Lucile Packard Foundation
Children's Health

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No Place to Hide: Children Will Be Hurt by Medicaid Cuts

Executive Summary

Two in five children nationwide rely on Medicaid for their health care needs. That includes eight in ten children in poverty and nearly half of all children and youth with special health care needs (CYSHCN).[1,2,3] Given the extraordinary role Medicaid plays for children, federal law ensures access to comprehensive pediatric health services—including preventive, diagnostic, and treatment care—to all Medicaid-enrolled children and youth.[4] Extensive research shows that Medicaid coverage contributes significantly to better health outcomes and positive, long-term effects on children's health, educational attainment, and lifelong well-being.[5]

Medicaid Covers

- 42% of all children nationwide[37]
- 77% of children living in poverty in the U.S.[38]
- 44% of children and youth with special health care needs nationwide[39]
- 41% of births in the U.S.[40]
- 37% of U.S. children with cancer[41]
- 99% of children and youth in foster care[42]

That coverage and the assurance of comprehensive care for children is at risk. Congress is actively considering large reductions in Medicaid funding through a "fast track" budget process known as reconciliation.[6] The reconciliation budget—the first formal step in the reconciliation process—was adopted by Congress in April and includes instructions for the House of Representatives to draft legislative proposals that produce at least $880 billion in federal savings that are expected to come largely from changes to Medicaid.[7] While the Senate has not targeted deep cuts in Medicaid, the final reconciliation bill will include the extension of tax cuts that would otherwise expire at the end of 2025, putting pressure on Congress to agree on large federal spending cuts to reduce the extent to which the tax cuts increase the federal deficit. Medicaid is in the crosshairs.

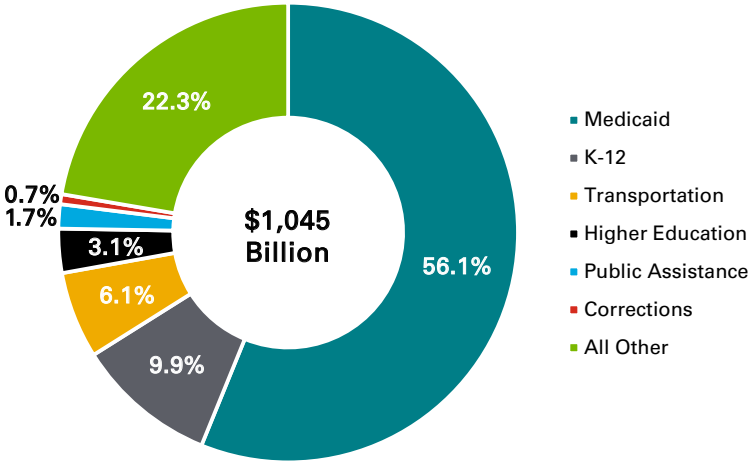
While not explicitly aimed at children, proposals that would deeply cut federal Medicaid funding and make changes to parents' eligibility will inevitably put children's coverage and their health and well-being at risk. Medicaid is by far the single largest source of federal revenue for states, so significant cuts to federal Medicaid funding will result in large funding holes for states (see Exhibit 1).[8] Given the breadth of the proposed cuts and the number of children and

youth enrolled in Medicaid, it will be impossible for states to protect children from funding cuts. Cuts to the Medicaid program could terminate health care for hundreds of thousands of children and force states to make difficult decisions that will result in reduced access to critical services children need to stay healthy and thrive.

Manatt Health's Medicaid Financing Model developed national and state-by-state estimates of the spending reductions and, where possible, enrollment impacts. Since Congress has not yet developed legislative language for the proposals under consideration, these estimates rely on previously filed bills and options developed by the Congressional Budget Office (CBO) for the basic parameters of each proposal. In some cases, where sufficient public data is not available to develop estimates, CBO national estimates are provided.

Exhibit 1: Federal Funds Expenditures by States, by Function (Fiscal Year (FY) 2024)[43]

Medicaid is the Largest Source of Federal Funding Received by States



Congressional Proposals Will Reduce Federal Medicaid Expenditures and Impact Children's Access and Care

These proposals under consideration by Congress would result in deep cuts in federal Medicaid funding:

Restricting States' Use of Provider Taxes to Finance a Portion of the Medicaid State Share

While all states rely primarily on state general funds to pay their share of the cost of Medicaid, every state but one uses at least one provider tax to finance a portion of their program costs.[9] Even with the assumption that states would replace half the revenues raised through provider taxes with other state funding, CBO estimates that a reduction of provider taxes would reduce federal Medicaid funding to states by between $48 billion and $248 billion over the next ten years (2025–2034), depending on the level of the reduction.[10,11,12]

Restricting Medicaid State Directed Payments (SDPs)

In many states, Medicaid reimbursement rates to providers do not cover the cost of care. States utilize SDPs to help mitigate these payment gaps by directing managed care plans to boost provider payments to strengthen access to and quality of care. The growth in these payments amount to $110.2 billion annually.[13,14] Hospitals receive most of these payments, and since the payments are tied to the provision of Medicaid services to Medicaid beneficiaries, high volume Medicaid providers, such as children's hospitals, benefit significantly from these payments.

Mandating Per Capita Caps

The current Medicaid financing structure requires the federal government to share the cost of all Medicaid services. There is no cap on federal funding so that when costs go up, the federal government assumes its share of the new costs. Per capita caps would undo this critical financing guarantee, placing pre-set limits on the amount of federal funding at levels designed to produce federal savings. The caps would be calculated per enrollee for enrollees in specified eligibility groups, and states are at risk if the cost of providing care to enrollees exceeds the caps. If per capita caps are applied to the entire Medicaid population, federal funding would drop by $838 billion over ten years,

equating to 15% of the federal funding states are projected to otherwise receive.[15] If per capita caps are applied to just the expansion population, federal funding would drop by more than $408 billion over ten years, equating to 22% of the federal funding states are projected to otherwise receive for the expansion group (which includes parents).[16]

Any one of these three proposals will result in deep reductions in Medicaid funding at the state level and will impact children's access and care. To accommodate the cuts in Medicaid funding, states would have little choice but to take all or some of the following actions: reduce provider reimbursement, lower eligibility, and reduce the scope of benefits and availability of services. Given the size of the proposed cuts and how large child enrollment is in every state, it will be impossible to protect children from harm.

Reducing rates paid to providers—either as a result of reductions in allowable SDPs or other Medicaid financing changes—will impede access to care for children. Cuts to Medicaid reimbursement could exacerbate access challenges to pediatric sub-specialists, including developmental-behavioral pediatrics and adolescent psychiatry. High volume-Medicaid providers, such as children's hospitals which derive 55% of their revenue from Medicaid, will be hit hard.[17]

Reducing Medicaid income eligibility levels for children will result in an increase in the number of uninsured or underinsured children. Under federal law, states must cover children with income up to 138% of the federal poverty level (FPL), but many states cover children at higher income levels, especially for young children.[18] A provision established under the Affordable Care Act (ACA) prohibits states from reducing eligibility levels below what was in place in 2010, but that provision expires in September 2027. Unless the provision is extended, states could look to reduce Medicaid income eligibility levels to the mandatory minimum level of 138% of the FPL for all children, causing many to become uninsured, with some securing coverage that will be more costly with less comprehensive benefits.

Reducing slots or benefits in 1915(c) home- and community-based services waivers would restrict CYSHCN's access to critical services, such as home health care, home modifications, and adaptive equipment. Home- and community-based services allow children with complex medical needs to remain safely in their home rather than having to be institutionalized, but these waiver services are optional. Therefore, as a cost-cutting effort, states may drop these services or limit their scope by the number of enrollees served or the amount of funds allocated to the waivers. For example, when faced with a significant loss of federal Medicaid funding, all 50 states and Washington, D.C., reduced spending on one or more Medicaid HCBS programs between 2010 and 2012 by limiting or cutting benefits or reducing enrollment.[19]

Tightening prior authorization requirements for pediatric services could result in reduced access to needed services. States can impose a "soft" limit on the amount of a specific service a child can receive and require prior authorization for services above those limits. Prior authorizations, which are typically applied to the most costly services, are known to depress the use of needed services and delay access to care.[20]

Implementing per capita caps would constrain states' ability to provide comprehensive care and could force states to reduce eligibility or make it harder for children to access care. Regardless of the extent to which children are included in the caps, children will be impacted. To avoid incurring costs above the cap, states would likely look to reduce coverage or care for the most costly individuals; children with medical complexity represent only 6% of all children enrolled in Medicaid but account for approximately 40% of Medicaid pediatric expenditures.[21]

Reducing Medicaid funding for children served in schools would limit services and squeeze school district budgets, of which Medicaid is the fourth largest federal funding source.[22] With less Medicaid funding flowing to schools, school districts will need to find new funding to replace lost revenue for services that schools are required by education laws to provide and for other services provided to all students, such as hearing screenings.

Congressional Proposals Will Result in Coverage Losses for Parents and Children

Congress is considering two proposals that, in addition to cutting federal funding, would result in significant parent and child coverage losses.

Reducing the Federal Match for Medicaid Expansion

The ACA established an enhanced federal matching rate of 90% for state Medicaid programs to ease the financial burden of the Medicaid expansion. Forty-one states, including Washington, D.C., expanded Medicaid to cover low-income parents as well as adults without children.[23] Congress is considering eliminating (or perhaps lowering) the enhanced federal matching rate for the Medicaid expansion population. Ending this funding would put the match for this optional population at the standard Medicaid matching rate, which varies by state and ranges from 50% to 77%.[24]

Medicaid expansion states would lose $836 billion of their federal funding for this group over the next ten years.[25] This would range from an 18% federal expansion group funding cut in West Virginia, to a 44% cut in federal expansion group funding across nine states, with the variation driven by differences in the state's regular match rate. States that are not able to replace the lost funding, or which have "trigger laws" that end the expansion in the event that the 90% match rate is repealed, would drop the expansion group. If all states eliminated their expansion groups, nationwide average annual enrollment would decline by 22 million (32% of enrollment in expansion states) compared to current law projections.[26,27,28]

Because parent coverage is closely tied to their children's coverage, annual child enrollment in expansion states could drop by an estimated 773,000 children (about 3.4% of all Medicaid enrolled children in expansion states).[29,30]

Mandating Work Reporting Requirements

Congress is considering mandating work reporting requirements, either for all "able bodied adults" or for those in the expansion group. Medicaid eligibility for adults would be conditioned on having a job or being engaged in other qualifying activities for a minimum number of hours per month (many proposals require 80 hours/month). Exemptions would likely be permitted. Both exempt and non-exempt people would need to regularly "report" (via paperwork or online) their status in order to show compliance, or establish or maintain their exemption. The degree to which an exemption or determination of compliance could be automated and whether the state has the systems-capacity and resources to do so would drive the extent to which coverage losses ensue. Under a proposal where work requirements include adults eligible for Medicaid through non-disability pathways ages 18 to 65, average annual coverage loss projections over ten years are as follows:[31]

In a scenario where states **do not (or minimally) automate administration** of work requirements, approximately **31 million individuals** would lose coverage, including approximately **1.5 million children**.	In a scenario where states **somewhat automate administration** of work requirements, approximately **14 million individuals** would lose coverage, including approximately **714,000 children**.	In a scenario where states make **greater use of automation** in administering work requirements, approximately **10 million people** would lose coverage, including approximately **502,000 children**.

Loss of coverage and gaps in coverage are particularly problematic for children, as interrupted coverage leads to missed well-child visits and delayed diagnosis and treatment. CYSHCN are particularly at risk. Children's coverage loss will also result, more broadly, in poorer child well-being. Medicaid enrollment is associated with reductions in school absenteeism and dropout rates, a decrease in the number of cases of reported child neglect, improvements in young children's mental health, and improved family financial stability.[32,33,34,35,36] When parents lose coverage, they are more likely to skip care or incur medical debt, leading to poorer parental health and greater financial instability for families, affecting parents' ability to work and to care for their children.

Conclusion

As the source of health coverage for over two in five children and nearly half of all children with special health care needs, Medicaid has enabled millions of children to receive preventive care, early treatment, behavioral health services, school-based health services, and long-term services and supports that set them up for lifelong success. The deep cuts that Congress is considering, along with changes in eligibility for parents, would terminate or reduce Medicaid coverage for hundreds of thousands of children and force states to limit access to critical pediatric services including long-term services and supports. Most members of Congress agree that it is vital to protect and strengthen children's access to coverage and care, but given the important role that Medicaid plays for the nation's children and families, children will inevitably be deeply hurt if Congress slashes funding for the Medicaid program.

To read the full *No Place to Hide: Children Will be Hurt by Medicaid Cuts* report, including 50-state estimates for each proposal on funding cuts to states and the expected coverage losses for children and parents, where applicable, click here.

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About the Lucile Packard Foundation for Children's Health

Support for this work was provided by the Lucile Packard Foundation for Children's Health. The Foundation is here to unlock philanthropy to transform health for all kids and moms, in Northern California and around the world. We are champions for children—driving extraordinary care for families today, while fueling research, discovery, and change in our health care systems for a better tomorrow. The views presented here are those of the authors and not necessarily those of the Foundation or its staff. Learn more at: LPFCH.org/CYSHCN.

About Manatt Health

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Cindy Mann
Partner
Manatt Health
cmann
@manatt.com

Kinda Serafi
Partner
Manatt Health
kserafi
@manatt.com

Jennifer Eder
Director
Manatt Health
jeder
@manatt.com

Emily C. Polk
Senior Manager
Manatt Health
epolk
@manatt.com

Madeleine Toups Tranchina
Senior Manager
Manatt Health
mtoupstranchina
@manatt.com

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27. Manatt Health, *Medicaid Financing Model* (April 2025). Percentage impacts relative to baseline are calculated based on projected baseline expenditures and enrollment for the 41 current Medicaid expansion states only.

28. States with a constitutional provision that requires states to participate in Medicaid expansion—South Dakota, Missouri, and Oklahoma—would not be able to drop the expansion without an amendment to their constitution.

29. A robust body of research demonstrates that changes in parental coverage rates reliably impact children's rates of coverage. 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 or implement work requirements, we assume the effect would occur in reverse, with five children losing coverage for every 100 expansion adults disenrolled.

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