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Medicaid Outlook: Threats and Opportunities

With a Republican trifecta in control of the White House, Senate, and House of Representatives, we could see Congress and the Administration pursue changes to Medicaid, which currently provides health coverage to more than 72 million Americans. The following table outlines potential threats to Medicaid and the processes through which such changes could be made. Threats include the addition of work requirements and changes to Medicaid financing either by altering the percentage of Medicaid expenditures paid for by federal funds and/or by altering supplemental payments. Actions could also be taken to alter Medicaid benefits, eligibility levels, or quality metrics to ensure access to care. Congress can alter Medicaid through legislation, either utilizing the normal process which includes a 60-vote threshold to overcome the filibuster in the Senate, or through budget reconciliation, which requires a simple majority (51 votes or 50 votes plus the support of the Vice President). Our primer on budget reconciliation includes additional details. A second table at the end of this document highlights two potential opportunities in the next Congress that could strengthen the Medicaid program. Additional opportunities could present themselves. The threats and opportunities included in these tables are not exhaustive but are quite thorough.

**This document was most recently updated on November 18, 2024.*

Medicaid Threats			
Medicaid Threats	**Congress** (Legislation, Budget Reconciliation, or Congressional Review Act)	**White House** (Executive Order, Waiver Approval, Rule Making)	**Notes**
Work Requirements	If health care were to be included in budget reconciliation in 2025, work requirements would be a top contender. TBD if the work requirements would be optional or mandatory for states.	Waiver approvals; CMS could issue clarification that work requirements, premiums, and cost-sharing are permissible. CMS could also issue communications urging states to adopt such measures. Litigation is likely. Extensive litigation has already occurred and there is no binding precedent. The Supreme Court took up two appeals and sent both cases back to lower courts.	Project 2025 urges CMS to "clarify that states can adopt work incentives for able-bodied individuals (similar to what is required in other welfare programs) and the ability to broaden the application of targeted premiums and cost-sharing to higher income enrollees." (see p.468). House Budget Committee Chair Jodey Arrington (R-Texas) told reporters in mid-November that a "responsible and reasonable work requirement for Medicaid benefits resembling the one that already exists for food stamps could yield about $100 billion in savings."

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Work Requirements *(continued)*		We do not believe CMS can require states to include work requirements under current legislation.	Of note, TANF and SNAP programs both receive federal allocations for work supports such as employment training and childcare subsidies as part of the implementation of their work requirements. SNAP and TANF work requirements also exclude individuals with disabilities, caregivers, and others.
Block Grants	Budget reconciliation legislation could convert the federal share of Medicaid funding to a block grant, allocating a fixed dollar amount to states. In 2017, Sens. Graham-Cassidy-Heller-Johnson introduced ACA repeal and replace legislation that included a Medicaid block grant proposal,	CMS could approve state "aggregate cap/block grant" waiver applications, as the previous Trump administration did in early Jan. 2021 with the Tennessee 1115 application (subsequently rescinded by the Biden administration).	This idea was included in the 2017 health care reconciliation bill before ultimately getting removed. On 11/14, Politico reported positive block grant comments from Sen. Cornyn and Rep. Greg Murphy.
Per Capita Caps	In 2017, the American Health Care Act (ACA repeal and replace) would have capped the federal Medicaid allotment to states on a per-enrollee basis.	CMS could approve state waiver applications to cap federal Medicaid funding.	This idea was included in the 2017 health care reconciliation bill before ultimately getting removed. There is no talk in Congress about bringing this back into the conversation at this time. However, on 11/14 Politico reported Rep. Buddy Carter saying "everything is on the table" with respect to Medicaid cuts. The Paragon Institute's July 2024 report on Medicaid Financing Reform notes per capita cap arrangements could "exacerbate improper enrollment in the program."

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Aggregate Caps	Budget reconciliation legislation could include a proposal to implement aggregate caps on the federal share of Medicaid funding.	CMS could approve a state's 1115 waiver application, as done during the first Trump administration (Tennessee).	
FMAP changes including creating a "balanced or blended FMAP", lowering the FMAP floor, and/or reducing or eliminating the enhanced FMAP for Medicaid expansion populations *(Additional details regarding each type of potential FMAP change are included below.)*	Changing FMAP rates requires Congressional action because they are defined in statute in the Social Security Act. When Congress passed the ACA, it created the enhanced FMAP and states can access that e-FMAP for certain populations through waivers approved by CMS. FMAP adjustments could be included in budget reconciliation or the regular legislative process.	CMS does not have the authority to change the SSA and thus cannot change FMAP or e-FMAP rates. CMS does, however, shape state access to them through approval of section 1115 waivers.	This idea has been proposed recently by the Paragon Health Institute, a group with significant influence among Republicans and likely staff of the Trump Administration.
Blended FMAP "balanced or blended match rate"	Legislation could create a blended FMAP where the federal match rate for Medicaid is consolidated across populations and/or across states, regardless of their expansion status and/or independent of their state's average per capita income which currently determines the FMAP percentage.	CMS cannot directly change FMAP rates as they are set by law, but the agency has authority over waivers that shape both eligibility and funding levels.	If implemented, a blended FMAP would reduce the federal contribution to states, especially those with large Medicaid expansion populations, and could limit the ability of states to provide comprehensive Medicaid benefits to low-income individuals.
Decreased enhanced FMAP for ACA Medicaid expansion	States that adopted ACA Medicaid expansion currently receive an enhanced FMAP of 90% for populations that were newly eligible under the ACA (low-income adults up to 138% FPL and parents). Legislation decreasing the enhanced	CMS cannot directly reduce the enhanced FMAP for Medicaid expansion populations through rulemaking, as this would require legislative changes. However, CMS could issue guidance that makes it harder for states to qualify for the enhanced FMAP or	Several states have triggers that would repeal Medicaid expansion in their state if the enhanced FMAP decreases. *These states can be strong allies to help oppose such efforts.*

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Decreased enhanced FMAP for ACA Medicaid expansion *(continued)*	FMAP for these populations would reduce federal funding for expansion states, shifting more of the financial responsibility and risk from the federal government to the states. A reduction could be pursued through budget reconciliation or normal legislative channels as part of efforts to reduce federal spending on Medicaid.	impose more stringent eligibility requirements for Medicaid expansion populations, reducing the number of individuals who benefit from the enhanced federal match. This could also take the form of issuing new guidance more narrowly defining "newly eligible", for example.	
Decreased enhanced FMAP for other special populations	Budget reconciliation or normal legislative processes could be used to restrict enhanced FMAP rates for special populations.	CMS has approved enhanced FMAPs through Section 1115 Medicaid waivers for multiple states to cover special populations.	
FMAP floor	The FMAP floor sets a minimum federal match rate for Medicaid, currently at 50% for states with the highest average per capita income. Legislation could reduce the FMAP floor, thereby decreasing the minimum percentage of Medicaid costs that are paid for with federal dollars. This could be done through budget reconciliation or standard legislative processes.	CMS could issue regulatory guidance impacting how states apply the FMAP floor or introduce waivers that adjust state contributions. The FMAP floor itself is set by Congress, however, and would require legislation to change.	
Supplemental Payment Restrictions or Elimination *(Including Disproportionate Share Hospital Payments (DSH))*	Legislation could be passed restricting or eliminating supplemental payments with the stated intention of increasing transparency and/or pursuing cost savings. This could include Disproportionate Share Hospital (DSH) payment reform.	MFAR rule from President Trump's first Administration could be reintroduced. Also, the incoming administration could look to limit the use of state-directed payment programs (DPP). However, many "red" states utilize DPPs to increase Medicaid payments to providers without leveraging additional state funds.	In 2019 under then-Chairman Grassley, the Senate Finance Committee released a report that scrutinized Medicaid supplemental payments, highlighting the growth in federal spending and lack of transparency. Section 202 of the Consolidated Appropriations Act of 2021 established state reporting

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			requirements for non-disproportionate share hospital (DSH) supplemental payments.
1115 Waivers / Demonstrations	1115 waivers/demonstrations could be eliminated through legislation but this is unlikely given the GOP's interest in state flexibility.	Waiver approvals/denials CMS could issue guidance urging states Northrup, Alyson <anorthrup@rwjf.org> to utilize waiver flexibility to pursue demonstrations that align with Administration policy goals. Similarly, they could oppose continued investments in certain waivers, such as new HRSN waivers. CMS is unlikely to revoke waivers that have already been approved.	Notable states with upcoming 1115 waiver expirations: GA (9/30/25), CO (12/31/25), IN (12/31/25), AR (12/31/26), CA (12/31/26), NY (3/31/27)
Medicaid Coverage for Incarcerated Individuals	Legislation could continue to remove barriers to Medicaid funding for individuals in and exiting incarceration. Legislation such as the Reentry Act of 2023 (H.R. 2400; S. 1165), for example, has bipartisan support and would remove barriers to Medicaid reimbursement for incarcerated individuals during the 30-day period before they are released.	CMS guidance outlined the Medicaid Reentry Section 1115 demonstration opportunity through which states can pursue demonstrations to help individuals transitioning out of incarceration. CMS had approved at least 11 waivers, with 13 additional waivers pending, as of late August.	See KFF analysis regarding CMS guidance and state adoption.
Reduced eligibility (i.e. reduced income limit; lifetime limits; asset tests, etc.)		Eligibility levels are primarily set by states and approved by CMS.	Project 2025 recommends that CMS "add targeted time limits or lifetime caps on benefits to disincentivize permanent dependence" (pg. 468).

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Reduced eligibility (i.e. reduced income limit; lifetime limits; asset tests, etc.) *(continued)*			Notably, however, CMS rejected Kansas' proposal to add a 36-month lifetime limit during President Trump's first administration and instead urged the state to consider community engagement programs (i.e. work requirements) that help build "pathways out of poverty."
Reversal of mental health parity requirements in Medicaid managed care	The Congressional Review Act (CRA) can be used to overturn the regulation because of when it was finalized.	CMS could choose not to enforce requirements included in the 2024 final regulation	
Reversal of Medicaid regulations finalized in 2024 *before* the CRA deadline. This applies to four final rules issued by the Biden-Harris Administration.	The Congressional Review Act does not apply to the identified final rules because they were finalized before the relevant CRA timeframe began.	The Administration could choose to delay implementation of certain provisions or issue new rule-making to reverse these policies.	The four Medicaid regulations finalized before the CRA timeframe are: *(1) Ensuring Access to Medicaid Services Final Rule; (2) Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule, (3) Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment Final Rule, and (4) Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule.*
Reversal of Medicaid coverage for former foster youth up to age 26	The ACA requires states to provide Medicaid coverage to former foster care youth until they turn 26 as long as they continue living in the state in which they		Congressional Research Services (CRS) released a related report on Medicaid coverage for former foster youth.

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Reversal of Medicaid coverage for former foster youth up to age 26 *(continued)*	were in foster care; the SUPPORT Act extended eligibility to youth regardless of whether they continue to live in the same state.		
Eligibility & Enrollment: reduced funding for eligibility determination personnel	The Social Security Act authorizes the federal government to pay up to 50% for state expenses related to Medicaid administration including eligibility determination. Efforts to decrease Medicaid spending could reduce this funding which in turn would decrease Medicaid enrollment.		State eligibility and enrollment systems are already underfunded in many states and have been a contributing factor to procedural disenrollment during the PHE unwind. In mid-November, House Budget Committee Chair Jodey Arrington (R-Texas) told reporters that "$160 billion in reduced costs could come from checking Medicaid eligibility more than once per year." Checking eligibility multiple times per year would require additional funding for eligibility determination efforts; inadequately funding these efforts or being unable to hire adequate staffing would put the burden on patients, many of who may not be able to comply with requirements and could consequently lose their coverage.
Eligibility & Enrollment: reduced funding for outreach efforts		The White House and CMS can choose to reduce or eliminate future investments in outreach efforts. Reducing these investments will lead to lower enrollment.	The Biden-Harris Administration made a historic 5-year investment that will carry through part of the Trump-Vance Administration.

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Eligibility & Enrollment: reduced funding for technical eligibility systems *(system maintenance, improvements, quality requirements)*		The White House and CMS can choose not to fund these investments, or to reduce funding compared to historic levels.	
Weakened Benefit Packages: fewer benefits, eliminated provider network requirements, added premiums, added co-pays		Regulations finalized by the Biden-Harris administration include requirements to ensure the adequacy of provider networks. CMS could choose not to implement such regulations or to rewrite them through new rule-making. CMS can approve state plan amendments from states seeking to reduce Medicaid expenditures by reducing benefits or adding cost-sharing such as premiums or copays.	Two relevant regulations that were finalized during the Biden-Harris Administration but have not yet been fully implemented include: (1) *Ensuring Access to Medicaid Services Final Rule*; *(2) Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule*. Additionally, if Congress chooses to overturn or the Administration chooses not to implement the provisions of the mental health parity rule that pertain to Medicaid managed care, benefits would be weakened as would access to care.
Privatization: Potential new state option to allow individuals to use Medicaid dollars to purchase coverage outside Medicaid.		CMS guidance could launch a new option followed by waiver approvals.	Project 2025 urges CMS to create an option for states to allow families to use Medicaid $ to purchase coverage outside Medicaid (see p.468).

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Medicaid Opportunities			
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Prohibiting spread pricing in Medicaid	Congress may prohibit spread pricing in Medicaid thus saving approximately $1 billion over 10 years. The change would be made as part of broader Congressional Pharmacy Benefit Manager (PBM) reform.		
340B	Congressional action on 340B could expand Medicaid patients' access to discounted drugs. The 340B statute is silent on critical issues that are central to critiques of the program – contract pharmacy arrangements, patient definition, child sites, and transparency reporting.	Sub-regulatory guidance issued by HRSA in prior years has offered agency interpretations on patient definition, contract pharmacy arrangements, and child sites. HRSA guidance has driven various legal actions taken by a range of 340B stakeholders.	Congressional action is likely to address the role of contract pharmacies, among other issues, and hopes to increase transparency to ensure savings are appropriately invested by hospitals. Codifying contract pharmacies in statute would likely require manufacturers to provide 340B discounts thus making additional rebates available to use towards uncompensated care. With Senator Thune as Majority Leader and Senator Cassidy – a longstanding critic of the 340B program – as Chair of the Senate HELP Committee, 340B is increasingly likely to be addressed by Congress.