AMSPDC Pediatrics Workforce Initiative
Medicaid Education Series

Session 2: Federal Threats to Medicaid

May 21, 2025

Association of Administrators in Academic Pediatrics

Association of Medical School Pediatric Department Chairs • AMSPDC

AMSPDC Pediatrics Workforce Initiative (PWI)

The AMSPDC Pediatrics Workforce Initiative was created in 2020 with the goal to increase the number and diversity of high-quality students who enter training in categorical Pediatrics, Medicine-Pediatric, and Combined Pediatric Subspecialty training programs, as well as improve the supply and distribution of pediatric subspecialists with the goal of meeting the health and wellness needs of the wide diversity of US children, adolescents, and young adults.

AMSPDC Pediatrics Workforce Initiative

Bob Vinci, MD

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Project Director

Strategically Aligned Workgroups with NASEM Report

Workgroup	Leader
Practice Collaboration	Ann Reed, MD
Economic Strategy	Mary Leonard, MD MSCE
Redesign Education	Becky Blankenburg, MD MPH
Physician Scientist	Sallie Permar, MD PhD

New in 2025: Launching a Public Awareness Campaign

In Case You Missed It!

Session 1: Medicaid 101 What Pediatric Department Leaders Should Know

James M. Perrin, MD, FAAP

Joan Alker, MPhil

Session Logistics and Reminders

- The session is being recorded and will be posted on the AMSPDC website
- Keep yourself muted unless speaking
- Please post questions in the chat at any time during the presentation
- All questions will be addressed during the Q&A
- During Q&A - raise hand or post question in chat

Association of Administrators in Academic Pediatrics

Association of Medical School Pediatric Department Chairs, AMSPDC

Speaker

Edwin Park, JD
Research Professor Georgetown University McCourt School of Public Policy's Center for Children and Families

Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Cuts in the House Republican Budget Reconciliation Bill

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May 21, 2025

OUTLINE

- Overview of Medicaid
- Overview of Budget Reconciliation
- Current Timing and Process
- Key Medicaid Cuts in House Reconciliation Bill
- Likely Coverage Impact

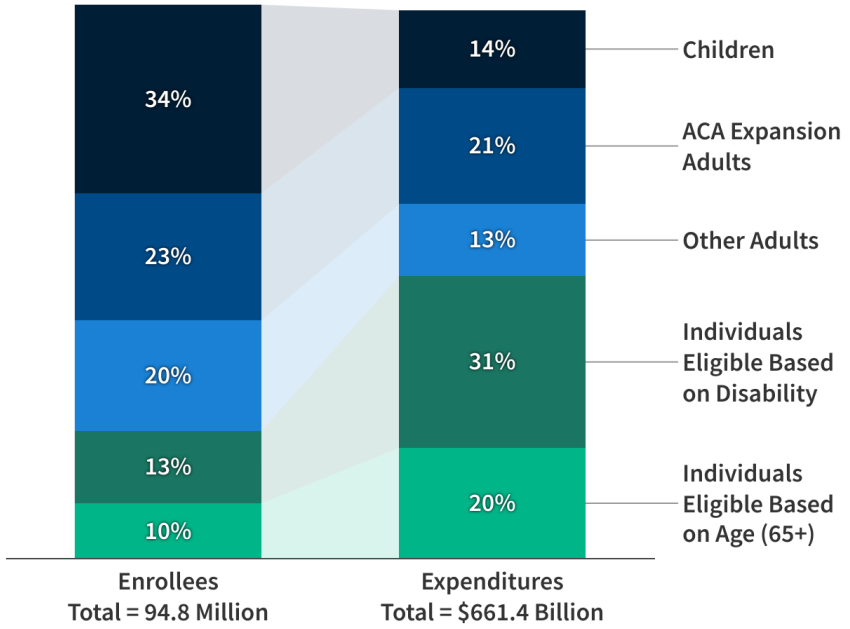
I. BRIEF OVERVIEW OF MEDICAID PROGRAM

- Largest federal health insurance program covering more than 72 million low-income people
- Covers:
  - 39% of children, 82% of poor children
  - 41% of births
  - 44% of people with disabilities
  - 44% of children and youth with special health care needs
  - 63% of nursing home residents
  - 35% of Black, 31% of Hispanic and 40% of American Indian/Native Alaskan people
  - 40.6% of children and 18.3% of non-elderly adults in rural areas (compared to 38.2% and 16.3% of urban children and non-elderly adults)
  - 23.3% of women of childbearing age in rural areas (compared to 20.5% of those in urban areas)
- Largest payer:
  - Long-term services and supports
  - Behavioral health
  - Treatment for SUD including opioid addiction
  - HIV

Medicaid Enrollment and Spending

Figure 13

People Eligible for Medicaid Based on Disability or Age (65+) Accounted for 1 in 4 Enrollees but Over Half of All Spending in 2021



Note: Includes full and partial benefit enrollees enrolled in at least one month of Medicaid during 2021. Total may not sum to 100% due to rounding.

Source: KFF analysis of the T-MSIS Research Identifiable Files, CY 2021

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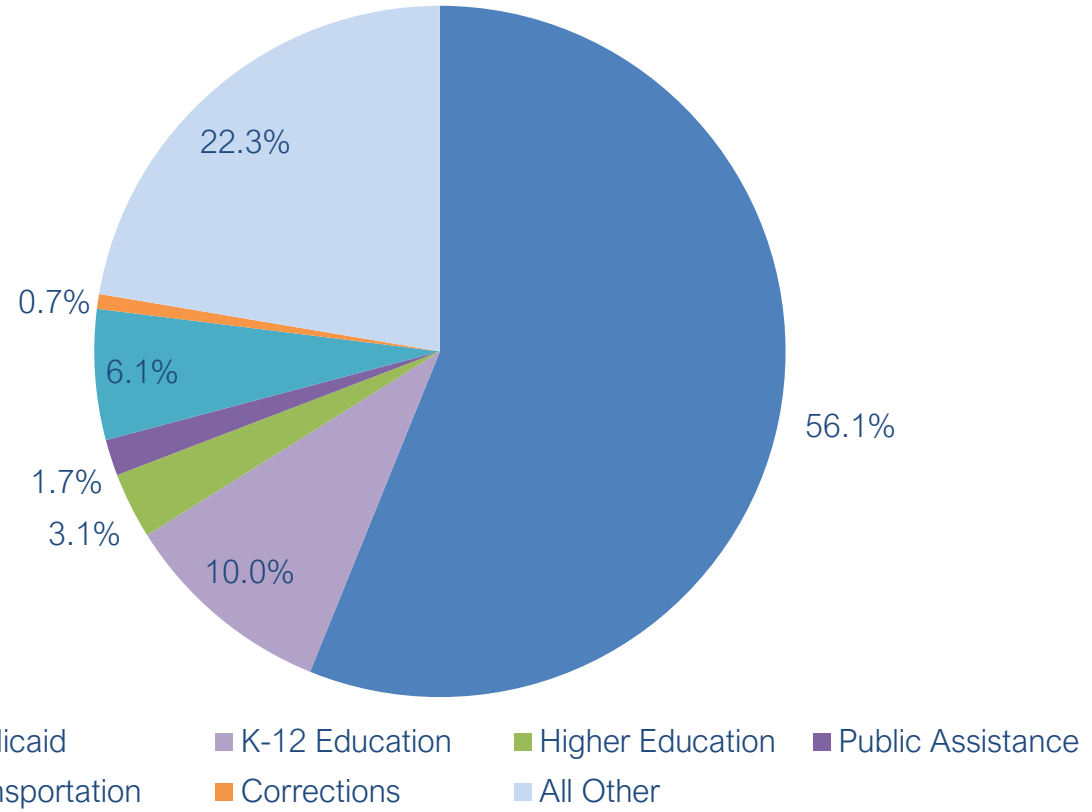
Medicaid Is Largest Source of Federal Funding for States



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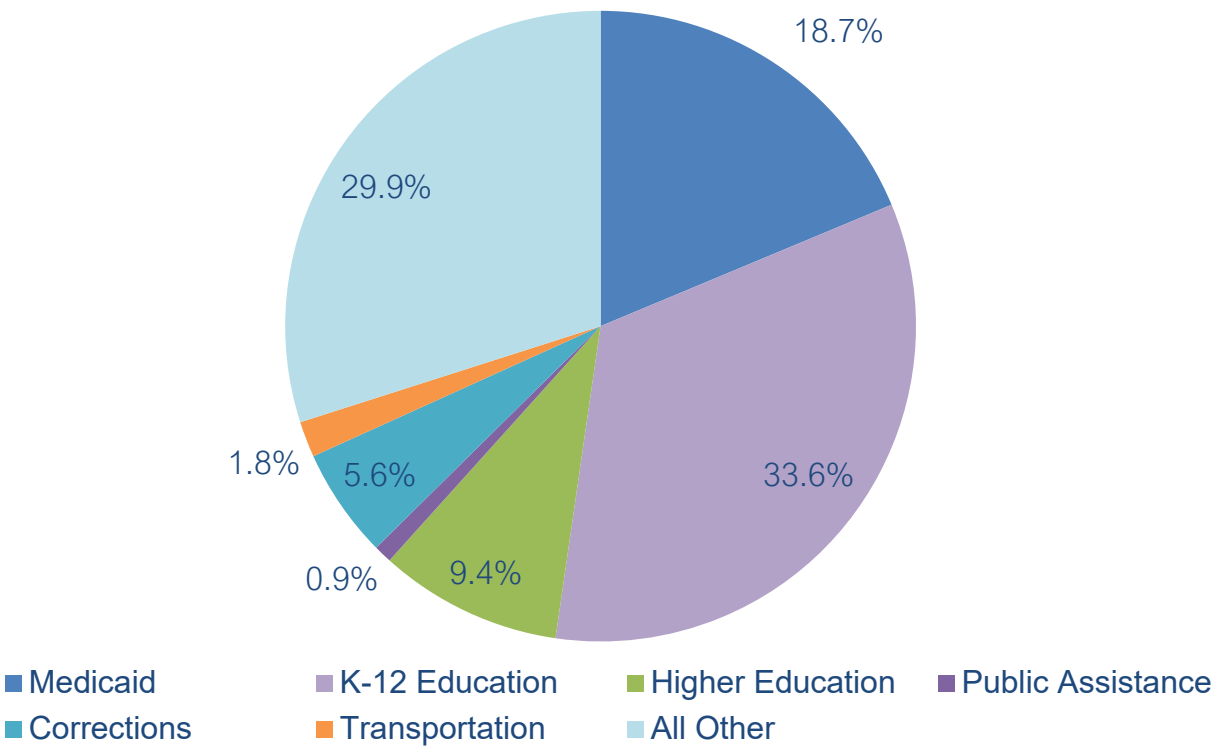
Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2024 (estimated).

Medicaid Much Smaller Share of States' General Fund Budgets than Education



Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2024 (estimated).

II. OVERVIEW OF BUDGET RECONCILIATION

- Budget reconciliation is an expedited legislative process related to revenues (e.g. taxes) and mandatory spending (e.g. Medicare, Medicaid, CHIP, ACA marketplace subsidies, SNAP)
- Bypasses Senate filibuster so requires only 50 votes
- Budget resolution has to be passed by House and Senate first.
- Budget reconciliation bill must satisfy committee "instructions" included in budget resolution
- Provisions must have a budgetary impact
- Can add to the deficits over next 10 years but cannot add to deficits in future decades. Used in the past for the Inflation Reduction Act, the American Rescue Plan Act and the 2017 Tax Cuts and Jobs Act. Reconciliation was also vehicle used for the failed ACA repeal/replace bills in 2017
- There could be two reconciliation bills this year (one per federal fiscal year) but only if House and Senate pass new budget resolution

Circumvention of Budget Reconciliation Rules

- Senate GOP likely to overrule or order parliamentarian/Congressional Budget Office to use current policy baseline so extension of expiring tax cuts (at cost of $3.8 to $4.6T/10 years) does not score
  - Ignore Byrd Rule on deficits in future decades, budgetary impact
- Senate and House committee instructions are inconsistent with each other but only Senate instructions will matter

III. CURRENT TIMING AND PROCESS

- House and Senate passed budget resolution in April, including instruction to House Energy and Commerce Committee to make at least $880 billion/10 years in mandatory spending cuts
- House Energy and Commerce Committee reported out its section of reconciliation bill on May 14th after 26.5 hour markup
- House Budget Committee approved combined reconciliation bill on May 18th
- House Rules Committee scheduled to consider bill today at 1am
- House floor vote potentially sometime later this week
- No Senate committee action so Senate will consider in June
- If bill is revised by Senate, back to House for vote
- Goal of final passage by end of July

IV. KEY MEDICAID CUTS IN HOUSE RECONCILIATION BILL

- Restricting use of provider taxes to finance Medicaid
- Undermining the Medicaid expansion
- Reducing participation among all eligible people including children
- Prohibiting Medicaid coverage of specific benefits and providers

A. PROVIDER TAX RESTRICTIONS

- States have longstanding flexibility in how they finance their share of Medicaid costs under federal-state financial partnership:
  - General revenues
  - Other government contributions
    - Local government matching funds (e.g. from counties and cities)
    - Intergovernmental transfers (IGTs)
  - Provider taxes
    - Taxes on hospitals, nursing homes, managed care plans and other providers
  - Other dedicated revenues
    - Tobacco taxes, legal settlements

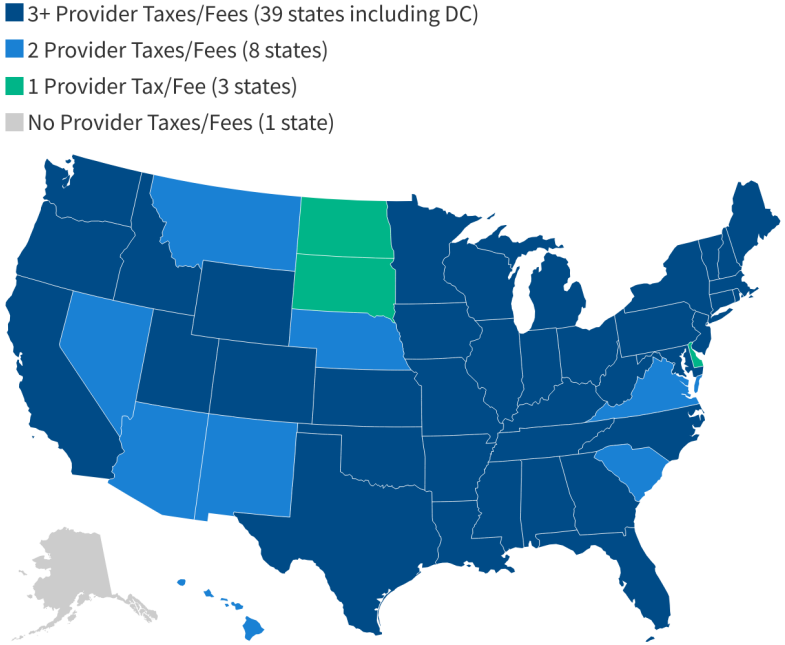
Provider Taxes

- Under federal rules that have been in place since 1991-1992, states may use revenues from taxes on health care providers like hospitals, nursing homes and managed care plans to raise revenues for Medicaid
- Taxes must be uniform, broad-based and not hold taxpayers harmless
- Provider taxes are a critical, growing source of state funding for Medicaid with all states but Alaska having at least one provider tax
- States use provider taxes for a variety of purposes including financing Medicaid expansion, increased provider payment rates (including through state-directed payments), increasing access to HCBS services for people with disabilities, and closing general budget shortfalls (including during downturns)

Number of Provider Taxes

Figure 1

All States but Alaska Had at Least One Provider Tax and Many States had Three or More Provider Taxes in SFY 2024



Note: SFY = state fiscal year. Includes Medicaid provider taxes as reported by states. FL did not respond to the 2024 survey; publicly available data used to verify taxes in place.

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

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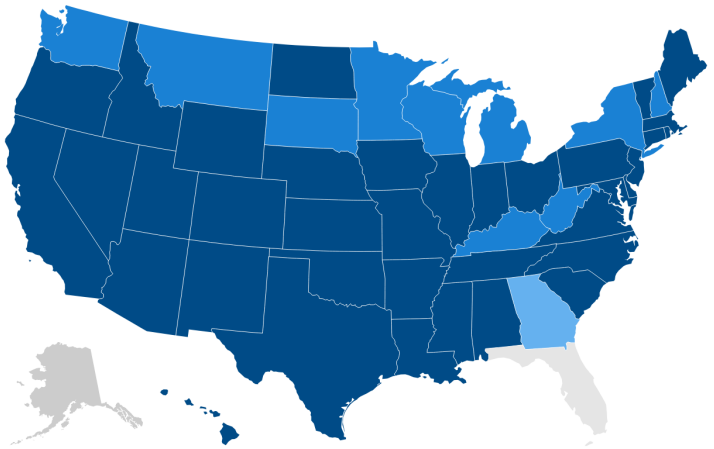
Size of Provider Taxes

Figure 2

38 States Have At Least One Provider Tax Over 5.5% of Net Patient Revenues

Size of provider taxes/fees as a percentage of net patient revenue in SFY 2024

- At Least 1 Provider Tax/Fee Over 5.5% (38 states including DC)
- At Least 1 Provider Tax/Fee Over 3.5% But None Over 5.5% (10 states)
  (48 states including DC with at least 1 provider tax/fee over 3.5%)
- No Provider Taxes/Fees Over 3.5% (1 state)
- No Provider Taxes/Fees (1 state)
- No Response (1 state)



Note: SFY = state fiscal year. Size of tax is reported as a percentage of net patient revenue (as of July 1, 2024). Includes Medicaid provider taxes as reported by states. FL did not respond to the 2024 survey; publicly available data used to verify taxes in place but not the size of the taxes.

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

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Provider Tax Restrictions

- No new taxes or increases in existing taxes upon date of enactment
  - States could not add new taxes or increase current taxes to help close budget shortfalls or finance improvements to Medicaid programs like child eligibility expansions or increased payments to hospitals and other providers
- Prohibition of certain existing taxes with "uniformity waivers" affecting at least 7 states upon date of enactment but could apply to more states
  - Immediate cost-shift to these states with no guaranteed transition period
  - Unless states could identify other financing sources, they would have to cut their Medicaid programs
  - Because of moratorium provision, states may not be able to "fix" existing taxes and would not be able to substitute new taxes to replace lost revenues
- Related provision prohibiting new State Directed Payments that exceed Medicare rates
  - Includes grandfathering provision

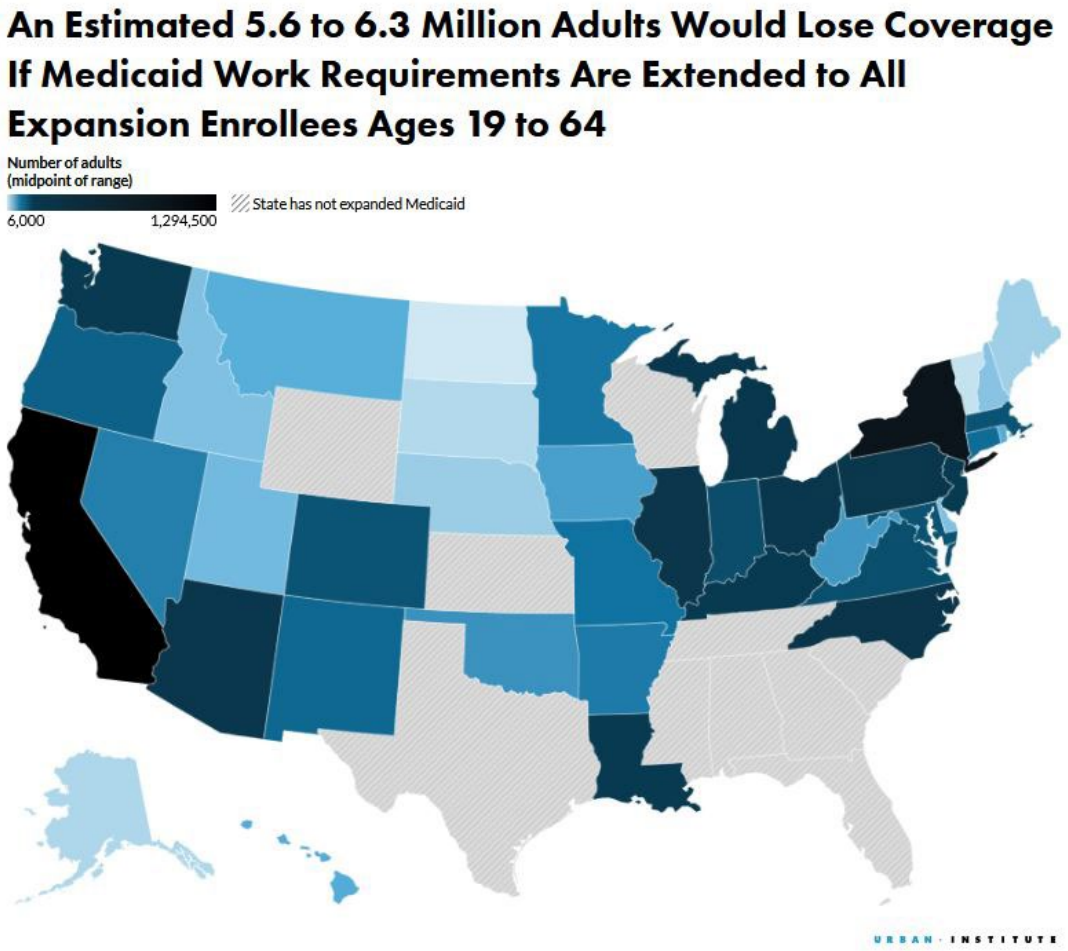
B. UNDERMINING MEDICAID EXPANSION

- Reconciliation bill dropped explicit cuts to federal funding for the Medicaid expansion which covers nearly 21 million low-income adults
  - Elimination of the 90% federal matching rate
  - Per capita cap on expansion funding
- But bill targets a number of cuts at the expansion which are intended to severely cut expansion enrollment among eligible people

Work Requirements

- Mandatory work requirements for expansion adults ages 19-64
- Most non-elderly adult Medicaid beneficiaries already work (64%) and nearly all others cannot work because they have disabilities/chronic conditions, are primary caregivers or are in school (28%)
- Experience with Medicaid work requirements show they have no effect on employment or hours worked but do cut enrollment because people cannot navigate work requirement system or successfully obtain exemptions for which they qualify
- States would not be required to automatically exclude exempted populations including parents with dependent children
- Work requirement would apply at application with unlimited lookback and during enrollment, potentially every month
- Federal requirement would supersede scope limitations/exemptions/system designs/implementation approaches envisioned in any state waiver proposals
- Those losing coverage would be ineligible for ACA marketplace subsidies

Coverage Impact of Work Requirement on Expansion



Other Proposals Targeting the Medicaid Expansion

- Require mandatory cost-sharing for near-poor expansion enrollees
- Increase frequency of eligibility redeterminations to six months
- Eliminate financial incentive for 10 remaining non-expansion states to adopt the Medicaid expansion

Likely Impact of Reduced Expansion Coverage on Children

- Benefits of coverage for parents on children
  - Higher participation in Medicaid and CHIP among eligible children
  - Increased utilization of needed care among children
  - Greater financial stability and less medical debt for the family
- Long-term benefits of children's coverage
  - Better health in adulthood
  - Greater educational attainment
  - Increased financial security

C. OTHER CUTS AFFECTING ELIGIBILITY AND ENROLLMENT

- Rescind two-part eligibility and enrollment regulations from 2024 that includes provisions to increase participation among eligible children, seniors, people with disabilities and other eligible people
  - CHIP waiting periods and lockouts, annual and lifetime dollar limits, transitions between Medicaid and CHIP
  - Simplified enrollment processes for seniors and people with disabilities including for Medicare Savings Programs
  - Congressional Budget Office previously estimated rescinding these rules would cut enrollment by 2.3 million people
- Effectively eliminate Medicaid coverage during reasonable opportunity period
- Limit retroactive coverage from 90 days to 30 days

D. CUTS TARGETING SPECIFIC SERVICES, PROVIDERS AND POPULATIONS

- Prohibit Medicaid and CHIP coverage of gender affirming care for children under age 18
- Limit free choice of provider requirement to prohibit federally funded Medicaid payments to Planned Parenthood
- Cut expansion matching rate from 90% to 80% to force expansion states to end coverage of immigrant children, pregnant women and others
  - 14 expansion states and D.C. that use state-only funding to provide coverage to undocumented children and some adults
  - 19 additional expansion states that have taken up state "ICHIA" option to provide federally funded Medicaid and CHIP coverage to lawfully present immigrant children and pregnant women

V. LIKELY COVERAGE IMPACT

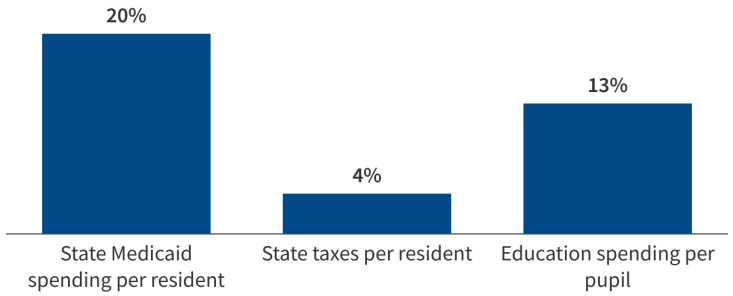
- Latest preliminary Congressional Budget Office estimates of at least $792 billion in gross Medicaid cuts/10 years
- Reduces Medicaid enrollment by at least 10.3 million relative to current law
- Increases number of uninsured by at least 7.6 million
- Combined with ACA marketplace changes included in Energy and Commerce bill, increase in uninsured of at least 8.6 million
- Separately, preliminary estimates that ACA marketplace subsidy cuts in Ways and Means bill will increase uninsured by 2.1 million
- Full coverage estimate (with all provisions scored and interactions between committee sections) not yet available but likely in the range of at least 10 million increase in uninsured

Estimating Magnitude of Impact on Medicaid, Taxes or Education

Figure 2

Context for Federal Medicaid Cuts in the House Energy and Commerce Reconciliation Bill

$62.2 billion in federal Medicaid cuts per year as a share of state Medicaid spending per resident, state taxes per resident, and state education spending per pupil



Note: Spending cuts reflect the average of the 10-year Congressional Budget Office (CBO) estimates less the $290 million in prescription drug savings. See Methods of "State-Level Context for Federal Medicaid Cuts of $625 Billion and Enrollment Declines of 10.3 Million" for more information.

Source: KFF analysis of 2024 Medicaid spending and enrollment data, U.S. Census Bureau 2024 Resident Population Data, U.S. Census Bureau 2023 Annual Survey of State Government Tax Collections, National Association of State Budget Officers (NASBO) 2024 State Expenditure Report, National Center on Education Statistics Digest of Education Statistics, K-12 Enrollment., CBO Preliminary Estimates of Energy & Commerce Committee Subtitle D, Part I - Medicaid.

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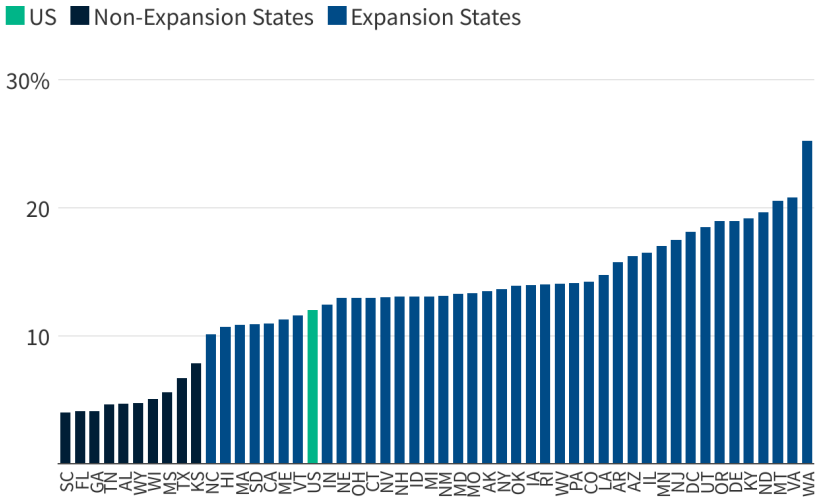
Estimating Magnitude of Impact on Enrollment

Figure 4

Estimated Medicaid Enrollment Loss From House Energy and Commerce Reconciliation Bill, By State

As a Percent of Projected Baseline Medicaid Enrollment in 2034



Note: CBO's estimated enrollment effects are allocated across the states proportionally to states' estimated reduction in federal funding less the prescription drug savings. See Methods of "State-Level Context for Federal Medicaid Cuts of $625 Billion and Enrollment Declines of 10.3 Million" for more information. Recognizing that CBO's estimates are average effects expected across all states and not a prediction of what will happen in specific states, the figure shows a range of enrollment losses for each state that is 25% higher (high end %) or lower (low end %) than the midpoint that reflects KFF's allocation of CBO's estimate.

Source: KFF analysis of 2024 Medicaid spending and enrollment data, U.S. Census Bureau 2024 Resident Population Data, U.S. Census Bureau, CBO Preliminary Estimates of Energy & Commerce Committee Subtitle D, Part I - Medicaid.

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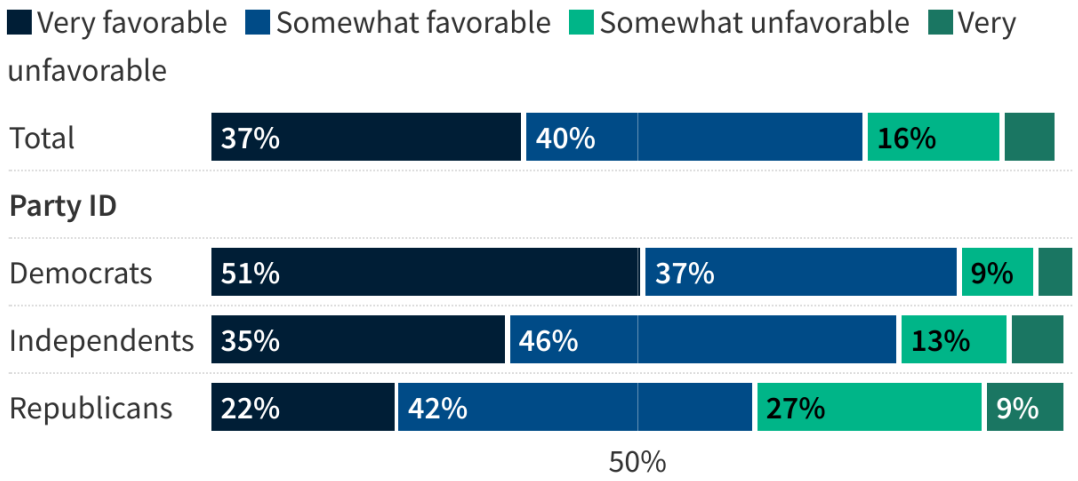
Medicaid Is Highly Popular

Figure 2

Majorities of Democrats, Independents, and Republicans Hold Positive Views Of Medicaid

In general, do you have a favorable or unfavorable opinion of Medicaid, the federal-state government health insurance for certain low-income adults and children and long-term care program for adults 65 and older and younger adults with disabilities?



Note: See topline for full question wording.

Source: KFF Health Tracking Poll (Jan. 7-14, 2025)

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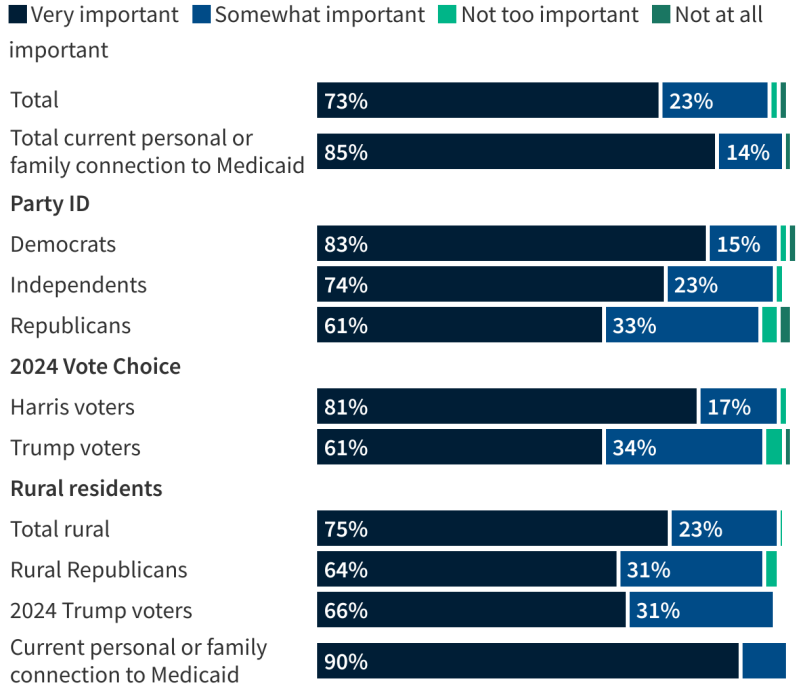
Figure 3

Over Nine in Ten Adults Say That Medicaid Is Important to Their Local Communities

How important, if at all, is Medicaid for **people in your local community**?



Note: See topline for full question wording.

Source: KFF Health Tracking Poll (Feb. 18-25, 2025)

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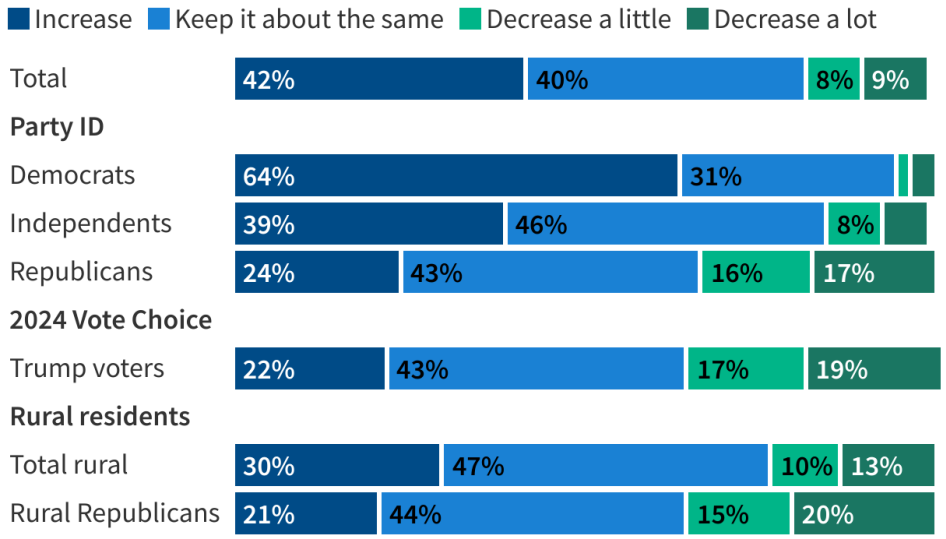
Trump Voters Oppose Medicaid Cuts

Figure 1

Large Shares Across Groups Want Congress To Increase or Maintain Spending on Medicaid

Do you want to see Congress increase spending on Medicaid, decrease spending, or keep it about the same? *IF DECREASE:* Would you like to see Congress decrease spending by a lot or a little?



Note: See topline for full question wording.
Source: KFF Health Tracking Poll (Feb. 18-25, 2025)

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A current debate in Congress centers on changes to tax and spending policies. This includes whether some tax policies that are set to expire this year should be continued, and how to pay for a loss in tax revenue with spending cuts. For each of the following possible changes, please tell me if you support or oppose it.
% Support/Oppose

	All Voters	Trump Voters	Swing Voters
Cutting Medicaid.	23/69	39/49	22/70

Do you support or oppose cutting Medicaid spending to pay for tax cuts?

	All Voters	Trump Voters	Swing Voters
Total Support	**20**	**36**	**21**
Total Oppose	**70**	**51**	**67**
Strongly Support	8	16	7
Somewhat Support	11	20	14
Somewhat Oppose	16	23	18
Strongly Oppose	54	27	49
Refused	10	14	12

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AMSPDC PWI - Share Your Stories

We’re collecting stories to put a human face on what’s happening to child health. Stories bring urgency, empathy, and depth to complex issues—and can meaningfully inform advocacy, guide leadership, and drive change.