MEDICAID & RECONCILIATION

Friday, January 17, 2025

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Strategic Consulting at the Intersection of Health Care Policy, Politics and Business

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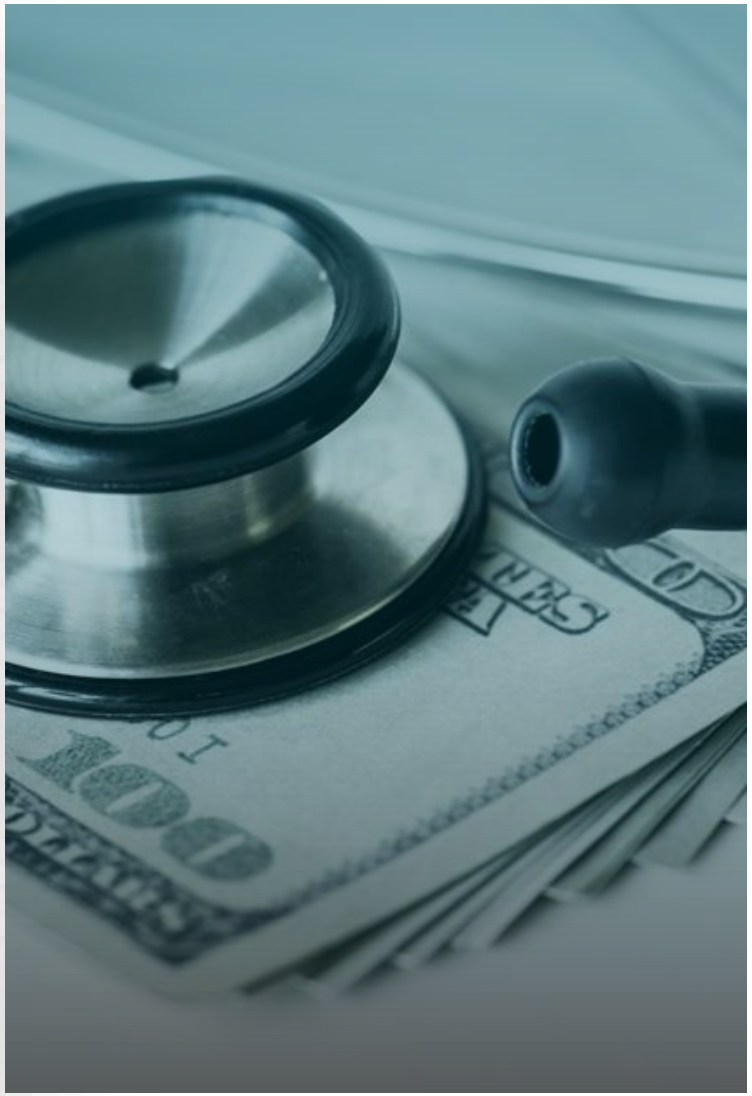

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BUDGET RECONCILIATION 2025

The Budget Reconciliation process allows for a **simple majority vote** for passage of legislation in the Senate.

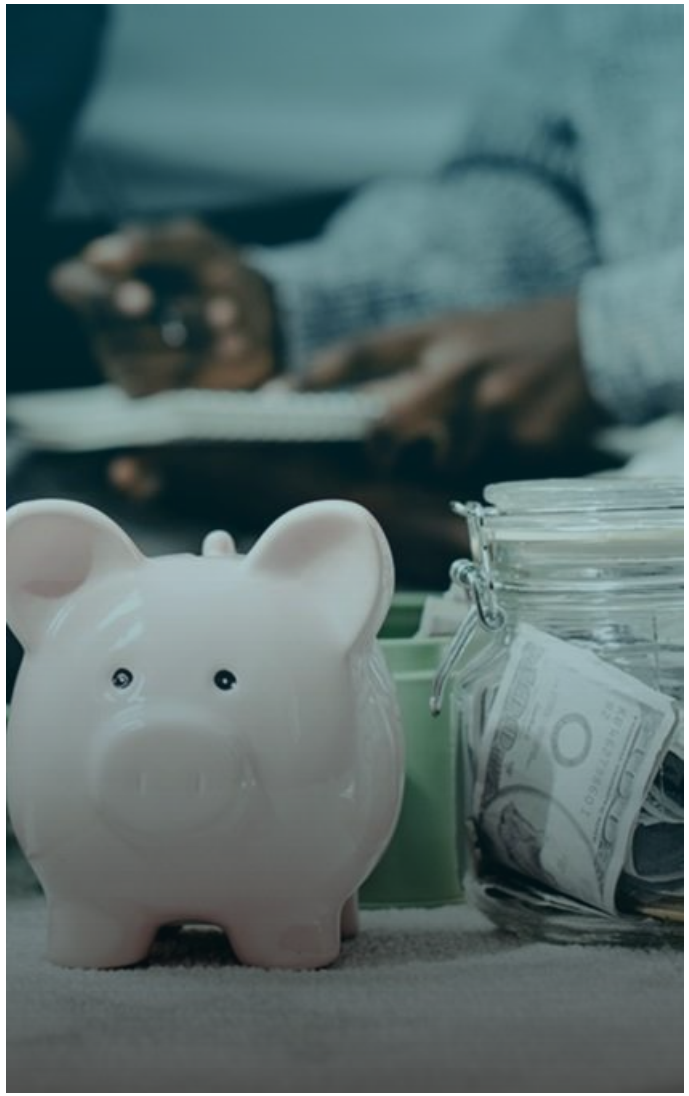
This powerful legislative tool typically plays a key role in advancing priorities on party-line votes when both chambers are controlled by the same party.

There are strict rules related to what can be included in a reconciliation package. It can be used to amend mandatory or entitlement spending, such as Medicare and Medicaid, tax laws and the federal debt limit. **Policies must have a budget impact.**

The process is already underway for 2025 with the House and Senate budget committees discussing options.

Key priorities include:

- Extending or making permanent the Tax Cuts and Jobs Act
- Border Security
- Energy
- Defense
- Medicaid
- ACA Tax Credits



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LEVEL SET

New spending and tax cuts can be “offset” with spending cuts.

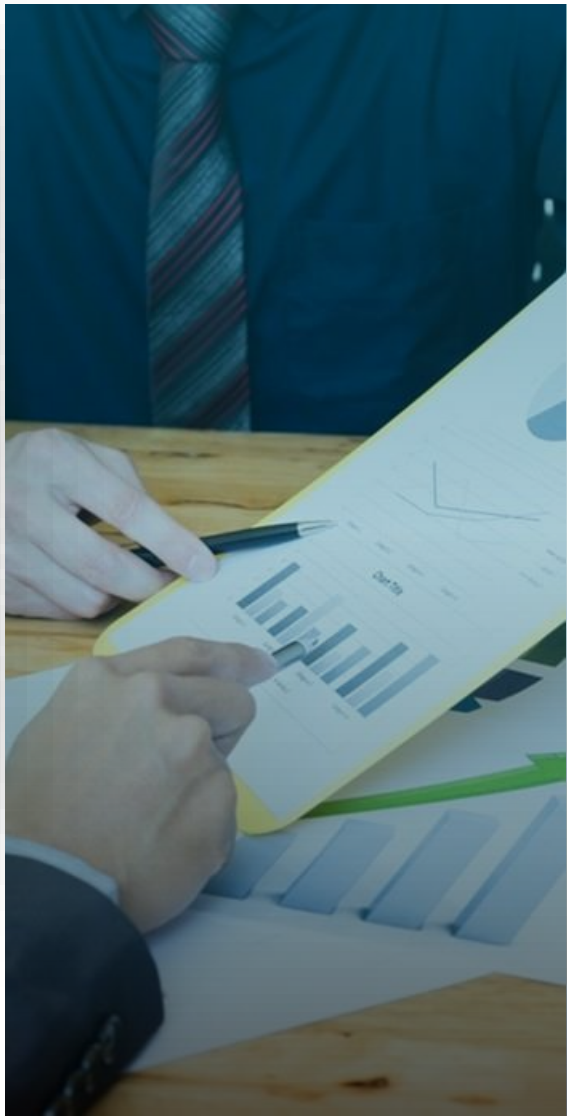
This is a very simplified discussion of these policies.

Republicans have taken Medicare and Social Security are off the table, leaving Medicaid as potential offset.

We will draw on previously released legislation, Project 2025 or other proposals to inform details, as 2025 decisions have not yet been made.

We will discuss the major options related to Medicaid.

Loper Bright decision means Congress will provide significant details on how Medicaid proposals will be implemented.



Leadership

- House Energy & Commerce & Senate Finance Committee will draft the policy
- Drew Snyder of Mississippi named to lead Center for Medicaid and CHIP Services at HHS

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MAJOR OPTIONS FOR MEDICAID IN BUDGET RECONCILIATION

Per Capita Caps

Limit Provider Taxes

Work Requirements

Eliminate Enhanced Match for Expansion Population

Lower Minimum Federal Medical Assistance Percentage (FMAP) or Blended Rate

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PER CAPITA CAPS (CBO Savings: $459-$893 Billion)

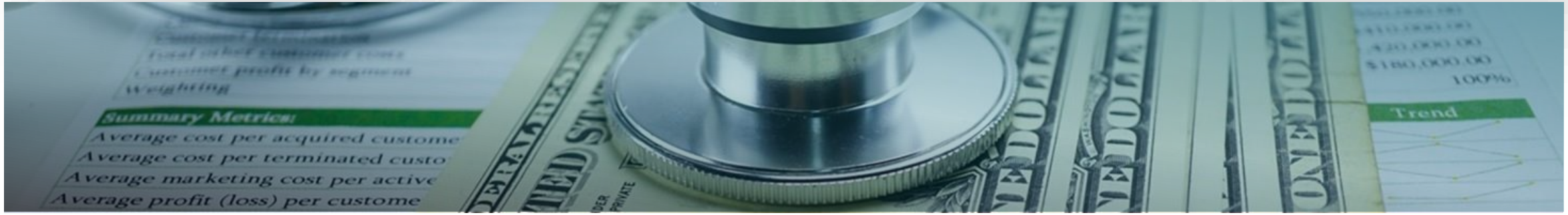
Today, Medicaid costs are shared with the federal government at varying match rates.

The Federal Medical Assistance Payment (FMAP) is determined **based on the state's per capita income relative to the national average.**

States with lower per capita incomes receive a higher FMAP, while higher income states receive a lower percentage. The minimum FMAP is 50% and the highest is 83%

CHIP FMAP averages 15% more than Medicaid

States draw down federal matching funds **based on actual costs incurred.** They submit a form on a quarterly basis demonstrating Medicaid expenditures.



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PER CAPITA CAPS

Per capita caps would shift federal Medicaid financing from open-ended based on expenses to a system of caps on per-enrollee spending for each Medicaid eligibility group, or one cap for Medicaid beneficiaries overall (less likely).

The federal government would choose a **"base year"** and use administrative data from previous years spending to set a level of funding based on actual program spending.

Congress would set an annual growth factor to allow for growth over time.

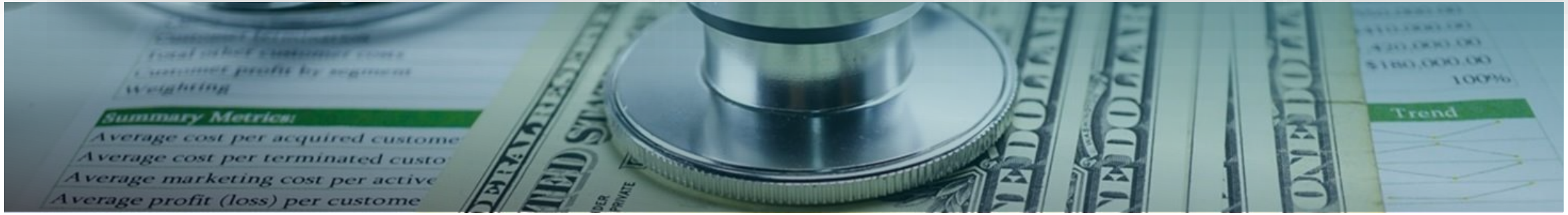
CPI-U, Medical Care Index, MEI

Per capita caps are an evolution of block grants because they take into account growth in Medicaid enrollment during economic downturns.

Lots of complex factors involved in setting base year and growth factors.

For example

What to do about high spending vs low spending states, or spending fluxuations year.



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PER CAPITA CAPS

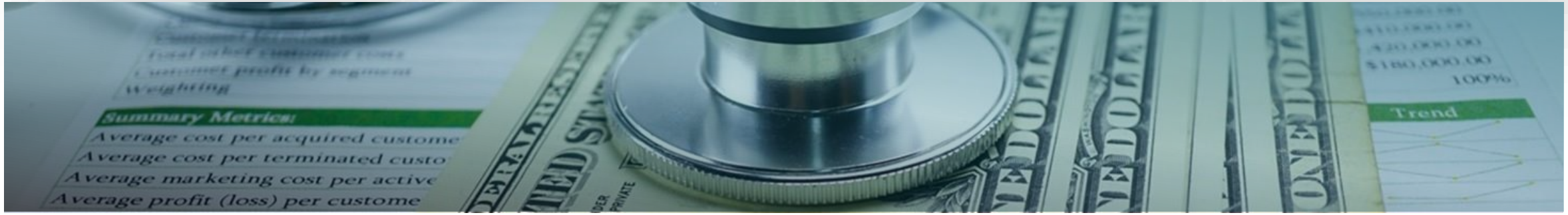
Decisions would have to be made on how to apply the caps – one across all categories or different caps for different eligibility categories.

Spending on children is an average of $3,000 per year while elderly and disabled beneficiaries are closer to $18-19,000 per year.

In the Better Care Reconciliation Act of 2017, Congress assigned five separate caps.

- Enrollees with disabilities
- Adults aged 65 or older
- Children
- Adults eligible through the ACA Medicaid expansion
- Other adults not eligible through the ACA expansion

Under BCRA, the growth factor was set at Consumer Price Index for medical care (CPI-M) for adults and children, and by the CPI-M plus one percentage point for elderly and disabled groups.



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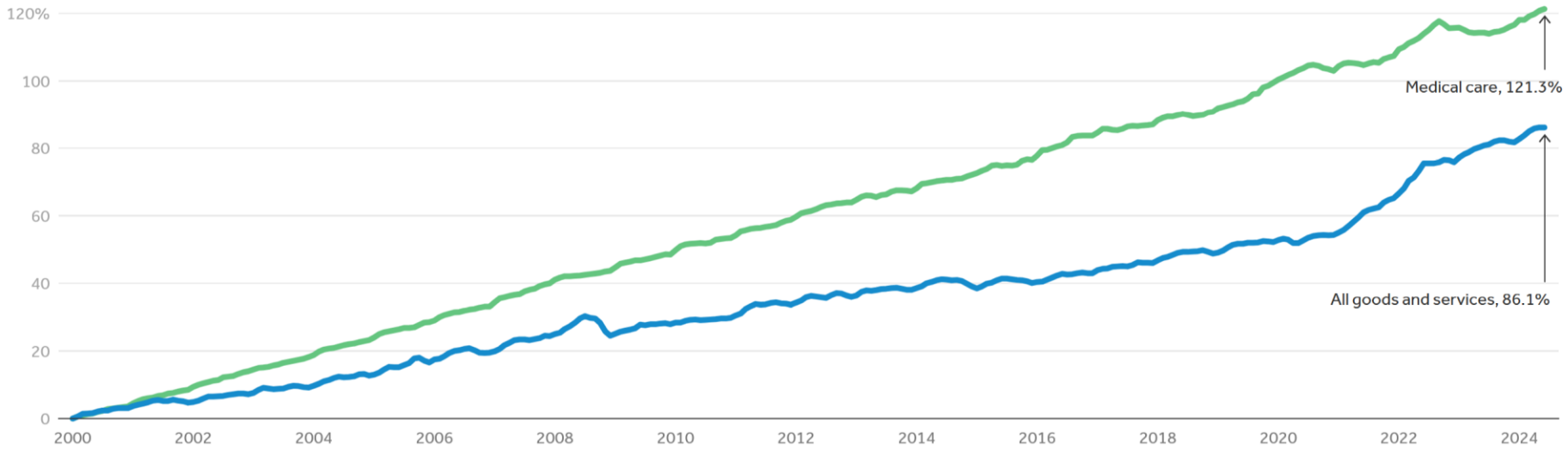
PER CAPITA CAPS

Medical care prices have generally grown faster than overall consumer prices

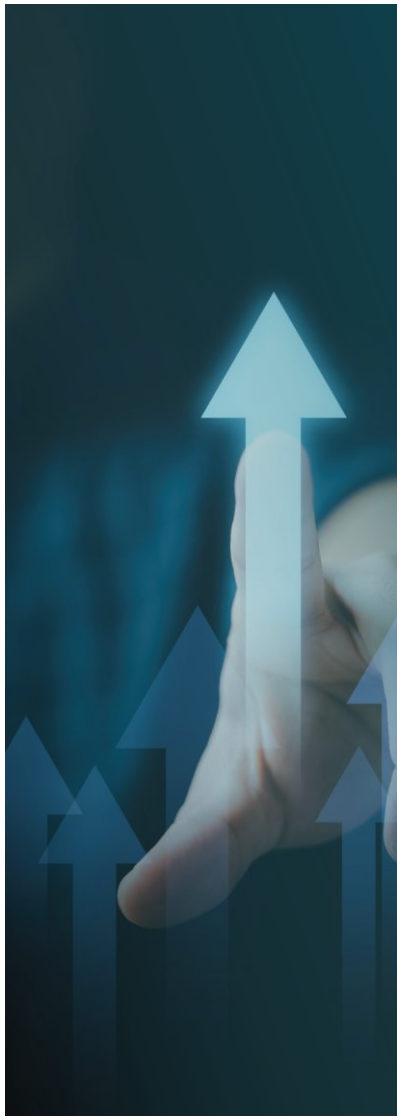
Cumulative percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care and for all goods and services, January 2000 - June 2024



Note: Data are not seasonally adjusted. Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data • Get the data • PNG

Peterson-KFF Health System Tracker



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LIMIT PROVIDER TAXES (CBO Savings: $48-$612 Billion)

About 68% of the state share of Medicaid costs was financed in 20924 by state general funds (personal income, sales, and corporate income taxes). The remaining 32% was financed by other funds including provider taxes, fees, donations, assessments, and tobacco settlement funds)

Provider taxes help states offset the cost of Medicaid without increasing general taxes or cutting services. Also keep pace with provider rates.

Hospitals and nursing homes are the most commonly taxed providers, but some states also tax managed care entities.

The process starts when a state legislature passes a bill to levy a tax on providers or MCOs.

The state requests that CMS approve a State Plan Amendment allowing the use of the provider tax to pay providers increased rates.

CMS ensures the taxes are broad-based, uniform, and do not directly or indirectly guarantee that a provider will be repaid for all or a portion of the tax.

The total amount of tax collected from healthcare providers cannot be greater than 6% of the revenue those providers earn from patient services.

Upon approval by CMS, tax revenue from the provider taxes is used for the state share of the increased Medicaid payments to providers.

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LIMIT PROVIDER TAXES

Federal officials, particularly Republicans, have long been skeptical of provider taxes.

Dozens of reports have been written by GAO, MACPAC and other agencies examining provider taxes.

They have been called “schemes,” “opaque,” and states “gaming” Medicaid financing.

An option for reducing the use of provider taxes is reducing the federally allowed threshold for how much tax revenue states can collect from healthcare providers as a percentage of their net patient revenue.

According to the Congressional Budget Office

- Lowering the safe harbor from 6.0% to 5.0% would save $48 billion from FY2025 to FY2034
- Lowering the safe harbor from 6.0% to 2.5% (savings of $241 billion from FY2025 to FY2034)
- Eliminating states’ ability to use Medicaid provider tax revenue to finance Medicaid (savings of $612 billion from FY2025 to FY2034).

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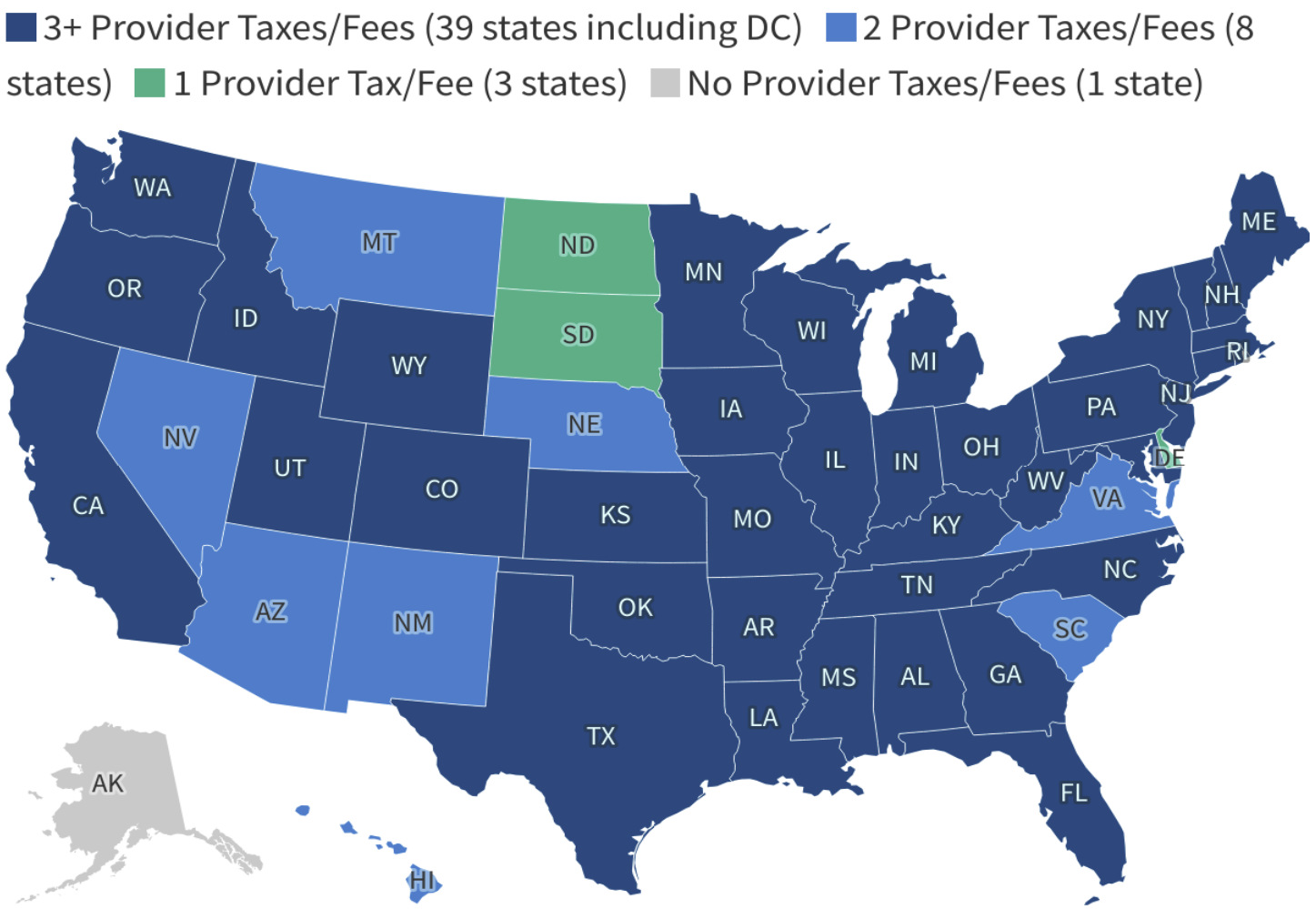
PROVIDER TAXES



The most common uses of provider taxes are supporting Medicaid payment rates, funding supplemental payments, averting Medicaid benefit cuts, and expanding Medicaid benefits (GAO 2014, GAO 2020

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024

KFF

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IMPOSE WORK REQUIREMENTS (Savings: $109 billion)

Work requirements would condition eligibility for Medicaid coverage for certain nondisabled adults on work, volunteer, school, or other qualifying activities.

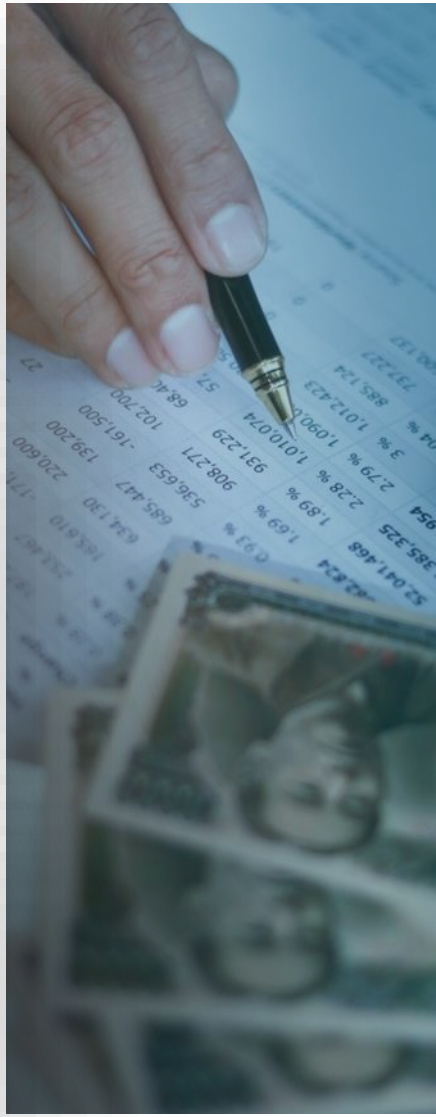
The work requirements varied significantly among states, but most common were 80 hours/month.

During the first Trump Administration, Republicans were limited to using 1115 waivers to achieve work requirements. **13 states** had approved work requirements, and nine additional states applied.

The Biden Administration rolled back work requirements in Medicaid.

Of the 13 states with approved requirements, only Arkansas implemented such requirements.

There were significant, ongoing court cases related to work requirements.



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IMPOSE WORK REQUIREMENTS

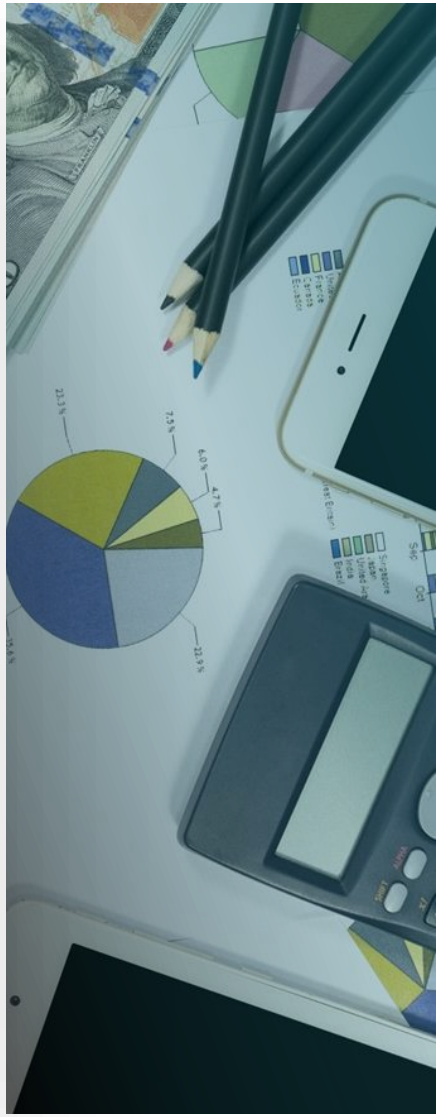
In December 2024, the Biden Administration issued an **Advisory Opinion** on Medicaid work requirements stating the Secretary of HHS lacks the authority to approve Medicaid 1115 waivers that impose requirements.

The opinion was intended to bolster an Administrative Procedure Act challenge to any future Medicaid work requirement policy by forcing the incoming Trump Administration

If Congress changed the statute, it would be a material difference from previous 1115 waivers.

The Better Care Reconciliation Act included a state option to impose work requirements.

- Defined work opportunities broadly
- Increased the federal match by 5% to implement work requirements
- Exempted pregnant women, people under 19 years of age, sole caretaker relatives, students under the age of 20 who are in school.



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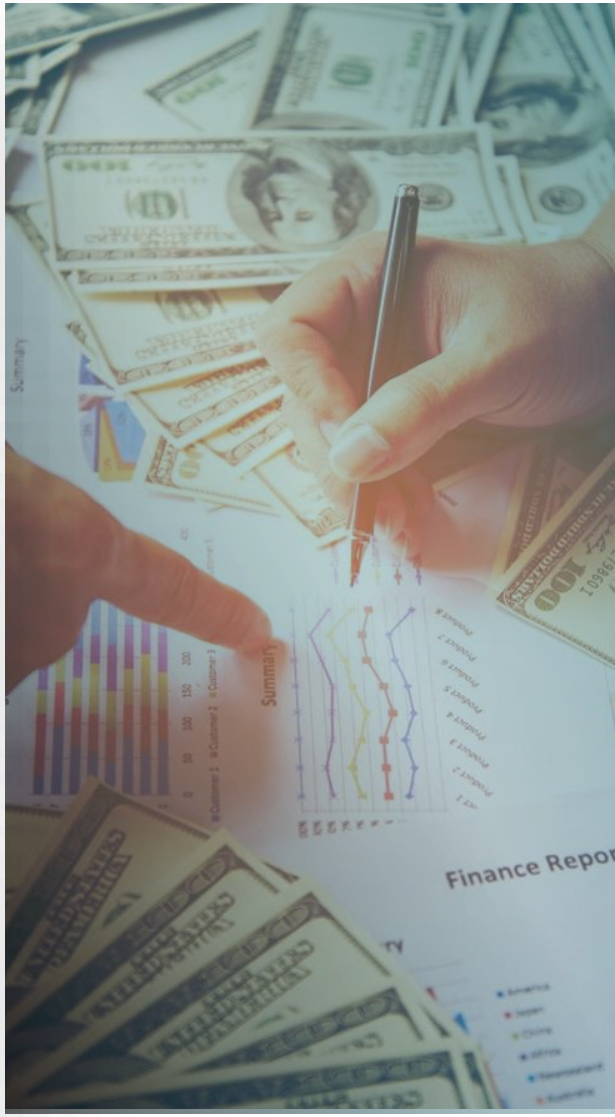
ELIMINATE ENHANCED MATCH FOR EXPANSION POPULATION (CBO Savings: $69-$561 billion)

As of January 2025, 40 states plus Washington, D.C. have adopted Medicaid expansion under the Affordable Care Act (ACA). The most recent additions are South Dakota and North Carolina, both implementing expansion in 2023.

The expansion population constitutes about **23%** of all Medicaid enrollees, about 21 million people.

The FMAP for the expansion population is set at an enhanced rate of **90%,** which was designed in the Affordable Care Act to encourage expansion.

Under BCRA, enhanced federal match phased-out over four years. 90% to 85% to 80% to 75% and then to the regular state match.



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ELIMINATE ENHANCED MATCH FOR EXPANSION POPULATION

Nine states have "trigger laws" related to Medicaid expansion, with an additional three states that reduction would

These laws stipulate that if the federal government's enhanced matching rate for the expansion population decreases below the current level of 90%, Medicaid expansion in these states would end.

The states with such provisions are: AZ, AR, IL, IN, MT, NH, NC, UT, VA.

Additionally, three other states have have laws that require their governments to mitigate the financial impact of losing federal Medicaid expansion. These are IA, ID, NM.

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LOWER FEDERAL MEDICAL ASSISTANCE PERCENTAGE CBO Savings: (CBO Savings $387 billion)

Currently, the FMAP formula considers a state's per capita income relative to the national average, with a statutory minimum rate set at 50%.

The House Budget Committee's proposal suggests reducing this minimum FMAP rate to an unspecified rate.

Such a reduction would primarily impact states that currently receive the 50% minimum rate, including CA, CO, CT, MD, MA, NH, NJ, NY, WA, and WY.

Project 2025 contemplates a blended rate for FMAP, and the House Republican Study Group proposes a uniform FMAP of 50% for all states.

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