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Medicaid Restructuring Options

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Background

On February 13, 2025, the House Budget Committee approved a budget seeking at least $880 billion in mandatory spending cuts on programs overseen by the House Energy and Commerce Committee. The Medicaid program is a likely target to provide a significant amount of those savings.

This *+Insight* provides an overview of Medicaid restructuring options, what those policies could entail, and their potential impact on state budgets and continued health coverage for millions of Americans enrolled in Medicaid today.

Medicaid Overview

From Medicaid 101 – Medicaid and CHIP Payment and Access Commission (MACPAC):

"Medicaid is a joint federal-state program that provided healthcare coverage to an estimated 93.8 million people in fiscal year (FY) 2022. As a major payer in the US healthcare system, it accounted for about 17.8 percent of national healthcare spending in calendar year 2021.

Medicaid's role among payers is unique. It provides coverage for health and other related services for the nation's most economically disadvantaged populations, including low-income children and their families, low-income seniors, and low-income people with disabilities. These populations are distinguished by the breadth and intensity of their health needs; the impact of poverty, unemployment, and other socioeconomic factors on their ability to obtain healthcare services; and the degree to which they require assistance in paying for care. Medicaid provides benefits not typically covered (or covered to a lesser extent) by other insurers, including long-term services and supports. It also pays for Medicare premiums and cost sharing for more than 13 million people who are enrolled in both programs. It is also a major source of financing for care delivered by certain providers, particularly safety net institutions that serve both low-income and uninsured individuals.

The Medicaid program was enacted as part of the Social Security Amendments of 1965 (P.L. 89-97), the same legislation that created Medicare. Like Medicare, Medicaid is an entitlement program. Eligible individuals have rights to payment for medically necessary healthcare services defined in statute; the federal government is obligated to fund a share of the outlays for those services.

Variability in Medicaid is the rule rather than the exception. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines, effectively creating 56 different Medicaid programs—one for each state, territory, and the District of Columbia. States also differ in Medicaid financing."

As long as a state operates its program within federal requirements, it can receive federal matching funds toward allowable state expenditures. These include payments to healthcare providers and managed care plans as well as expenditures associated with administrative tasks such as making eligibility determinations, enrolling and monitoring providers, overseeing managed care organizations and other contractors, and paying claims.

Medicaid has historically relied on federal funding that rises in tandem with enrollment and states' healthcare needs – as well as on contributions from states. Because federal contributions match state spending on an open-ended basis, as state spending increases, so does federal spending; conversely, as state spending decreases, so does federal spending.

There are mandatory and optional services within Medicaid. States must cover the mandatory services; however, many optional services are covered by the majority of states. For example, prescription drugs are an optional service that all states cover. The specifics of what is covered – the amount, duration, and scope – varies by state. For example, one state may elect to cap the number of inpatient hospital days an enrollee might receive each year, while another state may allow an unlimited number of inpatient hospital days. States can also seek approval from the federal government for waivers that allow other changes to their Medicaid programs, such as implementing work requirements, changes to income eligibility thresholds, asset limits, required premiums and disenrollment or lock-out periods for nonpayment, health savings accounts, and healthy behavior incentives.

Medicaid as a Source of Federal Savings

The new Congress and administration are focused on extending the Trump tax cuts that expire at the end of 2025 and reducing federal spending. President Trump has said that Social Security and Medicare will not be considered for funding cuts. For Social Security, that seems to be a bright line of no changes. For Medicare, there are payment policy changes that may well occur, but direct benefit impacts appear unlikely. That leaves Medicaid as a prime target to obtain federal savings. The three largest mandatory spending programs for the federal government are Social Security, Medicare, and Medicaid. Despite Medicaid being most states' second largest expense (after education), about 70% of Medicaid spending is made by the federal government.

The effects of each policy option being considered to reduce spending in the Medicaid program will depend significantly on how it is drafted, which populations are involved, and how much flexibility the states have in implementation. The majority of the options would decrease state Medicaid budgets and could cause states to lower reimbursement rates, reduce optional services, restrict eligibility, or decrease funding for other programs to pay for Medicaid.

Administrative Action

There are several ways that Medicaid can be changed via administrative action without congressional participation (such as regulations, subregulatory guidance, and waivers). The examples below describe possible administrative actions.

Repealing Biden-Era Medicaid Regulations

There are a number of Biden-era Medicaid regulations that could be revoked, repealed partially, or just not implemented. The Trump administration could take some of these steps on their own, but Congress could also choose to legislate them.

The Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule is one such rule that is likely to be repealed. In April 2024, the Centers for Medicare & Medicaid Services (CMS) finalized this rule to require long-term care facilities to satisfy minimum nurse staffing standards with the goal of addressing patient quality of care and safety concerns. The rule is controversial within the industry due to the costs to providers of implementing the requirements, workforce challenges, and potential reduced access to these facilities because of noncompliance-related closures. After CMS finalized the rule (still during the 118th Congress), Reps. Fischbach (R-MN) and Pence (R-IN) introduced a Congressional Review Act Resolution as well as H.R. 7513, the Protecting America's Seniors' Access to Care Act, which would repeal the final rule. In the current Congress, the 119th, Rep. Fischbach and 18 Republican cosponsors introduced H.R. 1303 to prevent the Department of Health and Human services (HHS) from implementing the rule.

The Congressional Budget Office (CBO) scored the repeal of this final rule as saving $22 billion over 10 years. These are significant savings projections that could be used by Congress to fund other priorities. As a result, it is likely that Congress will choose to repeal this rule via legislative action, rather than have the Trump administration act through its own authority.

Additionally, the Medicaid Program; Ensuring Access to Medicaid Services final rule (commonly referred to as the Access Rule) could be revisited. The rule has a particular focus on home- and community-based services (HCBS), including direct- Without the federal floor, several states would have FMAPs of less than 50%care worker compensation requirements, HCBS waitlists, grievance process development, critical incident reporting definitions, and HCBS quality reporting. The final rule also seeks to increase transparency in payment rates. Efforts have been made to repeal a key provision of the rule that requires that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for direct-care workers (as opposed to administrative overhead). In the 118th Congress, Rep. Cammack (R-FL) introduced H.R. 8114 to prevent CMS from implementing the 80/20 provision. Currently, there is no public score for this bill, but if CBO scores it as providing savings, Congress could choose to legislate repeal of that provision to save money to fund other legislative priorities. It is also possible that the Trump administration could choose to revoke, change, or decide not to implement or enforce this provision of the rule. There are components of this rule that are broadly supported by stakeholders, so it is unclear if Congress or the administration would seek full repeal, but that is certainly an option.

Released at the same time as the Access Rule, the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality final rule (Managed Care Rule) contains many policies that could remain in place. The Managed Care Rule includes updates to the transparency of funding in state-directed payments (SDPs) and creates limitations on funding through SDPs. SDPs allow states to direct how Medicaid managed care organizations (MCOs) pay providers in certain circumstances. While the policies around transparency could remain, it is possible that the Trump administration could change or decline to enforce the funding limitations. The requirement prohibits SDP amounts for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center from exceeding the average commercial rate (ACR). This payment ceiling does not apply to any other services. CMS began approving SDPs in 2017, during the first Trump administration, so they may want to maintain most of the state flexibility that was initially available. Additionally, Dr. Mehmet Oz, President Trump's nominee for CMS administrator, has been a proponent of increasing the use of managed care to provide federal health insurance coverage. Thus, it is possible that he will not want to federally restrict the negotiation process between states and MCOs.

There are two regulations relating to Medicaid eligibility and enrollment that also are likely to receive scrutiny: the Medicare Savings Program Eligibility Determination and Enrollment final rule and the Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule. Both of these rules make changes to the eligibility and enrollment process under Medicaid and are expected to increase overall Medicaid enrollment. Thus, if they were to be repealed, they would reduce enrollment. That means that repeal of either or both rules would create significant cost savings that could be attractive to Congress, which makes them both prime targets for repeal.

Finally, CMS issued a proposed rule on November 26, 2024, which includes a provision to grant Medicare and Medicaid coverage of anti-obesity medications (AOMs) for treatment of obesity when such drugs are indicated to reduce excess body weight and maintain weight reduction long-term for individuals with obesity. Citing "prevailing medical consensus towards recognizing obesity as a disease," CMS proposed a significant shift and reinterpretation of the statute to allow for coverage of these medications.

For Medicaid, the proposed reinterpretation would mean that AOMs must be included in Medicaid drug coverage when used for weight loss or chronic weight management for the treatment of obesity. States would maintain the discretion to use preferred drug lists and prior authorization to establish certain limitations on the coverage of these drugs. CMS estimated that the proposal would increase Medicare spending by $25 billion over 10 years and Medicaid spending by $14.8 billion over 10 years ($3.8 billion of which would be from the states). It is up to the Trump administration to assess the comments submitted and decide whether to finalize the provisions in the rule. Directly after Robert F. Kennedy, Jr., was sworn in,

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