Analyzing the Impact of Potential Medicaid Cuts: A Toolkit for States

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I. Introduction

Congress is considering significant cuts to Medicaid as part of the legislative process—called "budget reconciliation"—being used to advance President Trump's key legislative priorities.[1] Manatt Health (Manatt) has developed a 50-State Medicaid Financing Model that estimates the impact of different federal Medicaid policy proposals on Medicaid spending and, where applicable, enrollment. ***Based on the Manatt 50-State Medicaid Financing Model, this toolkit—including this written brief and companion Excel workbook—provides national and state-by-state data on the potential impact of key cuts under consideration in Congress.*** It is designed to assist state officials in preparing or reviewing their own estimates, as well as to offer estimates to states that are not undertaking their own analyses. Manatt intends to update these estimates as the budget reconciliation process continues, and as more specific details become available on the Medicaid cuts under consideration. Manatt will also update this toolkit in the coming weeks to estimate the impact of the proposal to make work reporting requirements a new condition of Medicaid eligibility.

II. Medicaid Program Funding: Current State

The Medicaid program provides coverage for almost 80 million people nationwide, including nearly 20% of adults and 40% of all children in the United States. The program pays for more than 60% of long-term care provided to older adults and individuals with disabilities, 42% of births, and 25% of mental health and substance use disorder treatment. Today, states and the federal government jointly finance Medicaid program costs, with nearly 68% of total Medicaid expenditures nationwide coming from federal funding. Medicaid is the largest single source of federal funds to states and serves as a key driver of state economies.

For most enrollees—including children, older adults, individuals with disabilities, and other adults not covered through Medicaid expansion—the federal government's share of Medicaid costs is determined by the "standard" medical Federal Medical Assistance Percentage (FMAP). The standard medical FMAP, which varies by state, is based on a statutory formula that calculates each state's FMAP based on its per-capita income relative to the national average. In addition, the statutory formula sets a minimum FMAP of 50% and a maximum of 83%.[2] For enrollees covered through Medicaid expansion, states currently receive a 90% FMAP, meaning the federal government covers 90 cents of every dollar spent on expansion enrollees.[3] Finally, the federal government guarantees it will share with states the cost of all Medicaid expenditures, ensuring that the program is jointly financed without arbitrary limits or caps. The federal government's commitment to match all of a state's Medicaid expenditures makes it possible for states, in turn, to guarantee Medicaid coverage for all eligible individuals.[4]

III. Modeling Approach

This toolkit assesses the impacts of several policy proposals under consideration in Congress for reducing federal Medicaid expenditures. Congress has not yet introduced legislation proposing specific Medicaid policy changes. As a result, the proposals under discussion are likely to evolve as Congressional negotiations continue. As part of

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[1] Budget reconciliation is a legislative process that allows Congress to expedite budget-related legislation with a simple Senate majority, bypassing the 60-vote filibuster threshold. The process begins with a budget resolution containing reconciliation instructions, followed by committees drafting legislation to meet fiscal targets, which are combined into a reconciliation bill. As of April 10, the House and Senate now have a joint budget resolution that includes instructions to cut up to $880 billion in federal Medicaid funding over 10 years.

[2] The 50% FMAP floor is established in section 1905(b) of the Social Security Act, which states that the FMAP shall in no case be less than 50 per centum or more than 83 per centum.

[3] The Affordable Care Act (ACA) expanded Medicaid to adults with incomes up to 138% of the federal poverty level (FPL).

[4] The Families First Coronavirus Response Act (FFCRA) included a requirement that states maintain continuous coverage for individuals enrolled in Medicaid after the start of the pandemic. FFCRA also temporarily increased the federal Medicaid matching rate for non-expansion enrollees.

this "pre-legislation" toolkit, the specific proposals for which we provide estimates and modeling assumptions are as follows:

1. **Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population.**
2. **Remove the 50% FMAP Floor for the Standard Medical FMAP or Reduce the 50% FMAP Floor to 40% *(Applicable to Select States Only)*.**
3. **Impose Per-Capita Caps for Medicaid Expansion Enrollees Only or for All Medicaid Enrollees.**

Since it is not clear how states would respond to cuts in federal Medicaid funding, this toolkit offers an explanation of each proposed policy change and, where possible, a range of scenarios for states to consider—making it possible for state officials to select estimates closest to how they think their state will respond. We also provide findings at the national level and takeaways from the state-by-state analysis to help inform state decision-making and contextualize individual state results. (See the accompanying Excel workbook for estimated impacts by state). To support states in evaluating and integrating these estimates into their own modeling efforts, we outline in more detail below the methodology and key assumptions that informed this analysis.

Methodological Summary

States may reference the methodology and assumptions outlined below as a starting point for reviewing the estimates included in this toolkit or developing their own. For states not conducting their own modeling, the methodology and assumptions presented here can serve as a useful reference to better understand and interpret the estimates provided in Section IV.

- ***Data Sources.*** Manatt's modeling uses data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files, the Medicaid Budget and Expenditure System (MBES), tabulations from the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC), and the Centers for Medicare & Medicaid Services (CMS) Medicaid Financial Management Reports (FMR). Manatt leverages Medicaid per-capita enrollment and expenditure trend rates from the Congressional Budget Office's (CBO's) June 2024 Medicaid Baseline, along with aggregate Medicaid spending and enrollment projections from its January 2025 Budget and Economic Outlook, which projects higher Medicaid spending than prior estimates due to greater than expected enrollment, higher per-capita costs, and increased use of state directed payments (SDPs).
- ***Enrollment and Expenditure Baseline.*** To assess the impact of proposals to reduce federal Medicaid spending, we develop a Medicaid enrollment and expenditure baseline, apply relevant policy parameters for each proposal, and estimate changes in Medicaid expenditures (including total, federal, and non-federal expenditures[5]) and enrollment (where applicable) resulting from each proposal. To support our analysis of federal proposals, we first develop baseline Medicaid enrollment and expenditure estimates by state and eligibility group through federal fiscal year (FFY) 2034 using the following approach:
    - Calculate Medicaid enrollment baseline for all 50 states and the District of Columbia (D.C.) across six eligibility groups: children, expansion adults, other adults, individuals with disabilities, older adults, and individuals receiving limited Medicaid benefits.[6] We start with FFY 2023 average monthly enrollment data by eligibility group and state from the T-MSIS Analytic Files. We then adjust eligibility group-specific enrollment by state to align with aggregate enrollment reported by states through the MBES for FFYs 2023 and 2024. For FFY 2025, we uniformly adjust enrollment

[5] In this brief, we use "state" and "non-federal" share interchangeably. This includes all allowable non-federal funding sources—including state general funds, local funds, provider taxes, intergovernmental transfers, and certified public expenditures.

[6] The eligibility group categories are based on MACPAC's approach; the CBO uses a similar categorization of eligibility groups. To the extent possible, states developing their own modeling may want to match these categories, even if state-specific eligibility groups are typically categorized differently.

by state and eligibility group to align with projections from the CBO's January 2025 Budget and Economic Outlook. For FFYs 2026 to 2034, we apply national, eligibility group-specific enrollment trend rates from the CBO's June 2024 Medicaid Baseline.[7] To the extent available, states developing their own estimates may want to consider leveraging state-specific enrollment projections by eligibility group.

  - Calculate Medicaid expenditure baseline by eligibility group and state. We begin by adjusting estimates of per-capita expenditures by state and eligibility group from the MACPAC analysis of FFY 2022 T-MSIS data to align with aggregate FFY 2023 expenditures reported by states through CMS Medicaid FMR.[8] For FFY 2024, we adjust aggregate state expenditures to account for new or expanded SDPs approved by CMS and to align with national Medicaid expenditure projections from the CBO. For FFYs 2025 to 2034, we trend forward per-capita expenditures using eligibility group-specific growth factors from the June 2024 CBO Medicaid Baseline. We then apply a uniform adjustment to align per-capita estimates with aggregate expenditure projections from the CBO's January 2025 Budget and Economic Outlook.[9] To the extent available, states developing their own estimates may want to consider leveraging state-specific expenditure projections by eligibility group. Our estimates include all Medicaid benefit expenditures except for Disproportionate Share Hospital payments. We calculate federal and non-federal expenditures by state and eligibility group by applying each state's standard medical FMAP or the enhanced 90% match for Medicaid expansion enrollees, as applicable, to total expenditures by eligibility group.[10]

- ***Comparison to the CBO's Estimates.*** Where possible, Manatt aligns with policy parameters and effective dates outlined by the CBO in its Options for Reducing the Deficit: 2025 to 2034 report. As such, we assume that FMAP reduction proposals (Proposal 1 and Proposal 2 below) would take effect in FFY 2026, and that imposition of a per-capita cap (Proposal 3) would begin in FFY 2028. There are certain areas where Manatt's assumptions differ from the CBO's. For example, the CBO estimates the impact of each proposal on all federal spending, including Medicaid, Marketplace, and employer-sponsored coverage, while Manatt's estimates are limited to Medicaid. In addition, the CBO produces national estimates and makes assumptions regarding how states in the aggregate will respond to federal cuts. Manatt's model is both a national and state-level model, and it produces a range of options for how states could respond to federal cuts.
- ***Modeling the Impact of Proposals.*** Using the enrollment and expenditure baseline described above, we calculate the impact of the Congressional proposals assuming several different potential state responses. Estimates do not account for interactive effects, meaning this toolkit considers each proposal's impact on expenditures and (where possible) enrollment independently. Should Congress introduce legislation that includes multiple Medicaid financing proposals, there would be interactions that could impact total funding reductions. For example, reducing the enhanced expansion FMAP to the standard medical FMAP

[7] We used trend rates from the CBO's June 2024 Medicaid Baseline to project forward enrollment in FFYs 2026 and beyond because the CBO's January 2025 Budget and Economic Outlook only provides enrollment projections for FFY 2025.

[8] Per-capita expenditures were calculated using average monthly enrollment.

[9] The Manatt 50-State Medicaid Financing Model uses state-specific data where possible. The Model also uses a combination of the CBO's eligibility group-specific enrollment and per-capita trend from its June 2024 Medicaid Baseline and its more recent January 2025 aggregate Medicaid enrollment and expenditure baseline to reflect the most updated national Medicaid forecast (the January baseline does not include eligibility group enrollment or per-capita trends). Based on a review of estimates developed independently in a number of states, using these assumptions from the CBO may result in somewhat higher estimates of expenditures on expansion adults than anticipated. Manatt will continue to evaluate its enrollment and expenditure estimates and may make adjustments at a later time should the CBO release a new Medicaid baseline.

[10] Currently, nine states that provided expanded coverage to parents and childless adults prior to the enactment of the ACA receive enhanced federal matching funds for the "not newly eligible" expansion adult group. All other states receive the regular match rate for not newly eligible expansion adults. We derive the proportions of newly and not newly eligible expansion enrollees by state from MBES enrollment reports.

and removing the 50% FMAP floor would require impacted states to contribute even more state funding to maintain their expansions, because their standard medical FMAP would be set at a lower rate. Unless otherwise noted, all expenditure estimates represent total Medicaid funds (i.e., federal and non-federal funds). This toolkit contains expenditure and enrollment estimates (where applicable) for each of the proposals under consideration during the 10-year, FFY 2025 to 2034 budget window. One-year estimates can be found in Tables 2, 5, 7, 9, and 11 of the Excel workbook.

IV. Model Results by Proposal

1. Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population.

Proposal Overview and State Response Scenarios

Congress is considering a proposal to reduce the enhanced federal match for Medicaid expansion enrollees from 90% to each state's standard medical FMAP. To date, 40 states and D.C. have expanded Medicaid, providing health coverage to more than 20 million adults.[11] Of those, 12 states have laws in place that would end Medicaid expansion or require state legislative action to continue expansion coverage if federal funding is reduced. We offer estimates of the impact of this proposal based on two potential state responses:

- ***Option A: States End Expansion.*** We estimate that the impacted states[12] respond to the loss of the 90% matching rate by eliminating Medicaid expansion. Under this scenario, expansion enrollment would be reduced to zero.[13] While some states may want to retain a partial expansion, the Medicaid statute generally precludes states from "scaling back" expansion to a lower income threshold, making retaining the expansion group closer to an "all or nothing" decision for each state.[14] When assessing the expected impact of eliminating expansion, we take into account two additional coverage shifts: (1) when parents lose coverage—as would occur under elimination of the expansion adult group—some children will also lose coverage;[15] and (2) a portion of individuals currently enrolled in Medicaid via the expansion pathway will

[11] 10 states have not expanded Medicaid: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.

[12] Here and in other Proposal 1 references, "states" includes D.C.

[13] Manatt generally assumes that all individuals enrolled through Medicaid expansion—including those categorized as newly eligible and not newly eligible—would lose coverage if states ended their expansions. Most individuals categorized as not newly eligible are in states that—per section 1905(z)(3) of the Social Security Act—can claim the enhanced 90% FMAP for not newly eligible childless adults because they offered health benefit coverage to both parents and nonpregnant, childless adults with an income of at least 100% of the FPL prior to enactment of the ACA (March 23, 2010). For other states, with the exception of Maine, that report not newly eligible expansion enrollment and claim the standard medical FMAP, we assume these individuals would also be disenrolled. However, because these enrollees currently receive the standard medical FMAP, states could transition their coverage to an alternative eligibility pathway at no additional cost, and, as a result, may choose to maintain their enrollment.

[14] States may explore other authorities, including section 1115 waiver authority—typically matched at the standard medical FMAP—to preserve coverage for certain expansion enrollees.

[15] A robust body of research demonstrates that changes in parental coverage rates reliably impact children's rates of coverage (see here and here). To estimate the effect across various proposals, Manatt developed a ratio to describe the relationship between adult enrollment gains/losses and child enrollment gains/losses based on the impact of Medicaid expansion on enrollment of children who already were eligible for Medicaid in the early years of implementation of the ACA. Specifically, we identify the number of children previously eligible for Medicaid that gained coverage in FY 2015 (the first full year of expansion) compared to the pre-expansion child enrollment baseline. We then divide by the number of expansion adults enrolled in Medicaid in FY 2015, to develop a ratio of expansion adult to child coverage gains, indicating that five children gained coverage for every 100 adults. Under a scenario where states drop their expansions, we assume the effect would occur in reverse, with five children losing coverage for every 100 expansion adults disenrolled.

enroll in Medicaid on the basis of disability.[16] As such, when states assess these estimates, they will want to consider whether they anticipate that eliminating expansion would have a smaller and/or greater impact on enrollment of children and people with disabilities.

- ***Option B: States Continue Expansion.*** Here, we assume that the impacted states elect to maintain coverage for expansion adults. This requires them to use state funds to replace lost federal funds associated with reducing the FMAP from 90% to a state's standard medical FMAP. To calculate expenditure impacts, we first estimate reduced federal expenditures as a result of the lower expansion match rate. We then identify the state dollars that would be needed to replace those lost federal funds and maintain baseline total expenditure levels.

National and State Impacts

Option A: States End Expansion. If all states with Medicaid expansion end expansion as a result of a reduction in the 90% matching rate, close to one third of current Medicaid enrollees (32%) would lose coverage. The total reduction in Medicaid expenditures would be $2.5 trillion, or a 27% reduction, over the FFY 2025 to 2034 budget window.[17] Importantly, the enrollment estimates are annual impacts—representing sustained reductions in coverage year-over-year, as opposed to a one-time decline.[18] Specifically, 22.0 million people would lose coverage in Medicaid expansion states: 21.5 million expansion adults would lose coverage; 846,000 children would lose coverage; and enrollment in the eligibility group for individuals with disabilities would increase by 342,000 enrollees. The impact of losing expansion is sizable in all affected states, but varies depending on the size of each state's Medicaid expansion enrollment compared to total program enrollment, and how per-capita costs for the expansion group compare to other eligibility groups. The loss of total Medicaid funding would range from 13% in Vermont to 44% in Louisiana; and enrollment declines would range from 20% in Massachusetts to 53% in Oregon.

Option B: States Continue Expansion. If expansion states fully replace lost federal funding to continue their Medicaid expansions, then there would be no impact on enrollment. To do this, expansion states would need to increase non-federal Medicaid spending by 26%—or $836 billion. Put differently, as a share of non-federal spending on expansion alone, states would need to nearly triple their spending to maintain current levels of expansion expenditures and enrollment. Here too, the magnitude varies significantly by state. To maintain expansion, the required increase in non-federal Medicaid spending ranges from 12% in Vermont to 49% in Montana, calculated as a share of each state's total non-federal spending. As a percentage of non-federal spending on expansion alone, the increase ranges from 101% in Louisiana to 400% in Maryland, Massachusetts, New Jersey, and Washington.[19]

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[16] In this context, Medicaid coverage on the basis of disability refers to the T-MSIS eligibility groups enumerated in this MACPAC exhibit. When states implemented Medicaid expansion for adults, a number of individuals who otherwise would have undergone disability determinations and enrolled in Medicaid via a disability pathway instead opted to avoid the complexity of a disability determination and sign up for coverage via the expansion pathway. We assume that the inverse of this effect will occur if states eliminate expansion coverage (i.e., a share of people with disabilities previously enrolled through the expansion group will seek disability determinations and enroll in disability-based coverage). To estimate the magnitude of this effect, we developed a ratio of observed decreases in enrollment through the disability pathway for every expansion adult that gained coverage in Louisiana and Montana. Based on data from these states, we estimate that every 100 expansion enrollees losing coverage would result in approximately one new enrollee through a disability pathway in the first year and two new enrollees in all subsequent years.

[17] Percentage impacts relative to baseline are calculated based on projected baseline expenditures and enrollment for the 41 current expansion states only.

[18] Specifically, we assume the proposal would be effective in FFY 2026 and calculate the reduction in average annual enrollment between FFY 2026 to 2034 compared to projected enrollment under current law.

[19] The percentage increase in non-federal spending associated with expansion depends partly on the difference between the 90% enhanced FMAP for expansion enrollees and the state's standard medical FMAP (i.e., states with a low standard medical FMAP will face

See Tables 2 and 3 of the Excel workbook for state-by-state impacts of this proposal.

2. Remove the 50% FMAP Floor for the Standard Medical FMAP or Reduce the 50% FMAP Floor to 40% (Applicable to Select States Only).

Proposal Overview and State Response Scenarios

Congress is considering proposals that would impact select states with relatively high per-capita incomes to reduce the current FMAP floor set at 50% to either the standard medical FMAP, or to 40%. Ten states—California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, Wyoming—and D.C[20] have standard medical FMAP rates set at the FMAP floor and would see their matching rates decline as a result of these proposals. To assess the impact, we first recalculate federal match rates across states using the existing statutory formula and data from the Bureau of Economic Analysis (without applying a minimum FMAP floor, or by applying a 40% floor in our FMAP calculations, as applicable). After removing the statutory FMAP floor, we find new, lower FMAPs in the impacted states ranging from 24% in Massachusetts to 48% in Maryland (see Table 4 of the Excel workbook).

We provide estimates of reducing the current FMAP floor set at 50% to the standard medical FMAP (below and in Tables 5 and 6 of the Excel workbook) and of reducing the current FMAP floor set at 50% to 40% (in Tables 7 and 8 of the Excel workbook only) based on two potential state responses:

- ***Option A: States Do Not Replace Lost Funding.*** We estimate the impact of the 10 states and D.C. maintaining their own expenditures but not attempting to replace lost federal funding. To develop our estimates, we recalculate federal expenditures at the lower federal match rate while assuming the same amount of non-federal spending.
- ***Option B: States Replace Half of Lost Funding.*** We estimate the impact of the 10 states and D.C. seeking to replace half of the federal funds lost under these proposals. If they do replace half of the lost federal funds, this, in turn, would allow them to draw down FMAP on their additional expenditures, albeit at the state's recalculated, lower standard medical FMAP.

Under both options, we estimate the impact on Medicaid expenditures, but do not otherwise attempt to predict how states would respond to the loss of federal funds. In practice, these states would need to reduce Medicaid reimbursement rates, reduce eligibility, and/or cut benefits to absorb the loss of federal funds.

National and State Impacts

Option A: States Do Not Replace Lost Funding. If the 50% FMAP floor is eliminated, and the 10 impacted states and D.C. do not replace any lost federal funds, they would see their total Medicaid expenditures drop by $664 billion (15%).[21] The impact would vary by state; five states would see reductions in total Medicaid spending of 15% or more, including 29% in Massachusetts and 23% in Connecticut.[22]

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larger increases in non-federal spending on expansion, and vice versa) and partly based on the proportion of not newly eligible expansion enrollees matched at the state's standard medical FMAP. For not newly eligible enrollees matched at the standard rate today, non-federal share costs will not change. Louisiana has the lowest percentage increase in expansion non-federal spending because of its relatively high standard medical FMAP and because, starting in July 2023, the state began reporting a significant proportion of not newly eligible expansion enrollees on its MBES report. Prior to July 2023, Louisiana only reported newly eligible expansion enrollment and expenditures.

[20] Unlike the 10 states impacted by this proposal, D.C.'s FMAP is currently set by statute at 70%. In our estimates, we assume that D.C.'s FMAP would be reduced to 50%.

[21] Percentage impacts relative to baseline are calculated based on projected baseline expenditures for the 10 states plus D.C. that are impacted by this proposal only.

[22] Under Option A, we estimate that D.C. would see a 26% reduction in total Medicaid spending.

Option B: States Replace Half of Lost Funding. If the 50% FMAP floor is eliminated, the 10 states and D.C. would need to increase their expenditures by $332 billion (19%) to replace half of the lost federal Medicaid funds with state funds. Under this scenario, the total reduction in Medicaid expenditures—accounting for the decline in federal funds and the increase in state spending—would be $140 billion (3%). While replacing the lost federal funds with state dollars would dramatically reduce the impact of the cuts, it also requires significant new expenditures from the affected states. For example, Massachusetts would need to increase its own Medicaid spending by 33% and Connecticut would need to increase its spending by 30%.[23]

See Tables 5 and 6 of the Excel workbook for state-by-state impacts of this proposal. As noted above, we have also modeled the proposal in which the 50% FMAP floor is reduced to 40% in Tables 7 and 8 of the Excel workbook.

3. Impose Per-Capita Caps for Expansion Enrollees Only or for All Medicaid Enrollees.

Proposal Overview and State Response Scenarios

Congress is considering proposals to impose per-capita caps on expansion adults or possibly all Medicaid enrollees. Under a per-capita cap for expansion adults, states would face a limit on the total amount of funding the federal government would be willing to match for expansion adults. This aggregate cap on federal expansion funds would be determined by multiplying the number of Medicaid expansion enrollees by a pre-determined per-enrollee annual spending rate. Under a per-capita cap for all Medicaid enrollees, the number of enrollees in each eligibility group is multiplied by each group's per enrollee rate to identify total available aggregate expenditures that the federal government will match. Depending on the proposal, per enrollee rates can differ by eligibility group. States cannot draw down federal Medicaid funds in excess of the aggregate capped funding amount. Per-capita cap estimates can differ greatly depending on policy decisions, including the base year to which the caps will be applied, the trend rate used to adjust the caps over time, and whether additional populations would be subject to the cap. As noted above, Manatt aligns with the policy parameters (i.e., the budget window, trend factor, and effective date) outlined in the CBO's Options for Reducing the Deficit: 2025 to 2034 report, but estimates could vary substantially depending on the specifics of the final budget reconciliation proposal and expected state response.[24]

For the per-capita cap proposal tied to the expansion group only, we first identify per-capita expansion expenditures from FFY 2024 (assumed to be the base year) for each state. We then trend the expansion per-capita caps forward by the CBO's estimate of CPI-U to establish caps from FFY 2028-2034 (we align with the CBO's assumptions that the caps would go into effect in FFY 2028). We then multiply the per-capita caps by projected expansion enrollment for each state between FFY 2028 to 2034 to establish federal funding limits for expansion enrollees in each year. Finally, for each state, we compare aggregate federal funding for expansion enrollees available under a per-capita cap to projected federal expansion expenditures under current law (without the cap). (To calculate the caps for all Medicaid enrollees, we leverage the same approach but apply the methodology to enrollees in each eligibility group.)

We provide estimates of the impact of imposing a per-capita cap on expansion adults (below and in the Tables 9 and 10 of the Excel workbook) and of imposing per-capita caps on all Medicaid enrollees (in Tables 11 and 12 of the Excel workbook only) based on three potential state responses:

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[23] Under Option B, we estimate that D.C. would need to increase its own Medicaid spending by 57%.

[24] The CBO assumes per-capita caps would be established using a FFY 2024 spending baseline. Caps would be trended forward based on the Consumer Price Index for All Urban Consumers (CPI-U). Manatt's estimates differ from the CBO's because the CBO assumes state behavioral responses (e.g., decisions to reduce provider payment rates, benefits, enrollment), while Manatt does not assume any such responses.

- ***Option A: States Reduce Non-Federal Spending.*** We estimate the impact of states reducing their spending so that all non-federal spending continues to be matched by the federal government. As a result, non-federal, federal, and total expenditures would decline.
- ***Option B: States Maintain Prior Funding Levels.*** We estimate the impact of states maintain their existing non-federal spending, even though a portion would no longer draw down federal matching funds. As a result, federal and total expenditures would decrease.
- ***Option C: States Fully Replace Lost Federal Funding.*** We estimate the impact of states fully replacing any lost federal funding. Similar to Option B above, we assume a portion of non-federal spending would be unmatched by the federal government. However, total expenditures would remain the same because states would increase their spending to fill in the federal funding gap.

In developing their own estimates, states will want to assess their projected expansion enrollment growth and per-capita spending trends under current law. While our modeled growth rates align with the CBO's national baseline, state-specific projections may differ significantly. Importantly, the baseline year and trend factor used for setting the cap would ultimately be determined by Congress.

National and State Impacts

Option A: States Reduce Non-Federal Spending. If states were to only contribute Medicaid funding that is matched by the federal government, total Medicaid spending would decline by $460 billion. This would represent a 6% decline in total Medicaid spending in expansion states and a 22% decline in spending on the expansion group. Additionally, the state-level impact would be sizeable in all Medicaid expansion states but would impact some more than others. States would see a reduction in total Medicaid spending ranging from 2% in Vermont to 10% in Louisiana.

Option B: States Maintain Prior Funding Levels. If states were to maintain their existing non-federal spending, total Medicaid spending would still fall by $408 billion. This would represent a 5% decline total Medicaid spending in expansion states and a 19% decline in spending on the expansion group. Here too, the impact would be substantial across all expansion states. States would see a reduction in total Medicaid spending ranging from 2% in Vermont to 9% in Montana. As a percentage of expansion spending, reductions would range from 12% in Vermont to 20% across several states.

Option C: States Fully Replace Lost Federal Funding. If states were to fully replace any lost federal funding, they would need to increase their own spending by $408 billion. This would represent a 16% increase in total state Medicaid spending in expansion states and—because of the enhanced federal match rate for expansion enrollees—a 171% increase to current state spending on the expansion population. Like Options A and B, all Medicaid expansion states would be impacted, with some impacted more significantly than others. Expansion states would need to increase their own Medicaid spending from 5% in Vermont to 34% in Montana. Increases in state expansion group spending are even more significant—ranging from 113% in Maine to 196% across several states.[25]

To absorb the lost federal funding under Options A and B, states would need to cut Medicaid eligibility, terminate some people from coverage, reduce provider payments, and/or scale back optional benefits.

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[25] We project that Alaska would see a 348% increase in state spending on the expansion group under Option C. This is driven by Alaska's high proportion of expansion expenditures matched at the 100% rate for services delivered through Tribal or Indian Health Service facilities. As a result, Alaska's state expenditures per dollar of expansion group spending are lower compared to other states. This would require larger increases to state spending on a percentage basis to offset any lost federal dollars.

See Tables 9 and 10 of the Excel workbook for state-by-state per-capita cap expansion impacts. As noted above, we have also modeled the proposal in which *all* Medicaid enrollees would be subject to per-capita caps in Tables 11 and 12 of the Excel workbook.

V. Conclusion

The proposals to reduce federal Medicaid spending could have a substantial impact on state Medicaid program eligibility and enrollment and state budgets. If one or more proposals are enacted, states will need to evaluate options such as using additional state funds to offset reductions, reducing coverage levels or services, and/or modifying provider reimbursement rates and capitation payments to managed care plans. As these proposals take shape, states can look to this toolkit to inform and validate their own fiscal and program impact estimates of federal policy changes.

This toolkit will be updated in the weeks ahead to estimate the impact of the proposal to make work reporting requirements a new condition of Medicaid eligibility. Estimates will also be revised once Congress releases legislation that includes specifics of their Medicaid funding proposals, including analysis of how the provisions interact. For states that are actively modeling the potential impacts of federal Medicaid proposals or that have already developed preliminary estimates, Manatt, through State Health and Value Strategies, is available to provide technical assistance. Additionally, SHADAC is continuing to publish estimates from states, updating this expert perspective as a resource. If your state would like to request technical assistance or has produced estimates that should be included in SHADAC's expert perspective, please contact us here.

Support for this toolkit was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is a leading national philanthropy dedicated to taking bold leaps to transform health in our lifetime. Through funding, convening, advocacy, and evidence-building, we work side-by-side with communities, practitioners, and institutions to get to health equity faster and pave the way together to a future where health is no longer a privilege, but a right.

RWJF believes that achieving strong, lasting connections across the healthcare, public health, and social services systems helps build healthier and more equitable communities that provide everyone a fair and just opportunity for health and wellbeing.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT MANATT HEALTH

This toolkit was prepared by Manatt Health. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit https://www.manatt.com/health.