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MEDICAID AND THE STATE BUDGET: MORTAL INJURY?

House Bill (HB) 1 and Senate Bill (SB) 1 under consideration today fall short of continuing all state services by at least $27 billion in state General Revenue (GR). The Legislative Budget Board (LBB) estimates Medicaid alone is short $7.6 billion GR—$18 billion including the loss of federal-matching funds. This under-funding would be more than seven times the depth of the disastrous 2003 Medicaid and Children's Health Insurance Program (CHIP) cuts. The $950 million GR reduction for 2004-05 reduced actual state spending on health care services by 9 percent, whereas a $7.6 billion GR reduction for 2012-13 would reduce projected Medicaid spending on health care by about 34 percent. For more information, see *Testimony,* "Texas Medicaid Funding in Filed Version of HB 1."

This *Policy Page* provides:

(1) An overview of the proposed Medicaid funding cuts across the health and human services agencies,

(2) Details on what cuts are allowed or prohibited under federal Medicaid law, and

(3) A discussion of how the proposed cuts might affect Texas' compliance with the terms of the *Frew* federal class-action lawsuit settlement related to children's access to care in Texas Medicaid.

Overview of Medicaid funding cuts in HB 1 & SB 1 as filed

The $49.4 billion All Funds in total Article II (state health and human services agencies) funding proposed for 2012-2013 would be $16.1 billion below 2010-2011, a 24.6 percent reduction (see LBB, *Summary of Legislative Budget Estimates*, p. 73 House version; p. 80 Senate version). Proposed total funding in the three largest HHS agencies is below current 2010-2011 spending levels by 24.3 percent at the **Health and Human Services Commission (HHSC)**, 37.9 percent at **Department of Aging and Disability Services (DADS)**, and 10.4 percent at the **Department of State Health Services (DSHS)**. Importantly, these proposed funding levels are below current budget levels, and thus would fall even further short of covering new costs related to population and inflation growth.

According to the LBB, Medicaid alone accounts for $14.2 billion of the $16.1 billion drop in HHS agency funding from 2010-2011 to 2012-2013. The Article II Medicaid funding shortfall in HB/SB 1 (hereafter, HB 1) has three major components described by the LBB:

1. **Medicaid funding in HB 1 assumes 10 percent rate cuts for Medicaid and CHIP providers of health services, to be added to rate cuts already taken in 2010-2011.** On Sept. 1, 2010, the state reduced Medicaid and CHIP physician, hospital and provider rates by 1 percent, and on Feb. 1, 2011, rates were reduced by another 1 percent. For Medicaid only, the additional 10 percent rate cut reduces spending by $1.6 billion GR, losing another $2.2 billion federal match ($3.8 billion, All Funds). These cuts affect virtually every kind of health care professional and provider, and all agencies that use any part of Medicaid.[1]

2. **HB 1 does not include any funding for caseload growth above 2010-2011 levels, nor does it provide funds for cost increases or inflation.** This is estimated by LBB to reduce Medicaid funding by $1.7 billion GR, losing another $2.5 billion federal matching funds ($4.2 billion, All Funds).

3. **HB 1 does not replace $4.3 billion GR from stimulus law**, causing loss of another $5.7 billion in federal funds ($10 billion All Funds).[2]

Based on these three components, the total GR funding gap below LBB-estimated current services need and the filed bills is thus at least $7.6 billion, with another $10.4 billion federal matching dollars lost as a result ($18 billion all funds). An additional $858 million GR in cost containment reduction assumptions (Medicaid Managed Care expansion and others; more below) are "built into" the filed budget bills; unless those policies are adopted and the savings achieved, the program would be even further short on funds in the budget bills.

At **HHSC**, the LBB reports recommended 2012-2013 funding that is $9.3 billion below 2010-2011 appropriations. Funding at that level assumes no caseload growth or inflation, 10 percent rate cuts, no replacement of ARRA stimulus funding, and a roughly 10 percent reduction in spending on so-called "optional" health services for Medicaid enrollees age 21 and over.

Recommended appropriations for Medicaid at **DADS** are, according to LBB, $5 billion All Funds below 2010-2011 level, a reduction of over 40 percent before even considering increased caseloads and inflation. The budget does not fund growth in the number clients who are aged or have disabilities, and no increase in community care waiver caseloads. Rates for most Medicaid long term care services are cut by 10 percent.[3] (Similarly proportioned cuts are also made to the non-Medicaid portions of DADS services.)

At **DSHS**, the broader agency cuts include at least $71 million in "un-replaced" Medicaid ARRA stimulus funding, and at **Department of Rehabilitative and Assistive Services (DARS)** the multiple cuts to Early Childhood Intervention (ECI) funding include not covering caseload growth or replacing $23.9 million in ARRA stimulus funding.

A Much Deeper Hole than in 2003. The cuts proposed in the filed budget for 2012-2013—$18 Billion All Funds, and $7.6 billion GR—we are considering today are seven (7) times as large as the Medicaid/CHIP combined cuts in the adopted 2004-2005 budget. Or looking at the cuts from another angle, the $950 million GR reduction for 2004-2005 was about 9 percent of actual state Medicaid spending on health care services, whereas a $7.6 billion GR reduction for 2012-2013 would reduce projected spending on health care by about 34 percent.

Cost Containment Efforts also Reduce Medicaid Spending. Major expansions of Medicaid Managed Care are assumed in the budget bills, which would reduce state Medicaid costs for 2012-2013 by $362.7 million GR (HHSC Rider 52). Another $450 million GR reduction to Medicaid is required to be achieved through a variety of different means (HHSC Rider 61), and HHSC has reported to the Legislative budget committees that another $45 million GR reduction in spending on adult Medicaid benefits that are classified as "optional" under federal law is assumed in the filed budgets.

A major budgetary issue related to the proposed Medicaid Managed Care expansion is the fate of about $2 billion in "upper payment limit" (UPL) payments that now go to hospitals. Because federal policy normally will not allow the UPL payments to be made for hospital services provided under Medicaid Managed Care, some major adjustment to the proposed expansion of STAR+PLUS managed care will have to be made. Otherwise, hospitals and local governments will lose about 5 times the value of the managed care savings projected. As this report is being released, it appears that HHSC, federal Medicaid officials and Texas hospitals may have agreed to pursue a special waiver that will essentially convert the current UPL program into one that will reward reforms in delivery, information, and payment systems. The waiver would have a special emphasis on reducing

preventable costs and readmissions, and would protect the UPL funding while allowing the Medicaid Managed Care savings to be achieved.

Cutting Medicaid and CHIP Provider Rates

Cuts already applied in 2010-2011. In the current 2010-2011 budget period, Medicaid and CHIP providers at HHSC, DADS and DSHS have already taken 2 percent to 3 percent cuts in fees, and (according to LBB summary documents) the proposed 10 percent reduction will be on top of those reductions. The current-budget cuts are projected to cut state GR spending by $106.4 million, at a loss of $198 million in federal matching dollars. A summary of the estimated impact of cuts for the current 44 current budget period 2010-11 is provided in table below.

Texas Medicaid Provider Rate Cuts: Current 2010-11 Budget Period

Agency and Benefits	General Revenue (millions)	Federal Match Lost	Percent Cut
HHSC: Physicians & other medical care professionals; Dental; Prescription medicine dispensing fees. (Applies to Medicaid and CHIP, Fee-for-service and Managed Care; includes $14.6 million GR/$256.5 federal lost in reductions for Medicaid managed care plans)	$76.9	$145.5	2 percent
DADS: Nursing Homes Home & Community-based care	$24.8 $3.4	$44.6 $6.3	3 percent 2 percent
DSHS: Children with Special Health Care Needs, Maternal and Child health; Family Planning; Targeted Case Management; and MH Rehab Services	$1.2	$1.7	2 percent
Total, current biennium rate cuts in force	$106.4	$198	

SOURCE Health and Human Services Commission (HHSC), projected as of January 2011

Bill assumes all Fees cut by another 10 percent for 2012-2013. Texas Medicaid payments for nearly all types of professionals and providers would be reduced across the board by 10 percent under the proposed budget bills. There are no firm minimum standards for provider pay under federal law, so every state creates its own methods and sets its own levels of pay. Texas has used this "flexibility" by eliminating any automatic updates for inflation from most provider reimbursement formulas (as have other states). Instead, increases for many services or provider types are only received if the legislature approves them. Legislative updates have offset inflation costs to a much greater degree for some provider types than for others. In the case of physicians and other professionals providing medical and behavioral health care, rate updates have been extremely rare, with just one increase in each of the last two decades, and with each of those advances partially lost to subsequent legislative rate cuts. In 2003, provider rate cuts made up the largest share of the cuts to Medicaid and CHIP, about $425 million out of the total $950 million GR. Rate cuts were restored in 2005 to their 2003 levels for certain Community Care programs and for residential care for persons with intellectual disabilities (all at the Department of Aging and Disability Services, DADS), but not for doctors, other professionals, hospitals, nursing homes, or CHIP. In 2007, significant rate increases for doctors and dentists totaling $512 million GR for 2008-2009 were approved by the legislature as part of a new corrective action plan for the *Frew* federal class-action lawsuit settlement related to children's access to care in Texas Medicaid.[4]

What Would Another 10 percent Cut Do? What about 33 percent? Against that backdrop, the impact of an additional 10 percent rate cuts will vary across the type of service and the particular health professional provider. For providers whose

patient population is predominantly covered by Medicaid, additional cuts could have dire results. For example, 551 nursing homes in Texas have a Medicaid census that exceeds 70 percent - in rough numbers they care for 45,700 total residents, and have 62,800 total staff. Some of these facilities may not be able to continue operations under a 12+ percent rate cut at all, while others may suffer damage (e.g., layoffs, reduced hours and services) but still be able to keep their doors open. Providers that are already reimbursed at very low levels (e.g., personal attendant care for persons with disabilities) may also find that a cut of this magnitude makes continued operations impossible. Of deep concern is the impact of further rate cuts on doctors' and dentists' willingness to treat Medicaid and CHIP patients at all. The Texas Medical Association's biennial survey of physicians has already seen a decline of physicians accepting new Medicaid patients from 75 percent in 1996 to 42 percent in 2010.

It is important to recall that a 10 percent rate cut would only account for an estimated $1.7 billion of the LBB's estimated $7.6 billion GR under-funding. Agency officials and health provider associations have acknowledged that if the full Medicaid funding shortfall were to be filled using rate cuts alone, that fee reductions of one-third or more (33 percent or more) would be required.

Research: Low Rates, Budget Cuts drive up Medicaid E.R. use, Increase Fees & Premiums for Insured. According to the National Center for Health Statistics, reducing Medicaid physician fee levels affects both volume and site of care of Medicaid patients. Lower rates are associated with reduced primary care physician visits and increased (and more costly) emergency room visits. Medicaid patients are more likely to seek emergency department care if they are unable to find a primary care physician. Emergency department visits for primary care treatable issues are most associated with hypertension, asthma, urinary tract infections, and diabetes.[5]

A 2008 report from Milliman Associates (one of the world's largest independent actuarial firms) measured cost shift from Medicare and Medicaid payments to hospitals and physicians: the difference between actual and average payment rates for Medicare and Medicaid versus private payers. The study found that cost shifting adds an estimated $1,512, or 10.6 percent, to the average premium for a family of four, plus increases family coinsurance and deductibles by an additional $276. Medicaid's hospital cost shift is less than for Medicare, but Medicaid causes much higher physician pay cost shift because of very low Medicaid rates. Taken together, the estimated annual cost shift is $88.8 billion, which is 15 percent of the current commercial insurance spending on hospital and physician services. Stated differently, the authors say that if there were no cost shift, hospital and physician costs for privately insured patients would be 15 percent lower.[6] Uncompensated care provided to the uninsured results in additional cost-shift, so any cuts in the number of Medicaid-covered Texans would be expected to also drive up fees and premiums for insured Texans.[7]

In addition to cost-shifting, cost-cutting is another way providers—particularly hospitals—make up for reduced revenues when rates are cut. Safety net hospitals with large public caseloads "may reduce quality to a greater extent than those with smaller public case loads as public reimbursements decline." [8]

Medicaid and CHIP Stability: State Maintenance of Effort Requirements

Medicaid and The Supplemental Nutrition Assistance Program (SNAP- formerly food stamps) are intended to work as "counter-cyclical" programs; that is, eligibility is not capped so that they won't get cut at the very time that they are most needed—when the economy and state revenues take a hit. But while SNAP benefits are 100 percent federally-funded and do not affect state budgets in a recession, the fact that state Medicaid benefits require a substantial state funding share mean that states experiencing revenue shortfalls often look to close their budget gaps with Medicaid program cuts. In 2003 and again in 2009, Congress increased the federal share of Medicaid spending to help state weather economic downturns.

Texas History. In 2003, the Texas legislature adopted a budget that cut Medicaid and CHIP spending by $950 million GR, for a total All-Funds impact of just under $2.6 billion. Cuts that year included: across-the-board rate cuts for providers (the largest cut); CHIP eligibility policy and premium changes that drove down enrollment by 40 percent (over 200,000 fewer children); complete elimination of eyeglasses, hearing aids, mental health professional services, and podiatry for all of Texas Medicaid's predominantly elderly and disabled adult population; CHIP benefit cuts (vision, dental, and mental health); reduced eligibility for maternity care by Texas Medicaid; and complete elimination of the Medically Needy "spend-down" coverage for parents with catastrophic care needs. Those 2003 cuts were imposed despite Texas' receipt in May 2003 of $553 million in Medicaid fiscal aid and another $709 million in flexible grants. However, after initial adoption, LBB-Governor's office actions were taken during the 2004-05 biennium to reduce the cuts to $1.6 billion All Funds and $620 million GR.

ARRA and ACA set new Floors for State Medicaid Eligibility. Because Congress wanted in 2009 to ensure that targeted Medicaid match relief in the current global recession would be used protect enrollees from enrollment cuts, and to prevent states from accepting the enhanced federal funds but still cutting off coverage, the American Recovery and Reinvestment Act (ARRA- the stimulus bill) required states to keep their Medicaid eligibility criteria and enrollment/renewal procedures no more restrictive than those in place on July 1, 2008, putting their federal match increase at stake if they did not comply. Those requirements are in effect through the end of June 2011, when the stimulus Medicaid funding is scheduled to end for Texas. HHSC reports indicate Texas will have received over $6.5 billion in ARRA enhanced federal Medicaid matching funds at that point. The current increased federal Medicaid funding authorized under the ARRA (stimulus) act is set to expire at the end of June 2011 due to Congressional decisions to curtail relief to the states along with all other spending.

Though ARRA's program stability floors (known as "maintenance of effort" requirements or MOE) expire in June, they have been replaced in federal law by similar standards included in the Affordable Care Act of 2010 (ACA - national health reform). The new standards prevent states from reducing their Medicaid and CHIP eligibility standards for adults until January 2014, and for children until 2019. States that cover adults—other than pregnant women and persons with disabilities—at incomes above 133 percent of the federal poverty level can request a waiver to make cuts *in that population only* if their budget officials certify a funding crisis; however, Texas does not cover any such adults in Medicaid. Under the new floors, states would lose all federal Medicaid and CHIP funding if they violate the standards. For Texas, that would mean a loss of around $17 to $18 billion federal dollars a year at current program levels.

Federal Medicaid authorities released new guidance on the details of these MOE standards in late February 2011.[9] The new guidance clarifies a number of detailed questions about how the standard is to be applied, but some questions remain that may either be clarified in future guidance or only through specific state inquiry. For example, guidance clarified that the small number of states with major 1115 expansion waivers currently in place (e.g., AZ) would be allowed to let those waivers, typically approved for a 5-year period, to expire. Failure to request renewal would not be considered an MOE violation; however, a state would be required to evaluate all waiver enrollees for Medicaid eligibility under regular (non-waiver) eligibility standards. Unanswered at this point is whether this is also the case for 1915(c) community based care waivers.

What About CHIP and the Stability MOE? Texas CHIP statute allows for freezes on enrollment and waiting lists if program appropriations are too low, and the question has been posed whether setting such a freeze would violate the federal stability floor standard. Guidance to date has not addressed that issue; Arizona was allowed to continue a CHIP freeze that was already in effect when the ACA was signed. How a new freeze would be viewed is not spelled out, but it is expected that a new freeze may not be approved by federal CHIP authorities, even if the authorizing state law would allow it.

Repealing Stability Floors: A False Choice. Some elected officials have suggested that Texas would benefit from repealing the federal Affordable Care Act MOE stability floors. This focus on MOE poses a false choice, suggesting our only choices are between cutting provider rates deeply or cutting kids and seniors off of coverage. In truth, Texans have a much wider range of choices besides relying solely on cuts to balance this budget, and all of those choices must be on the table. Moreover, all Medicaid cuts will hurt vulnerable Texans: kids, seniors, Texans with disabilities, and pregnant women. No vulnerable Texan, health care provider, or taxpayer would be better off (or hurt less) under eligibility cuts than they would if you cut their benefits or fees.

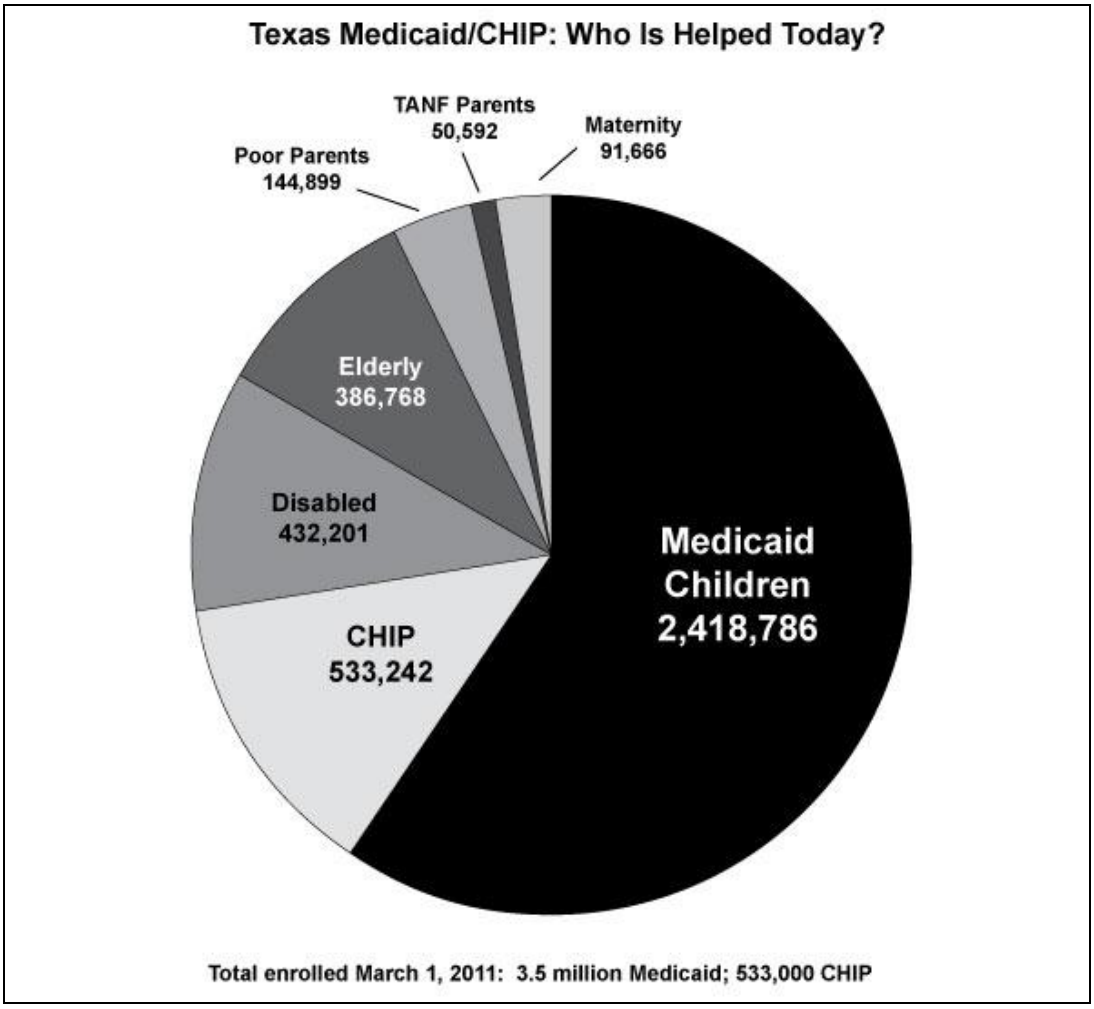
Medicaid Services: Mandatory and Optional	
Federal Law Requires	**Federal Law Allows**
• Inpatient/outpatient hospital • Physician services • Lab and x-ray • EPSDT (Texas Health Steps) • Ambulance • Home health • Rural Health Clinics/FQHCs • Nursing facilities • Immunizations and comprehensive care for children • Family planning • Nurse Midwife, Nurse Practitioner	• Prescription coverage (all states cover, but limits allowed for adults; TX limits 3 prescriptions/mo. except in HMOs, waiver programs) • Institutional care for developmentally disabled • Community care for elders or people with disabilities • Dental care, Eyeglasses, Hearing aids • Private duty nursing • Case management • Podiatry • Chiropractic

Cutting Medicaid or CHIP Benefits: What is on the Table?

What the Law Allows. Under federal law, Medicaid health services that are "allowable" for payment may not be subject to arbitrary limits in the amount, duration, or scope of what is covered for a child (under age 21); as long as a service is medically necessary, it must be provided. For adults 21 and older, state Medicaid programs have a number of benefits they are required to include for adults, and a second list of services states are allowed (but not required) to cover. And, unlike children, services for adults can be limited in amount, duration, and scope. To illustrate, Texas adults enrolled in Medicaid who are not in an HMO are limited now to filling 3 prescriptions per month. Given these federal standards, states looking to cut Medicaid spending cannot cut benefits for children at all, but can look at completely eliminating benefits for adults that are classified "optional", and can consider limits on the amount, duration, or scope of any benefit for an adult.

CHIP programs under federal law have to cover a broad range of services for children, but states are allowed to limit those benefits to a much greater degree than for children's Medicaid. When Congress reauthorized CHIP in 2009, it added a minimum standard for dental benefits and mental health coverage in separate CHIP programs[10] like Texas CHIP. Despite the stronger overall federal CHIP standards, CHIP benefits are potentially subject to some modest reductions in scope of some benefits. While legislative budget committees are considering increased co-payments for CHIP, no benefit cuts have been proposed to date.

2003 Medicaid and CHIP Benefit Cuts. In 2003, the Texas Legislature eliminated these Medicaid benefits entirely for adults: eyeglasses, hearing aids, podiatry, chiropractic, and mental health services provided by psychologists, social workers, licensed professional counselors, and licensed marriage and family therapists. In addition, community care waiver enrollment was frozen, and the personal needs allowance of nursing home residents—the amount of their social security or SSI benefits they are allowed to keep—was cut from $60 to $45 per month. In CHIP, vision and dental coverage, hospice care, skilled nursing, and most mental health services were eliminated. CHIP mental health benefits were increased back to a level roughly 50 percent of the original CHIP mental health coverage when federal CHIP authorities determined the "bare-bones" mental health coverage failed to meet federal law standards. All of these benefits were subsequently restored in 2005, after hardships for Medicaid and CHIP enrollees resulting from cuts were widely protested.



Benefit Cut Proposals under Discussion Now. The filed budget bills assume a $45 million GR reduction in optional adult Medicaid benefits. No specifics as to what cuts would be made to achieve that reduction were provided. As of early March, Senate and House committees have discussed making significant reductions in the scope of coverage for hearing aids, mental health, case management, eyeglasses, podiatry, and therapies that adults can access, but not complete elimination as was done in 2003. As the graphic here illustrates, the great majority of the adults on Texas Medicaid—the group who would be affected by these reductions in benefits, since children are exempt—are seniors and adults with disabilities, followed by a smaller number of very poor parents and women who are receiving maternity coverage.

Medicaid Cuts, Federal Law, and the *Frew* Lawsuit Settlement

By participating in the federal-state Medicaid partnership, the state assumes the legal responsibility for meeting federal law standards. Federal Medicaid law includes two different provisions that states have looked to for their obligations with regard to provider payment and access to care.

Care Available to Same Extent as the general Population. While federal Medicaid law does not include specific standards or benchmarks for the method or amount of Medicaid provider fees, federal law does direct that access to care be comparable to that of "the general population."

Federal law at 42 U.S.C. Section 1396a (a)(30)(A) says:

> A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b (i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services **and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.**

ACA Clarifies Definition of Medical Assistance. The second provision of the Medicaid statute often looked to for guidance regarding states' Medicaid access obligations is the definition of Medicaid "medical assistance."[11] The definition had long been interpreted by the courts to obligate the state Medicaid programs to not only make payments for part or all of the costs of care or services, but also to ensure the provision of the care and services. Responding to several recent contrary decisions that held states had no obligation beyond paying Medicaid bills, Congress clarified the language in the Affordable Care Act to include the actual care and services, and not just the payments for them, in the definition of medical assistance. This new standard takes the obligation of states beyond simply being a payor, heightening the state's legal responsibility to ensure access to care. The Congressional Record on this statutory change makes clear Congress' desire with this change of language to clarify its intent to be consistent with "longstanding administrative use and understanding of the term."[12]

***Frew*: What has Texas Medicaid Agreed to Do?** Moving beyond a general look at the federal law governing how Texas Medicaid must address access to care, the Texas program is also legally bound by the *Frew* Consent Decree. As noted above, major increases to dental and physician/professional fees were adopted in 2007 as part of the Corrective Action Plans approved by the federal court, so the proposed deep cuts in payment rates for Medicaid health care providers naturally have raised the question of whether such cuts will result in Texas Medicaid being out of compliance with the terms of the *Frew* federal class-action lawsuit settlement related to children's access to care in Texas Medicaid.

One section of the latest Corrective Action Plan (CAP, April 2007) agreed to by the state and the plaintiffs and approved by the federal court is entitled, "Adequate Supply of Health Care Providers." The order states that "*payment levels will be sufficient to attract enough providers to serve the class, and comply with the Decree and this Order with respect to all class members, whether or not they are enrolled in managed care.*" It goes on to specify the increases to Medicaid dental, physician, and other professional fees that have been agreed to for the 2008-2009 biennium.[13] HHSC agrees to provide a status report every year on its Medicaid Provider base, and develop a plan to address any shortages in children's Medicaid provider supply identified in any region. After 4 years (presumably in 2011), the CAP directs the plaintiffs and HHSC to confer over the need for further action to ensure adequate provider supply.

The HHSC has made exemption of children's Medicaid from the 10 percent rate cuts its first priority "Exceptional Item 1a," at a cost of $106 million GR ($252.3 million all funds), and has asked for a parallel exemption for CHIP in Exceptional Item 1b at a cost of $18.4 million GR ($62.3 million all funds).[14] While ultimately any enforceability and remedies will be determined by future litigation, it seems clear that cuts of the magnitude being contemplated by the budget committees would receive deep scrutiny by the court, and would be likely to result in further litigation, making funding of these exceptional items the wise course of action.

Cut-Only Approach Would Cripple Texas Health Care

Savings proposals related to reforms to payment and delivery systems, enrollee cost-sharing increases, as well as proposals by some lawmakers to request major federal law changes or exceptions for Texas Medicaid, are under consideration by the 82nd Legislature. Major proposals will be discussed in an upcoming *Policy Page*. It is critical to understand, however, that aggressive implementation of all the best practices and reforms available can come nowhere near to reducing Texas Medicaid costs by $7.6 billion GR ($18 billion all funds).

If there is a take-home point from this analysis, it is that Medicaid funding cuts on the scale of the $7.6 billion or more estimated by the LBB in the filed budget would have a profound and crippling effect on the 3.5 million Texans relying on Medicaid, the 533,000 children relying on CHIP, our health care safety net, and local taxpayers. As we publish this analysis, both chambers are near to adopting budgets that will not reduce the size of these cuts by much. And, readers should recall that the entire state budget revenue shortage is around $27 billion GR, so Medicaid cannot be spared by cutting other programs more deeply: every part of state government is already reduced by around 25 percent under this budget. Only by spending the entire Rainy Day Fund and raising substantial new revenues can we avoid devastating cuts to access to care for our most vulnerable, and the loss to our state of over $10 billion in our federal tax dollars.

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ENDNOTES

[1] Some Medicaid services assumed exempt from the 10 percent cuts include certain rural hospitals, and services provided by federally qualified health centers (FQHCs); the status of inpatient care at children hospitals is not clear, however.

[2] Legislative Budget Board, "Summary of Legislative Budget Estimates, House Version," January 2011, pp. 80-81. In recent hearings, HHSC has estimated the cuts at a higher $1.9 billion GR.

[3] Services exempt from the 10 percent cuts at DADS include Medicare Nursing home co-payments, PACE programs, and State Supported Living centers (formerly "State Schools").

[4] The *Frew* lawsuit was filed in 1993, and the plaintiffs and state signed a Consent Decree (settlement) approved by the federal court in 1996. A new corrective action order was approved by the court in 2007 in response to plaintiffs' complaints that the terms of the initial settlement were not being met.

[5] Sandra L. Decker Ph.D., "Changes in Medicaid Physician Fees and Patterns of Ambulatory Care," Inquiry Journal 46 (Fall 2009).

[6] Milliman, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers," America's Health Insurance Plan, accessed February 20, 2011, last modified December 2008, http://www.ahip.org/content/pressrelease.aspx?docid=25218

[7] Families USA, "Hidden Health Tax: Americans Pay a Premium," Families USA: The Voice for Health Care Consumers , accessed February 20, 2011, last modified May 2009, http://www.familiesusa.org/resources/publications

[8] Austin Frakt Ph.D., "How Much Do Hospitals Cost Shift? A Review of the Evidence," Health Care Financing and Economics, accessed February 20, 2011, last modified December 2010, http://www.hcfe.research.va.gov/docs/wp_2011_01.pdf .

[9] See CMS website, http://www.cms.gov/smdl/downloads/SMD11001.pdf

[10] Some states have separate CHIP programs like Texas, others expanded Medicaid for kids using CHIP funds, and some do a combination of the two.

[11] 42 U.S.C. § 1396d(a).

[12] H.R. Rep. No. 299, 111th Congress, 1st session 2009, at 649-50, 2009 WL 3321420 (October 14, 2009).

[13] Specifically, a 50 percent increase in pediatric dental rates above 2006-2007; a 25 percent increase for physician and professional fees over 2006-2007; and an additional $50 million targeted specialists' fees. *No. 3:93CV65 – Frew vs. Hawkins* Corrective Action Order: Provider Supply.

[14] The *Frew* lawsuit does not apply to CHIP, which is governed by different federal laws.