www.washingtonpost.com/powerpost/want-medicaid-coverage-a-drug-test-should-come-first-wisconsin-governor-says/2017/04/02/190068f0-160c-11e7-ada0-1489b735b3a3_story.html?utm_term=.a149871bdb0b.

[17] "Drug Testing Welfare Recipients: Recent Proposals and Continuing Controversies," Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, October 12, 2011, https://aspe.hhs.gov/basic-report/drug-testing-welfare-recipients-recent-proposals-and-continuing-controversies.

[18] Bryce Covert, "What 7 states discovered after spending more than $1 million drug testing welfare recipients," ThinkProgress, February 26, 2015, https://thinkprogress.org/what-7-states-discovered-after-spending-more-than-1-million-drug-testing-welfare-recipients-c346e0b4305d.

Act (MHPAEA) and the ACA, health plans routinely didn't include substance use treatment or tightly constrained what they covered and for how long, so enrollees rarely used the benefits. The MHPAEA required most health plans to cover mental and behavioral health conditions at the same level as physical health conditions.[19] The ACA went a step further, requiring all health plans in the individual and small-group markets to provide a package of minimum federal standards, known as "essential health benefits" (EHBs), for the services that health plans must cover, including SUD services.[20] States and managed care plans have flexibility to design EHB benefit and payment structures, but they must adhere to MHPAEA.[21]

These coverage improvements have already increased insurance payments for SUD services. Nationally, the share of SUD treatment spending paid by private insurance rose from 16 to 18 percent between 2009 and 2014, while the share paid by Medicaid rose from 20 to 21 percent.[22] While these increases are modest, 2014 was the first year of the ACA's Medicaid expansion; SUD treatments reimbursed through insurance have likely grown since then, especially as more states expanded Medicaid in 2015 and 2016.

Continue State Flexibility and Innovation to Improve SUD Service Delivery

House Speaker Paul Ryan, HHS Secretary Price, and other Republican leaders often wrongly describe Medicaid rules as inflexible and as a barrier to state innovation. Federal rules set minimum standards for eligibility, benefits, beneficiary protections, provider payments, and how benefits are delivered, but states have flexibility to develop new ways to deliver care that improve quality and reduce health costs.[23]

CMS has responded to the growth of opioid use and the need for better SUD services by providing states with guidance, new service delivery models, and peer learning opportunities that allow states to develop innovative strategies specific to their needs.

Expanding Medicaid coverage for SUD services. CMS issued guidance to state Medicaid directors in July 2015 explaining Medicaid's opportunities for states to expand and improve the delivery of SUD treatment.[24] Using strategies included in the guidance, states can cover services like inpatient treatment or short-term residential treatment, add innovative outcome-based services, and

[19] Some health plans are exempt from the MHPAEA requirements, such as certain self-insured plans (that is, those for which the employer takes the financial risk of providing benefits).

[20] The MHPAEA exemptions do not apply to those non-grandfathered plans in the individual and small-group markets that are required by ACA regulations to provide EHB.

[21] Dania Palanker *et al.,* "Repealing the ACA Could Worsen the Opioid Epidemic," Georgetown University Health Policy Institute, Center on Health Insurance Reforms, February 2017, http://chirblog.org/repealing-aca-worsen-opioid-epidemic/.

[22] Mark *et al., op cit.*

[23] Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie.

[24] CMS Center for Medicaid and CHIP Services, Dear State Medicaid Director Letter: Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder, July 2015, https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.

streamline delivery of treatment with state-funded wraparound supports such as housing and employment. Several states including California, Kentucky, Maryland, Massachusetts, and New Hampshire have new Medicaid initiatives for people with SUDs underway. Others like Illinois, New Jersey, and West Virginia have proposals currently under consideration for CMS approval.

CMS' Innovation Accelerator Program. In 2014, CMS created the Medicaid Innovation Accelerator Program to provide technical assistance to states as they implemented new payment reform and service delivery systems and explored ways to reduce health care expenses while improving care. Reducing SUDs was one of CMS' first targeted initiatives. CMS conducted a web-based learning series to give states an opportunity to identify and share best practices.

CMS also conducted a "High Intensity Learning Collaborative" with six states: Kentucky, Louisiana, Michigan, Pennsylvania, Texas, and Washington. These states had the opportunity to learn from each other and receive guidance from CMS on how to efficiently tailor their Medicaid programs to provide SUD services. Since entering into the collaborative, these states have improved their data reporting and payment systems, created quality improvement systems to track treatment outcomes, increased access to SUD providers, and created policies to ensure that medically assisted treatment is properly prescribed.[25]

Medicaid health homes and accountable care organizations targeted to people with behavioral health needs. States are experimenting with new ways to deliver services to people with complex needs.[26] Two of the most popular Medicaid initiatives are "health homes" and "accountable care organizations."

- **Health homes** allow states to provide comprehensive care coordination for people with chronic conditions, including mental illness and SUDs. States receive an enhanced federal matching rate for health home services provided during the first two years of their health home programs. These services are particularly effective for people with complex needs — many of whom have SUDs coupled with other mental or physical health conditions — because they coordinate multiple providers or specialists, which can be difficult to manage without assistance.

  Missouri was one of the first states to take advantage of the ACA's Medicaid health home program. In 2013, the state reported that 50 percent of adults in health homes had a substance use disorder and that the enhanced services people received resulted in reduced hospital use, reduced emergency room use, and more appropriate use of prescription drugs. Overall, the state reduced Medicaid costs for those enrolled in the health home program by 17 percent.[27]

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[25] For more information on the Innovation Accelerator Program on Reducing Substance Use Disorders, see https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/learn-hilc-iap.pdf.

[26] Hannah Katch, "States Are Using Flexibility to Create Successful, Innovative Medicaid Programs," Center on Budget and Policy Priorities, June 2016, http://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs.

[27] Missouri Foundation for Health, "Issues in Missouri Health Care 2013," November 2016, https://mffh.org/wordpress/wp-content/uploads/2016/04/Issues-in-Missouri-Health-Care-2013.pdf.

- **Accountable care organizations** (ACOs) are also designed to more effectively serve high-cost, high-need people with chronic conditions, mental illness, or SUDs. ACOs are groups of doctors, hospitals, or other health care providers, sometimes led by managed care organizations, who together coordinate health care services for specific populations. ACOs first focused on Medicare beneficiaries but Medicaid agencies are increasingly using them to streamline services for their beneficiaries. For example, Oregon created regional ACOs called Care Coordination Organizations (CCOs). The state identified better integration of behavioral and primary health as a goal for the CCOs and this effort has shown results. Oregon's largest CCO, Health Share, cut emergency department visits by 18 percent, enrolled 80 percent of its members in integrated health services, and earned 100 percent of its potential payments for meeting quality measures.[28]

[28] Sarah Klein, Douglas McCarthy, and Alexander Cohen, "Health Share of Oregon: A Community-Oriented Approach to Accountable Care for Medicaid Beneficiaries," Commonwealth Fund, October 2014, http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1769_klein_hlt_share_oregon_aco_case_study.pdf.

APPENDIX TABLE 1

Medicaid Cuts Would Hurt States' Ability to Provide Substance Use Treatment

States' drug-related death rates and potential Medicaid cuts under the American Health Care Act

State	Drug-Related Death Rate (per 100,000 in 2015)	Projected Accumulated Federal and State Cuts from 2019-2028	Percentage of Current Spending
Alabama	15.7	$3 billion	-3.8%
Alaska*	16.0	$2 billion	-10.7%
Arizona*	19.0	$27 billion	-12.3%
Arkansas*	13.8	$4 billion	-5.9%
California*	11.3	$80 billion	-11.1%
Colorado*	15.4	$24 billion	-20.1%
Connecticut*	22.1	$13 billion	-10.9%
Delaware*	22.0	$4 billion	-15.0%
Florida	16.2	$13 billion	-3.6%
Georgia	12.7	$7 billion	-4.2%
Hawaii*	11.3	$5 billion	-15.7%
Idaho	14.2	$2 billion	-4.3%
Illinois*	14.1	$41 billion	-14.9%
Indiana*	19.5	$11 billion	-8.7%
Iowa*	10.3	$6 billion	-9.8%
Kansas	11.8	$2 billion	-3.4%
Kentucky*	29.9	$20 billion	-14.0%
Louisiana*	19.0	$14 billion	-9.7%
Maine	21.2	$1 billion	-3.9%
Maryland*	20.9	$23 billion	-16.3%
Massachusetts*	25.7	$23 billion	-11.1%
Michigan*	20.4	$24 billion	-9.8%
Minnesota*	10.6	$21 billion	-12.2%
Mississippi	12.3	$2 billion	-3.5%
Missouri	17.9	$5 billion	-3.5%
Montana*	13.8	$4 billion	-9.9%
Nebraska	6.9	$1 billion	-3.3%
Nevada*	20.4	$7 billion	-14.6%
New Hampshire*	34.3	$4 billion	-15.1%
New Jersey*	16.3	$48 billion	-20.6%
New Mexico*	25.3	$13 billion	-15.2%
New York*	13.6	$90 billion	-11.4%
North Carolina	15.8	$9 billion	-4.0%
North Dakota*	8.6	$2 billion	-15.9%
Ohio*	29.9	$32 billion	-10.0%
Oklahoma	19.0	$3 billion	-3.8%
Oregon*	12.0	$20 billion	-16.4%

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Pennsylvania*	26.3	$31 billion	-10.2%
Rhode Island*	28.2	$6 billion	-14.8%
South Carolina	15.7	$3 billion	-3.5%
South Dakota	8.4	$1 billion	-4.0%
Tennessee	22.2	$7 billion	-4.6%
Texas	9.4	$25 billion	-4.5%
Utah	23.4	$2 billion	-4.5%
Vermont*	16.7	$3 billion	-13.5%
Virginia	12.4	$5 billion	-3.8%
Washington*	14.7	$32 billion	-19.9%
West Virginia*	41.5	$5 billion	-9.8%
Wisconsin	15.5	$2 billion	-2.0%
Wyoming	16.4	$330 million	-3.1%
District of Columbia*	18.6	$2 billion	-7.3%

*Denotes states that expanded Medicaid.

Sources: Drug-related death rate: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Continuing progress on the opioid epidemic: The role of the Affordable Care Act," January 11, 2017, https://aspe.hhs.gov/pdf-report/continuing-progress-opioid-epidemic-role-affordable-care-act.

Funding cuts: John Holahan *et al*., "The Impact of Per Capita Caps on Federal and State Medicaid Spending," Urban Institute, U.S. Health Reform – Monitoring and Impact, March 2017, http://www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_1.pdf. These estimates are based on the bill as reported by the House Budget Committee and assume that states would reduce their spending proportionately in response to federal Medicaid funding cuts.