United Methodist HealthMinistryFund

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Impact of Potential Federal Medicaid Changes on Kansas

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Manatt Health Model

- **Manatt evaluated the impact in Kansas of "pre-legislative" policy proposals under consideration in Congress,** aligning the policy parameters with recent federal bills and options developed by the Congressional Budget Office (CBO).
- Manatt's **50-state model is built "from the bottom up"** relying on publicly available state data and hospital data from the Kansas Hospital Association and informed by CBO's projections of enrollment / costs over time.
- Estimates will be **updated and interactions considered when there is legislative language.**
- See appendix for **data sources.**

Medicaid Provider Tax Reductions: Impact Based on Current Tax

For more information on Manatt's model and potential state responses and associated impacts, see appendix

If Kansas did not replace its lost revenue, reducing the provider tax limit to 2.5% would cut federal funding for KanCare by:

↓ **$60 million** ***(in one year)****

↓ **$636 million** ***(over ten years)***

Kansas' Medicaid state funds would decrease by		Kansas' total Medicaid funding would decrease by
$39 million *(in one year)**	**AND**	**$98 million** *(in one year)**
$413 million *(over ten years)*	**AND**	**$1.1 billion** *(over ten years)*

The projected loss in federal funding in one year is nearly comparable to all KanCare spending on dental services in FY 2023 ($76 million).

* Reflects first year of estimated implementation in 2026

Source: KHI Medicaid Primer 2024

SDP Reductions: Impact on Hospitals Based on Current SDP

For more information on Manatt's model and potential state responses and associated impacts, see appendix

If Kansas did not replace its lost revenue, limiting SDPs from current levels to Medicare-equivalent rates would cut federal funding for Kansas hospitals by:

↓ **$209 million** ***(in one year)****

↓ **$ 2.2 billion** ***(over ten years)***

 State Medicaid funds for hospitals would decrease by		 Total Medicaid funding for hospitals would decrease by
$135 million ***(in one year)****	**AND**	**$344 million** ***(in one year)****
$1.4 billion ***(over ten years)***	**AND**	**$3.7 billion** ***(over ten years)***

The projected loss in federal funding in one year is nearly twice the amount of all KanCare spending on hospital outpatient services in FY 2023 ($107 million).

* Reflects first year of estimated implementation in 2026
Source: KHI Medicaid Primer 2024

Provider Tax and SDP Reductions: Impact on State Revenue Increases

If Congressional proposals to reduce provider taxes and SDPs are enacted, Kansas would lose some and perhaps all of the revenue and federal match expected from the new tax and SDP.

- Kansas is expected to receive **double the federal funding** under its new 6% provider tax on hospital inpatient and outpatient services.
- Reducing provider taxes to 5%, 4% and 3% are not applicable under Kansas' current 3% provider tax on hospitals. Any of these scenarios would **force the state to forgo the additional revenue from the increased provider tax and SDP** already approved by the legislature.

The increased provider tax passed by the Kansas legislature is expected to bring in an additional:

↑ **$180 million**
in annual revenue

↑ **$315 million**
in federal aid annually, when invested in Medicaid

Source: Kansas Reflector, House Passes Budget; Kansas Division of Budget; HB 2250

Medicaid Work Reporting Requirements: Impact

For more information on Manatt's model and potential state responses and associated impacts, see appendix

Implementing work requirements on non-elderly and non-disabled adults would cut federal funding for KanCare by:

↓ **$111 to 192 million**

(in one year)*

↓ **$1.2 to 3.6 billion**

(over ten years)

Thousands of Kansans will have their coverage terminated

18,600 to 56,600
people will lose coverage**

Including

900 to 2,800
Children****

The highest projected loss in enrollment is comparable to all Kansans with disabilities enrolled in KanCare in FY 2023 (61,000). The highest projected loss in federal funding in one year is in the ballpark of all KanCare costs of running the Medicaid program in FY 2022 ($250 million).

- The bottom of each range reflects the model's more automation scenario, which assumes Kansas automatically exempts or determines 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 minimal automation scenario, which assumes Kansas does not automatically exempt or determine compliant adults from work reporting requirements. We assume that 92% of those subject to work requirements would lose coverage. These figures reflect Georgia's experience implementing work requirements. Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation in 2026.
**Enrollment figures reflect average annual enrollment declines from FY2026-2034.
***Research shows that coverage losses for parents lead to coverage losses for children. See: Health Affairs, Medicaid Work Requirements in Arkansas
Source: KHI Medicaid Primer 2024

Per Capita Cap: Impacts

For more information on Manatt's model and potential state responses and associated impacts, see appendix

A per capita cap would cut federal funding for KanCare by:

↓ **$347 million**
(in one year)*

↓ **$3.2 billion**
(over ten years)

Kansas could respond by spending only state dollars matched by federal dollars, leading to a decrease in total Medicaid funding of:

$573 million
(in one year)*

$5.2 billion
(over ten years)

The projected loss in federal funding in one year is more than half the amount of all KanCare payments to physicians, mid-level practitioners, and clinics in FY 2023 ($627 million).

* Reflects first year of estimated implementation in 2028
Source: KHI Medicaid Primer 2024

What’s at Stake for Kansas?

Kansas Medicaid is the backbone of Kansas’ health care system. While the policies may evolve, if they add up to deep cuts to federal Medicaid, they will have major ripple effects on people and providers and will further weaken rural health care

Federal funding accounts for about two-thirds of Kansas’ Medicaid spending. If Congress makes deep cuts to that funding, Kansas will have few options other than to reduce or terminate coverage and benefits and lower reimbursement rates, all leading to more uninsured people, higher uncompensated care, and increased medical debt.

The depth of cuts proposed in the House budget will likely mean that no one – not children, seniors in need of long-term care, people with disabilities, pregnant women – will escape the impact. Because of the fragility of rural health care in Kansas, rural communities may be hit the hardest.

Medicaid work requirements would jeopardize enrollees' ability to access needed health care and create added administrative burden for the state and Medicaid enrollees. They would have an outsized impact on rural Kansans.

Appendix

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.

Medicaid Provider Tax Changes*: 1-Year* KanCare Impacts

Scenario	Change in Medicaid Spending Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	TOTAL	
Scenario A: Reduction of Provider Tax Limit to 5%	-	-	-	Not applicable under Kansas' current 3% provider tax. Any of these scenarios would force the state to forgo the additional revenue from the increased provider tax already approved by the legislature.
Scenario B: Reduction of Provider Tax Limit to 4%				
Scenario C: Reduction of Provider Tax Limit to 3%				
Scenario D: Reduction of Provider Tax Limit to 2.5%	**-$60M**	**-$39M**	**-$98M**	Would decrease federal funding for Kansas Medicaid by **$60 million** overall (2% 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 estimates implementation

Medicaid Provider Tax Changes*: 10-Year* KanCare Impacts

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%	-	-	-	Not applicable under Kansas' current 3% provider tax. Any of these scenarios would force the state to forgo the additional revenue from the increased provider tax already approved by the legislature.
Scenario B: Reduction of Provider Tax Limit to 4%				
Scenario C: Reduction of Provider Tax Limit to 3%				
Scenario D: Reduction of Provider Tax Limit to 2.5%	**-$636M**	**-$413M**	**-$1.05B**	Would decrease federal funding for Kansas Medicaid by **$636 million** (2% 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.

State Directed Payment Changes: KanCare Impacts

Scenario	Change in Medicaid Spending Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	Total	
Reduce State Directed Payments from Current Levels to Medicare-Equivalent Rates	**-$209M**	**-$135M**	**-$344M**	Total Medicaid funding for Kansas hospitals would decrease by up to $344 million in FY2026 (22% decline compared to expected total Medicaid hospital funding in Kansas under current law).

Scenario	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	Total	
Reduce State Directed Payments from Current Levels to Medicare-Equivalent Rates	**-$2.22B**	**-$1.44B**	**-$3.67B**	Total Medicaid funding for Kansas hospitals would decrease by up to $3.67 billion over ten years (22% decline compared to expected total Medicaid hospital funding in Kansas under current law).

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

* Reflects first year of estimated implementation.

Medicaid Work Reporting Requirements: KanCare Impacts

Scenario	Changes Over 1-Year Period (2026)**				Key Takeaway
	Total	Federal	State	Enrollment Impact	
Work Requirements on All Adults Eligible Through Non-Disability Pathways* Ages 18-64	**-$182M to -$317M**	**-$111M to -$192M**	**-$72M to -$125M**	**-19,000 to -32,000**	Total Medicaid enrollment would decline by 5%-9% and total Medicaid spending would decline by 3%-6%. As many as 1,600 children would lose coverage.

Scenario	Changes Over 10-Year Period (2025-2034)				Key Takeaway
	Total	Federal	State	Enrollment Impact (Average annual)	
Work Requirements on All Adults Eligible Through Non-Disability Pathways* Ages 18-64	**-$1.9B to -$5.9B**	**-$1.2B to -$3.6B**	**-$759M to -$2.3B**	**-19,000 to -57,000**	Total Medicaid enrollment would decline by 5%-15% and total Medicaid spending would decline by 3%-10%. As many as 2,800 children would lose coverage.

Notes:

- The bottom of each range reflects the model's more automation scenario, which assumes Kansas automatically exempts or determines 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 minimal automation scenario, The lowest automation scenario assumes Kansas does not automatically exempt or determine compliant adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 92% would lose coverage. These figures reflect Georgia'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

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

State Response	Changes in Medicaid Spending Over 1-Year Period (2028)*			Key Takeaway
	Federal	State	TOTAL	
Option A: Kansas Only Spends State Dollars that are Matched by Federal Dollars	-$347M	-$225M	-$573M	Total Medicaid spending would decrease by **$573 million** (10%).
Option B: Kansas Maintains Prior State Funding Levels Regardless of Federal Match	-$347M	-	-$347M	Total Medicaid spending would decrease by **$347 million** (6%).
Option C: Kansas Fully Replaces Lost Federal Funding	-$347M	+$347M	-	Kansas would need to increase its own Medicaid spending by **$347 million**—an increase of 15%—to maintain existing total Medicaid spending levels.

There is growing momentum around a per capita cap on only Medicaid expansion enrollees. While this does not directly impact Kansas as the state has not expanded Medicaid, it would make it harder for the state to receive the financial benefits from expanding Medicaid in the future (e.g., $509 million in additional funding).

Note:
- 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.

Source: KHI, Impacts of Federal Policy Decisions on Medicaid

Per Capita Caps *(All Enrollees): 10-Year* KanCare Impact

State Response	Change in Medicaid Spending Over 10-Year Period (2024-2035)			Key Takeaway
	Federal	State	TOTAL	
Option A: Kansas Only Spends State Dollars that are Matched by Federal Dollars	-$3.15B	-$2.04B	-$5.19B	Total Medicaid spending would decrease by **$5.19 billion** (11%).
Option B: Kansas Maintains Prior State Funding Levels Regardless of Federal Match	-$3.15B	-	-$3.15B	Total Medicaid spending would decrease by **$3.15 billion** (7%).
Option C: Kansas Fully Replaces Lost Federal Funding	-$3.15B	+$3.15B	-	Kansas would need to increase its own Medicaid spending by **$3.15 billion**—an increase of 17%—to maintain existing total Medicaid spending levels.

Note: Totals may not sum exactly due to rounding.

Source: KHI, Impacts of Federal Policy Decisions on Medicaid