Missouri Foundation for Health

Impact of Potential Federal Medicaid Changes on Missouri

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Prepared by

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Manatt 50-State Medicaid Financing Model

- Congressional Republicans are considering several policy options to **reduce federal Medicaid funding** as part of the budget reconciliation process.
- Manatt Health (Manatt) developed a financial model to **estimate 1-year and 10-year (2025-2034) expenditure and enrollment impacts across the 50 states** for different proposals under consideration.
- This slide deck:
  - Provides an **overview of proposals to reduce federal Medicaid funding under consideration** and a reminder of **key, relevant MO HealthNet program** details
  - Summarizes **estimated Missouri-level impacts** for key "pre-legislation" proposals based on the Manatt Medicaid Financing Model.

Congressional Proposals to Reduce Federal Medicaid Funding

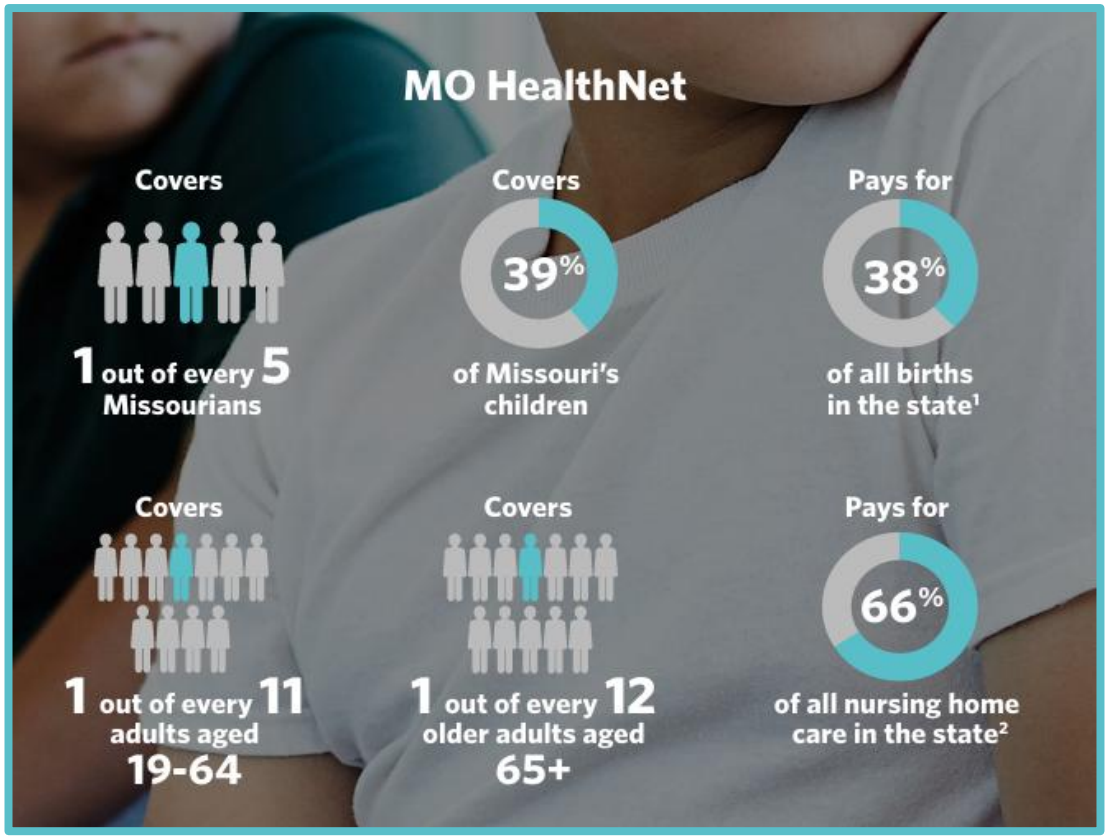
Leading proposals to reduce federal Medicaid funding would shift costs for Medicaid program enrollment, benefits and administration to states. Proposals relevant to Missouri included in the Manatt model include the following:

- **Reductions in the FMAP for expansion adults** from 90% FMAP to the state's regular FMAP
- **Structural changes to the Medicaid financing structure through a per capita cap financing structure** that would replace the guarantee to states of federal Medicaid matching funds
- **Curtailing or eliminating state directed payments (SDPs)** used by states to supplement payments to hospitals, boost essential providers, or promote delivery system reform
- **Further limiting use of provider taxes** as a source of non-federal share financing.
- **Establishing work reporting requirements**

Level Setting:
Missouri Medicaid (MO HealthNet)

Missouri Medicaid 101: Coverage

MO HealthNet provides health care coverage to over 1.25 million Missourians.



MO HealthNet is a critical source of coverage for rural Missourians:

- Nearly **two of every five children (38%)** covered by Medicaid live in rural areas
- More than **one of every 10 adults (15%)** covered by Medicaid live in rural areas
- More than **one of every 10 seniors (13%)** covered by Medicaid live in rural areas

Source: Missouri Medicaid Basics; Medicaid's Role in Small Towns and Rural Areas

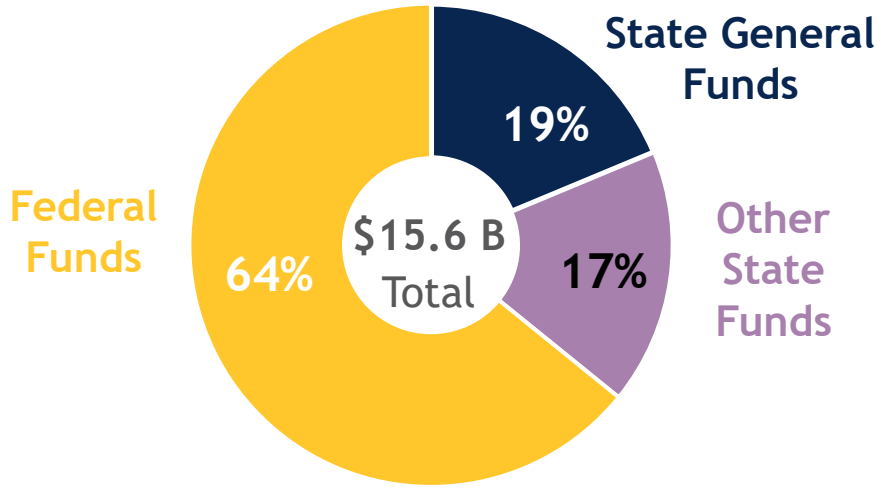
Missouri Medicaid 101:Financing

In 2023, Missouri spent $15.6B on MO HealthNet, nearly two-thirds of which was federal funds.

Medicaid accounts for approximately 23% of Missouri's state general fund spending and 62% of Missouri's federal fund spending.

The federal government reimburses Missouri at varying rates—or Federal Medical Assistance Percentages (FMAP)—depending upon the expenditure type and the population.

Missouri Medicaid Budget (FY 2023)



Missouri FMAP Rates (Fiscal Year 2026)

Expenditure Type (Selection)	Federal / State Split
Standard FMAP (services for most Medicaid enrollees)	Federal: 66%*
CHIP FMAP (services for low-to-moderate income children)	76%
Medicaid Expansion FMAP (services for expansion enrollees)	90%
Administrative Costs	50%

*During the COVID-19 public health emergency, Missouri received federal matching funds (+6.2%) for populations covered under its "regular" FMAP in exchange for maintaining continuous coverage for those enrolled as of March 18, 2020, or at any time during the period thereafter. The standard FMAP returned to pre-public health emergency levels in 2023.

Source: Missouri Medicaid Basics; NASBO

Missouri Medicaid 101: Medicaid Expansion

As of October 2024, nearly 340,000 adults have enrolled in the Adult Expansion Group after launching in October 2021.

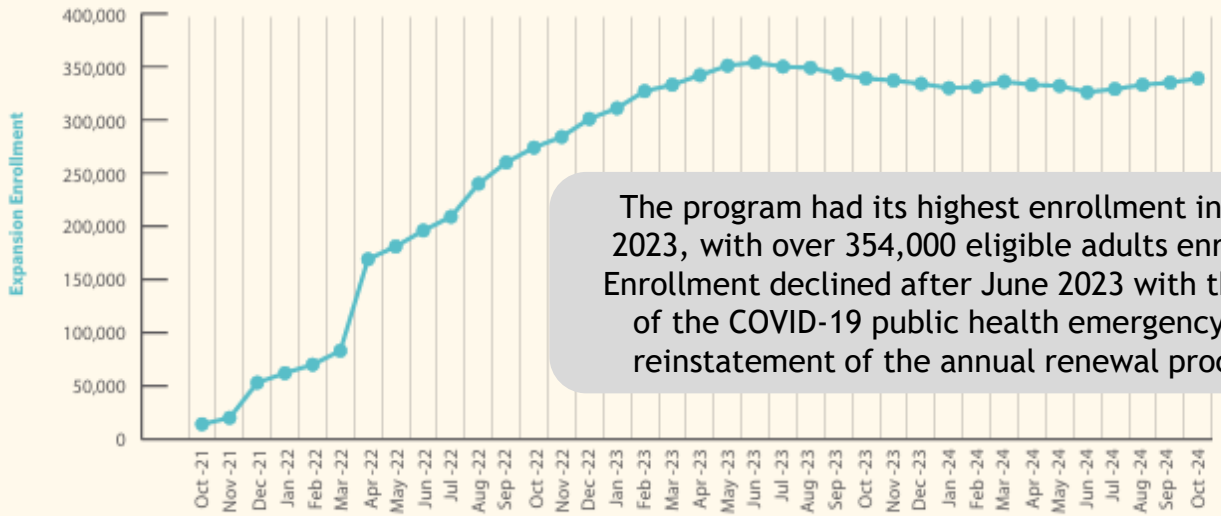
Medicaid Expansion 101

- The Affordable Care Act (ACA) permits states to expand Medicaid coverage to include nearly all adults under 65 with incomes up to 138% of the federal poverty level.
- The federal government covers 90% of the costs for adults in the Medicaid expansion group.
- To date, 40 states plus Washington, D.C. have adopted the expansion.

Missouri-Specific Context

- Missouri expanded Medicaid via constitutional amendment, as required by the ballot measure that passed in 2020.
- Since it is codified in Missouri's constitution, a statewide vote and an amendment to the constitution would be needed to eliminate Medicaid expansion.

Adult Expansion Group Enrollment (October 2021 - October 2024)



The program had its highest enrollment in June 2023, with over 354,000 eligible adults enrolled. Enrollment declined after June 2023 with the end of the COVID-19 public health emergency and reinstatement of the annual renewal process.

Source: Missouri Medicaid Basics; Federal Medicaid cuts could leave Missouri with huge budget shortfall • Missouri Independent

Implications of Potential Federal Medicaid Changes to Missouri Medicaid

More information on the methodology Manatt used to inform the following slides is available in the appendix.

Reduction to Expansion FMAP: Overview

Reductions in the federal match for the expansion population would lead to significant reductions in federal Medicaid funds available to Missouri.

Potential Federal Policy Change

- **Federal proposals could reduce the 90% federal match** for the Medicaid expansion population to the state's standard Medicaid match rate.

Missouri-Specific Context

- This change would reduce Missouri's Medicaid match rate for the expansion group to **66%**
- Missouri's constitution requires the state to provide Medicaid coverage to the expansion population.

Reduction to Expansion FMAP: State Response Options

The impact for MO HealthNet of a reduction to the expansion FMAP depends on how the state responds. Manatt's model includes two potential state responses:

A

Option A: Missouri Replaces Lost Federal Funds

In this option, the model assumes that Missouri would *increase state spending* to fully replace lost federal dollars in order to maintain the expansion group's eligibility and benefits at current levels.

B

Option B: Missouri Seeks a Constitutional Amendment to Eliminate Expansion Group

Alternatively, in this option the model assumes Missouri amends its constitution and eliminates coverage for expansion enrollees.

Reduction to Expansion FMAP: *1-Year* MO HealthNet Implications

State Response	Changes Over 1-Year Period (2026)*				Key Takeaway
	Medicaid Spending			Enrollment	
	Federal	State	TOTAL		
Option A: Missouri Fully Replaces Lost Federal Funding	-$995M	+$995M	-	-	Missouri would need to increase its own Medicaid spending by **$995 million** (20%) in FFY 2026 to maintain current levels of total Medicaid expansion expenditures and enrollment.
Option B: Missouri Seeks a Constitutional Amendment to Eliminate Expansion	-$3.5B	-$371M	-$3.8B	-338,000	Total Medicaid spending would decrease by **$3.8 billion** (23%) and enrollment would decline by 338,000 (27%) in FFY 2026 .

Notes:
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Reduction to Expansion FMAP: *10-Year* MO HealthNet Implications

State Response	Changes Over 10-Year Period (2025-2034)				Key Takeaway
	Medicaid Spending				
	Federal	State	TOTAL	Enrollment	
Option A: Missouri Fully Replaces Lost Federal Funding	-$11.2B	+$11.2B		-	Missouri would need to increase its own Medicaid spending by **$11.2 billion** (21%) over 10 years to maintain current levels of total Medicaid expansion expenditures and enrollment.
Option B: Missouri Seeks a Constitutional Amendment to Eliminate Expansion	-$38.9B	-$4.0B	-$42.9B	-347,000 *	Total Medicaid spending would decrease by **$42.9 billion** (24%) and enrollment would decline by 347,000 (27%) over 10 years.

Notes:
- Totals may not sum exactly due to rounding.
* Reflects first year of estimated implementation.

Per Capita Caps: Overview

The current federal Medicaid financing structure allows states to guarantee Medicaid coverage for all medically necessary health care expenses for all eligible individuals. Per capita caps would change that structure, shifting financial risk for Medicaid cost growth to Missouri.

Potential Federal Policy Change

- Congress could mandate or allow per capita caps to be applied to some or all Medicaid enrollees to limit federal funding to a fixed amount per enrollee (allows spending growth over time by a pre-set amount and adjusts for enrollment growth).

How does a per capita cap work?

- A per capita cap does not institute a cap on what Medicaid can actually expend per individual enrollee.
- A per capita cap establishes a methodology that calculates a cap on available federal Medicaid funding based on the program's number and type of enrollees.

Per Capita Caps: State Response Options

The impact of a per capita cap for MO HealthNet depends on how the state responds. Manatt's model includes three potential state responses:

A

Option A: Missouri Only Spends State Dollars that are Matched by Federal Dollars

In this option, the model assumes that Missouri would *spend only state dollars that can be matched by federal funding*.

B

Option B: Missouri Maintains Prior State Funding Levels Regardless of Federal Match

In this option, the model assumes that Missouri would *maintain prior levels of state spending*, regardless of whether federal matching dollars were available.

C

Option C: Missouri Fully Replaces Lost Federal Funding

In this option, the model assumes that Missouri would *increase state spending* to fully replace lost federal dollars to maintain program eligibility and benefits at current levels.

Per Capita Caps *(All Enrollees): 1-Year* MO HealthNet Impact

State Response	Changes Over 1-Year Period (2028)*			Key Takeaway
	Federal	State	TOTAL	
Option A: Missouri Only Spends State Dollars that are Matched by Federal Dollars	-$1.6B	-$562M	-$2.1B	Total Medicaid spending would decrease by **$2.1 billion** (12%).
Option B: Missouri Maintains Prior State Funding Levels Regardless of Federal Match	-$1.6B	-	-$1.6B	Total Medicaid spending would decrease by **$1.5 billion** (9%).
Option C: Missouri Fully Replaces Lost Federal Funding	-$1.6B	+$1.6B	-	Missouri would need to increase its own Medicaid spending by **$1.5 billion**--an increase of 29%--to maintain existing total Medicaid spending levels.

Notes:
- See appendix for additional details on per capita cap modeling assumptions
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Per Capita Caps *(All Enrollees): 10-year* MO HealthNet Impact

State Response	Change in Medicaid Spending Over 10-Year Period (2024-2035)			Key Takeaway
	Federal	State	TOTAL	
Option A: Missouri Only Spends State Dollars that are Matched by Federal Dollars	-$15.0B	-$5.2B	-$20.3B	Total Medicaid spending would decrease by **$20.3 billion** (14%).
Option B: Missouri Maintains Prior State Funding Levels Regardless of Federal Match	-$15.0B	-	-$15.0B	Total Medicaid spending would decrease by **$15.0 billion** (10%).
Option C: Missouri Fully Replaces Lost Federal Funding	-$15.0B	+$15.0B	-	Missouri would need to increase its own Medicaid spending by **$15.0 billion**--an increase of 36%--to maintain existing total Medicaid spending levels.

Notes:
- See appendix for additional details on per capita cap modeling assumptions
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Per Capita Caps *(Expansion Enrollees): 1-Year* MO HealthNet Impact

State Response	Changes Over 1-Year Period (2028)*			Key Takeaway
	Federal	State	TOTAL	
Option A: Missouri Only Spends State Dollars that are Matched by Federal Dollars	-$666M	-$74M	-$740M	Total Medicaid spending would decrease by **$740 million** – representing a 4.1% decrease in total spending and a 17% decease in spending on the expansion group.
Option B: Missouri Maintains Prior State Funding Levels Regardless of Federal Match	-$666M	-	-$666M	Total Medicaid spending would decrease by **$666 million** – representing a 3.7% decrease in total Medicaid spending overall and a 15% decrease in spending on the expansion group.
Option C: Missouri Fully Replaces Lost Federal Funding	-$666M	+$666M	-	Missouri would need to increase its own Medicaid spending by **$666 million** to maintain existing total Medicaid spending levels—representing a 13% increase in state Medicaid spending overall and a 151% increase in state spending on the expansion population.

Notes:
- See appendix for additional details on per capita cap modeling assumptions
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Per Capita Caps *(Expansion Enrollees): 10-Year* MO HealthNet Impact

State Response	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	TOTAL	
Option A: Missouri Only Spends State Dollars that are Matched by Federal Dollars	-$7.0B	-$781M	-$7.8B	Total Medicaid spending would decrease by **$7.8 billion**—representing a 5% decrease in total Medicaid spending and a 22% decrease in spending on the expansion group.
Option B: Missouri Maintains Prior State Funding Levels Regardless of Federal Match	-$7.0B	-	-$7.0B	Total Medicaid spending would decrease by **$7.0 billion**—representing a 5% decrease in total Medicaid spending overall and a 20% decrease in spending on the expansion group.
Option C: Missouri Fully Replaces Lost Federal Funding	-$7.0B	+$7.0B	-	Missouri would need to increase its own Medicaid spending by **$7.0 billion** to maintain existing total Medicaid spending levels—representing a 17% increase in state Medicaid spending overall and a 196% increase in state spending on the expansion population.

Notes:
- See appendix for additional details on per capita cap modeling assumptions
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

State Directed Payment (SDP) Changes: Overview & Policy Scenario

SDPs are an important mechanism for funding health care providers that care for Medicaid enrollees. With CMS approval, states can direct managed care organizations to make specific payments to providers under certain conditions or guidelines.

Potential Federal Policy Change

- **Federal proposals could curtail or eliminate SDPs** used by states to supplement payments to hospitals, boost essential providers, or promote delivery system reform
- States are permitted to use SDPs to pay providers at rates up to the "average commercial rate", which is the rate commercial payers would typically negotiate for the same service

Missouri-Specific Context

- In 2024, Missouri's SDPs, which include base hospital payments, **totaled approximately $2.8 billion.**
  - Manatt's model estimates that approximately **$660 million of this represents payments in excess of Medicaid base payments.**

Policy Scenario: Manatt's model includes a proposal to reduce the current levels of SDPs to Medicare-equivalent rates

State Directed Payments: MO HealthNet Impact

Policy Scenario	Changes Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	TOTAL	
Reduce current levels of SDPs to Medicare-equivalent rates	-$87M	-$34M	-$121M	Reducing hospital SDPs from current levels to Medicare-equivalent rates would decrease **federal** Medicaid funding for Missouri hospitals by **$87 million** in FFY 2026(3% decline compared to the expected federal Medicaid hospital funding in Missouri under current law)

State Response	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	TOTAL	
Reduce current levels of SDPs to Medicare-equivalent rates	-$952M	-$362M	-$1.3B	Reducing hospital SDPs from current levels to Medicare-equivalent rates would decrease **federal** Medicaid funding for Missouri hospitals by **$952 million** over ten years (3% decline compared to expected federal Medicaid hospital funding in Missouri under current law).

Notes:
- Totals may not sum exactly due to rounding.
* Reflects first year of estimated implementation.

Medicaid Provider Tax Changes: Overview

States levy taxes on a variety of provider types (e.g., hospitals, nursing facilities, managed care plans) to help finance the state cost of the Medicaid program; these are typically set as a percentage of all payor revenues or costs. Under federal rules, taxes generally may not exceed 6% of net patient revenues for the class of providers subject to the tax.

Potential Federal Policy Change

- **Federal proposals could reduce the federal cap on provider taxes,** limiting revenues states use to fund a portion of the non-federal share of Medicaid expenditures.

Missouri-Specific Context

- Missouri's provider taxes on hospitals, nursing facilities, pharmacies, and ambulances generates approximately $4 billion in revenue annually.*
- Hospital taxes in Missouri generated $1.2 billion in 2024. These taxes are equal to about 4.8% of net patient revenues.

*Source: St. Louis Public Radio

Medicaid Provider Tax Changes: Scenarios

The loss of federal revenue that MO HealthNet would experience depends on the size of the reduction to the provider tax limit. Manatt's model estimates the impact on Missouri's hospital taxes across four scenarios:

A

Scenario A: Reduction of Provider Tax Limit to 5%

B

Scenario B: Reduction of Provider Tax Limit to 4%

C

Scenario C: Reduction of Provider Tax Limit to 3%

D

Scenario D: Reduction of Provider Tax Limit to 2.5%

Medicaid Provider Tax Changes: *1-Year* MO HealthNet Implications

Scenario	Changes Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	TOTAL	
Scenario A: Reduction of Provider Tax Limit to 5%	-	-	-	Would not decrease federal Medicaid spending
Scenario B: Reduction of Provider Tax Limit to 4%	-$629M	-$243M	-$872M	Would decrease federal funding for Missouri Medicaid by **$629 million** overall (5% compared to expected federal Medicaid funding under current law).
Scenario C: Reduction of Provider Tax Limit to 3%	-$1.4B	-$547M	-$2.0B	Would decrease federal funding for Missouri Medicaid by **$1.4 billion** overall (12% compared to expected federal Medicaid funding under current law).
Scenario D: Reduction of Provider Tax Limit to 2.5%	-$1.8B	-$699M	-$2.5B	Would decrease federal funding for Missouri Medicaid by **$1.8 billion** overall (16% compared to expected federal Medicaid funding under current law).

Notes:
- These impacts only consider provider taxes collected from hospitals and Medicaid spending on hospitals.
- Key takeaways focus on the *federal* impact—i.e., the funds that hospitals lose. The reductions in state share reflect dollars not being collected through the provider tax on hospitals.
- Percentage impacts may be overstated by a small amount since the Manatt Medicaid Financing Model excludes Disproportionate Share Hospital (DSH) payments from the model baseline (i.e., if DSH were included in the baseline, the percentage impacts would be somewhat lower). This does not impact the dollar projections.
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Medicaid Provider Tax Changes: *10-Year* MO HealthNet Implications

Scenario	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	TOTAL	
Scenario A: Reduction of Provider Tax Limit to 5%	-	-	-	Would not decrease federal Medicaid spending
Scenario B: Reduction of Provider Tax Limit to 4%	-$6.8B	-$2.6B	-$9.5B	Would decrease federal funding for Missouri Medicaid by **$6.8 billion** overall (5% compared to expected federal Medicaid funding under current law).
Scenario C: Reduction of Provider Tax Limit to 3%	-$15.4B	-$5.9B	-$21.3B	Would decrease federal funding for Missouri Medicaid by **$15.4 billion** overall (12% compared to expected federal Medicaid funding under current law).
Scenario D: Reduction of Provider Tax Limit to 2.5%	-$19.7B	-$7.5	-$27.2B	Would decrease federal funding for Missouri Medicaid by **$19.7 billion** overall (16% compared to expected federal Medicaid funding under current law).

Notes:
- These impacts only consider provider taxes collected from hospitals and Medicaid spending on hospitals.
- Key takeaways focus on the *federal* impact—i.e., the funds that hospitals lose. The reductions in state share reflect dollars not being collected through the provider tax on hospitals.
- Percentage impacts may be overstated by a small amount since the Manatt Medicaid Financing Model excludes Disproportionate Share Hospital (DSH) payments from the model baseline (i.e., if DSH were included in the baseline, the percentage impacts would be somewhat lower). This does not impact the dollar projections.
- Totals may not sum exactly due to rounding.

Medicaid Work Reporting Requirements: Overview

Under the first Trump administration, CMS approved thirteen states' Medicaid waivers that conditioned Medicaid coverage for working-age adults (under 65) on meeting work reporting requirements; work reporting requirements are again gaining traction.

Potential Federal Policy Change

- **Federal proposals could mandate work reporting requirements**, whereby Medicaid eligibility for low-income adults (under 65) is conditioned on compliance.
  - House and Senate Republicans have recently introduced legislation to impose work reporting requirements in Medicaid (i.e., H.R. 1059, H.R. 1452, and S. 447).

Missouri-Specific Context

- Missouri Republicans have pushed for Medicaid work requirements repeatedly over the years. In February 2025, Republicans proposed a constitutional amendment that would impose work reporting requirements on Medicaid recipients.
- Missouri's constitution currently states that "no greater or additional burdens or restrictions on eligibility or enrollment standards, methodologies, or practices" can be placed on the expansion group.

Medicaid Work Reporting Requirements: Scenarios

The impact for MO HealthNet of implementing mandatory work reporting requirements depends at a minimum on how many adults the work requirements apply to. Manatt's model estimates the impact on Missouri's Medicaid enrollment and expenditures across two scenarios:

A

Scenario A: Work Requirements Apply Only to Expansion Adults Ages 19-55

B

Scenario B: Work Requirements Apply Only to Expansion Adults and Other Adults Ages 18-65

Medicaid Work Reporting Requirements: *1-Year* MO HealthNet Implications

Scenario	Change in Enrollment	Changes Over 1-Year Period (2026)**			Key Takeaway
		Federal	State	TOTAL	
Scenario A: Work Requirements Apply Only to Expansion Adults Ages 19-55	-84,000 to -119,000	-$873M to -$1.2B	-$104M to -$149M	-$978M to -$1.4B	Total Medicaid enrollment would decline by **7%-9%** and total Medicaid spending would decline by **6%-8%.**
Scenario B: Work Requirements Apply to Expansion Adults and Other Adults Ages 18-65*	-136,000 to -194,000	-$1.2B to -$1.8B	-$240M to -$342M	-$1.5B to -$2.1B	Total Medicaid enrollment would decline by **11%-15%** and total Medicaid spending would decline by **9%-13%.**

Notes:

- The bottom of each range reflects the model's lower coverage loss scenario, which assumes Missouri uses IT solutions to automatically exempt or determine compliant 60% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 72% would lose coverage. These figures reflect Arkansas' experience implementing work requirements.
- The top of each range reflects the model's higher coverage loss scenario, which assumes Missouri uses IT solutions to automatically exempt or determine compliant 50% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 82% would lose coverage. These figures reflect New Hampshire's experience implementing work requirements.
- Totals may not sum exactly due to rounding.

* Includes non-elderly, non-disabled adults not enrolled through the expansion group (i.e., parents).

** Reflects first year of estimated implementation

Medicaid Work Reporting Requirements: *10-Year* MO HealthNet Implications

Scenario	Change in Enrollment	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
		Federal	State	TOTAL	
Scenario A: Work Requirements Apply Only to Expansion Adults Ages 19-55	**-86,000 to -123,000**	**-$9.8B to -$14.0B**	**-$1.2B to -$1.7B**	**-$11.0B to -$15.7B**	Total Medicaid enrollment would decline by **7%-9%** and total Medicaid spending would decline by **6%-9%.**
Scenario B: Work Requirements Apply to Expansion Adults and Other Adults Ages 18-65*	**-140,000 to -199,000**	**-$13.9B to -$19.7B**	**-$2.6B to -$3.7B**	**-$16.5B to -$23.5B**	Total Medicaid enrollment would decline by **11%-15%** and total Medicaid spending would decline by **9%-13%**

Notes:

- The bottom of each range reflects the model's low coverage loss scenario, which assumes Missouri uses IT solutions to automatically exempt or determine compliant 60% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 72% would lose coverage. These figures reflect Arkansas' experience implementing work requirements.
- The top of each range reflects the model's high coverage loss scenario, which assumes Missouri uses IT solutions to automatically exempt or determine compliant 50% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 82% would lose coverage. These figures reflect New Hampshire's experience implementing work requirements.
- 10-year enrollment figures represent the estimated decline in average annual enrollment from 2026 - 2034.
- Totals may not sum exactly due to rounding.

* Includes non-elderly, non-disabled adults not enrolled through the expansion group (i.e., parents).

Appendix

Sources for Estimated Impact of Federal Medicaid Policies

The estimated impacts in this presentation were generated by the Manatt Medicaid Financing Model, which uses publicly available data to establish a baseline of expenditures and enrollment projections for leading Congressional proposals to reduce Medicaid funding.

- Expenditure and enrollment estimates consider impact during the 10-year (Federal Fiscal Years (FFYs) 2025-2034) budget window and assume the same policy parameters as the Congressional Budget Office (CBO).*
- Enrollment estimates:
  - Include (1) non-elderly, non-disabled adults, including parents/caretaker relatives and pregnant women, and (2) enrollees reported in T-MSIS as receiving coverage of only emergency services, family planning services, COVID-19 diagnostic products or testing-related services, or assistance with Medicare premiums and cost sharing.
  - Exclude children enrolled in Medicaid expansion CHIP coverage

*To align with CBO estimates, the model assumes that the expansion FMAP proposal takes effect in FFY 2026 and that the per capita cap proposal takes effect in FFY 2028. CBO assumes per capita caps would be established using a FFY 2024 spending baseline and would take effect at the start of FFY 2028. Caps would be trended forward based on the Consumer Price Index for All Urban Consumers (CPI-U). If Congress chooses a per capita cap model that diverges from CBO's parameters (e.g., choosing a different base year or trend rate), estimates would differ.

Manatt Health Modeling Data Sources

Manatt Health is using a range of data sources to inform its modeling:

- Medicaid financial management report (FMR) data, collected from "CMS-64" reports that provides information on aggregate Medicaid spending by state, currently available through FY 2023.
- Quarterly Medicaid enrollment and expenditure data for Medicaid expansion enrollees collected through the Medicaid Budget and Expenditure System (MBES), available through December 31st, 2023.
- Enrollment by eligibility group from FFY 2023 Transformed Medicaid Statistical Information System (T-MSIS) data.
- Tabulations from the Medicaid and CHIP Payment and Access Commission (MACPAC) of FFY 2022 T-MSIS data on per capita expenditures by eligibility group.
- SDP preprint data published by CMS.
- Enrollment and expenditure growth projections from the Congressional Budget Office (CBO).
- State-specific data derived from state web sites and/or discussions with state Medicaid and budget officials when there are gaps in otherwise publicly-available data.