Research brief

MEDICAID CUTS & KANSAS

How federal legislative proposals would impact funding for KanCare

United Methodist HealthMinistryFund

REACH healthcare foundation

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Medicaid is a critical source of health insurance coverage for Kansans, including for children, parents, seniors, people with disabilities and behavioral health needs, and rural communities.

Congressional lawmakers are considering several policy options to substantially reduce federal Medicaid funding. In the U.S. House of Representatives, the cuts could be at least $880 billion over 10 years. Federal funds currently cover two-thirds of Kansas' Medicaid program costs.

Deep cuts in federal funding would require Kansas to either sharply increase state spending just to maintain coverage, cut services, terminate coverage, and/or reduce provider payments and access to care, not just for those enrolled in Medicaid. No group of enrollees would be shielded from the cuts, and rural communities would face an outsized impact.

The United Methodist Health Ministry Fund and REACH Healthcare Foundation, two health philanthropies based in Kansas, partnered with Manatt Health to estimate 1- and 10-year impacts of potential cuts to the federal Medicaid program. Manatt, a national professional services firm focused on health policy transformation, payment reform and Medicaid redesign, paid special focus on expenditures and enrollment impacts for Kansas.

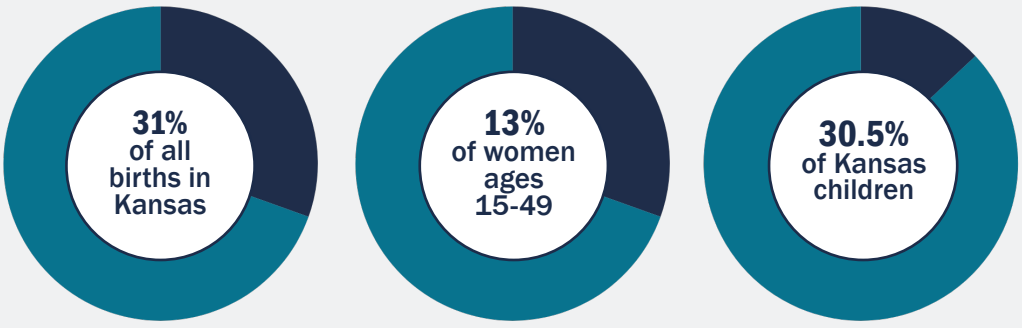
Manatt and the foundations acknowledge these estimates are developed "pre-legislation," prior to actions Congress is expected to take in spring/summer 2025. However, the policy parameters are closely aligned with options developed by the Congressional Budget Office and previously introduced legislative proposals. Interactive effects are not considered in this modeling. As specific policy provisions to enact cuts are legislated, Manatt will adapt the inputs accordingly. Manatt has built its model from the bottom-up, leveraging publicly available state data and tailoring the model to the needs and landscape of the state of Kansas. Its methodology and preliminary estimates for Kansas have been reviewed and informed by the Kansas Hospital Association and other partners and stakeholders.

The early projections are instructive and alarming. Lawmakers, health care providers, advocates, consumers and the public will benefit from understanding what is at stake if federal cuts to the Medicaid program are enacted.

MEDICAID IN KANSAS

KanCare covers more than 366,000 adults and children. It is managed by the Kansas Department of Health and Environment and Kansas Department for Aging and Disability Services. KanCare plays a significant role in providing health coverage to Kansans. It covers 57% of all nursing home residents and more than 30% of the state's children. Of note, KanCare does not provide coverage for working-age adults unless they are a parent/caregiver or have a disability.

WHO DOES KANCARE COVER?



4 in 7 nursing home residents

1 in 4 working-age adults with disabilities

The more people who are covered by health insurance, the less uncompensated care for the health system. That keeps everyone's costs down and helps financially unstable hospitals keep their doors open, which is especially important in rural communities. Rural areas face greater health care challenges overall, as rural residents experience higher rates of chronic diseases, hospitals are operating on tighter margins or have been closed, and doctor shortages are more extreme. More rural residents rely on Medicaid than those living in urban areas in Kansas.

MEDICAID COVERAGE IN RURAL KANSAS

32% OF RURAL CHILDREN ENROLLED

11% OF RURAL ADULTS ENROLLED

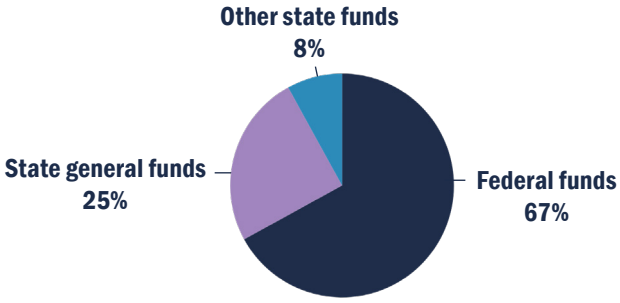
12% OF RURAL SENIORS ENROLLED

HOW KANCARE IS FUNDED

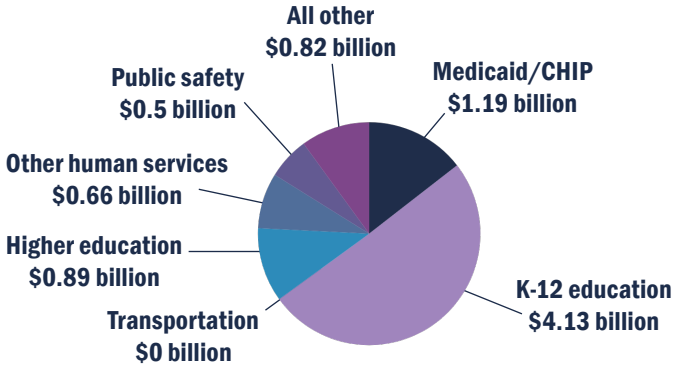
Medicaid spending is shared by states and the federal government. The percentage of costs paid by the federal government, known as the federal medical assistance percentage (FMAP), is determined by a formula set in law that provides a higher federal match rate for states with lower per capita incomes. The rate can vary upon expenditure type and population. In Kansas, the standard FMAP is 60.67%.

Medicaid is currently the largest source of federal funds to the state, accounting for about 15% of state general fund spending and 46% of Kansas federal fund spending. In fiscal year 2023, Kansas spent nearly $5.5 billion on Medicaid, with federal funding covering over two-thirds of that expenditure.

If cuts are enacted to the federal Medicaid program, there will be considerable financial implications for the state general fund, particularly in combination with other state-level tax cuts recently enacted by the state legislature.



KANSAS MEDICAID BUDGET FY 2023
$5.5 BILLION TOTAL



STATE GENERAL FUND FY 2022
$8.92 BILLION TOTAL

SERVING VULNERABLE POPULATIONS

KanCare not only is a key source of coverage for rural Kansans, but it's also a key source of coverage for people with mental health and substance use disorders, children and their parents, and seniors. It's also a critical source of funding for the providers and hospitals that serve these more vulnerable, high-need populations. Medicaid serves as an economic engine of survival for hospitals, who rely heavily on Medicaid reimbursement dollars to keep their doors open. More than 60 rural Kansas hospitals are at risk of closing, with 26% at immediate risk of closure — the highest in the nation.

26 RURAL KANSAS HOSPITALS AT IMMEDIATE RISK OF CLOSURE

63 RURAL KANSAS HOSPITALS AT RISK OF CLOSURE

1/3 OF ALL BEHAVIORAL HEALTH CARE COVERED BY KANCARE

1/10 KANSANS ARE UNINSURED; A SIMILAR NUMBER STRUGGLE WITH MEDICAL DEBT

40% OF KANCARE SPENDING COVERS LONG-TERM CARE SERVICES

IMPLICATIONS OF POTENTIAL MEDICAID CHANGES TO KANSAS

Leading proposals to reduce federal Medicaid funding would shift costs for Medicaid program enrollment, benefits and administration to the state of Kansas. Manatt modeled the impact of four major proposals relevant to Kansas:

- **Changes to the Medicaid financing structure through a per capita cap,** which would replace the guarantee to states of federal Medicaid matching funds and put Kansas at risk for all Medicaid costs above the caps.
- **Limiting states' use of provider taxes,** which Kansas relies on to fund its share of Medicaid costs.
- **Curtailing or eliminating state directed payments (SDPs)** used by states to supplement payments to hospitals, boost essential providers, or promote delivery system reform.
- **Establishing work reporting requirements.**

PER CAPITA CAPS

The current Medicaid financing structure does not put any caps on federal funding, which allows states to guarantee Medicaid coverage for all medically necessary health care expenses for eligible individuals.

Congress could mandate per capita caps to be applied to some or all Medicaid enrollees to limit federal funding to a pre-set amount designed to reduce federal spending. Caps are set by eligibility group. States would not be at risk for enrollment growth but would have to fully pay without federal support for health costs above the cap. How a per capita cap for all enrollees would impact Kansas depends on how the state responds. Manatt modeled three potential state responses below.

1-YEAR KANCARE IMPACT

*Changes in spending over 1-year period (2028)**

OPTION A: Kansas only spends state dollars that are matched by federal dollars (*Manatt assumed Kansas would only spend dollars that could be matched by federal funding*)			OPTION B: Kansas maintains prior state funding levels regardless of federal match (*Manatt assumed Kansas would maintain prior levels of state spending, regardless of whether federal matching dollars were available*)			OPTION C: Kansas fully replaces lost federal funding (*Manatt assumed Kansas would increase state spending to fully replace lost federal dollars to maintain program eligibility and benefits at current levels*)		
Federal	**State**	**TOTAL**	**Federal**	**State**	**TOTAL**	**Federal**	**State**	**TOTAL**
-$347 million	-$225 million	**-$573 million**	-$347 million	—	**-$347 million**	-$347 million	+$347 million	—

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

10-YEAR KANCARE IMPACT

Changes in spending over 10-year period (2025-2034)

OPTION A: Kansas only spends state dollars that are matched by federal dollars (*Manatt assumed Kansas would only spend dollars that could be matched by federal funding*)			OPTION B: Kansas maintains prior state funding levels regardless of federal match (*Manatt assumed Kansas would maintain prior levels of state spending, regardless of whether federal matching dollars were available*)			OPTION C: Kansas fully replaces lost federal funding (*Manatt assumed Kansas would increase state spending to fully replace lost federal dollars to maintain program eligibility and benefits at current levels*)		
Federal	**State**	**TOTAL**	**Federal**	**State**	**TOTAL**	**Federal**	**State**	**TOTAL**
-$3.15 billion	-$2.04 billion	**-$5.19 billion**	-$3.15 billion	—	**-$3.15 billion**	-$3.15 billion	+$3.15 billion	—

Note: Totals may not sum exactly due to rounding.

KEY POINTS:

OPTION A: Total Medicaid spending would decrease by 10% ($573 million) over 1 year and by 11% ($5.19 billion) over 10 years.

OPTION B: Total Medicaid spending would decrease by 6% ($347 million) over 1 year and by 7% ($3.15 billion) over 10 years.

OPTION C: To maintain existing total Medicaid spending levels, Kansas would need to increase its own Medicaid spending by 15% ($347 million) over 1 year and by 17% ($3.15 billion) over 10 years.

PROVIDER TAXES

For decades, states have levied taxes on a variety of provider types, such as hospitals, nursing facilities and 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. Kansas assesses provider taxes on hospitals at 3% of net patient services revenue and taxes nursing and other facilities per licensed bed. In 2024, the Kansas Legislature enacted an increase in the hospital provider tax to 6% to finance additional payments to Kansas hospitals; this increase is not yet in effect. As of 2024, Kansas received $180 million in annual revenue from its taxes on hospitals, qualifying the state for $315 million each year in federal aid. If the increase to 6% is implemented, it would nearly double the federal funding Kansas receives on hospital inpatient and outpatient services.

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. The loss of revenue KanCare would experience would depend on the size of the reduction to the provider tax limit. Reductions of provider tax limits to 5%, 4% and 3% have been considered. They are not included in the modeling below, though, as it is not applicable under Kansas' current 3% provider tax. However, any of these scenarios would force Kansas to forgo the additional revenue from the increased provider tax already approved by the legislature.

1-YEAR KANCARE IMPACT

*Changes in spending over 1-year period (2026)***

SCENARIO: Reduction of provider tax limit for hospitals to 2.5%		
Federal	**State**	**TOTAL**
-$60 million	-$39 million	**-$98 million**

10-YEAR KANCARE IMPACT

*Changes in spending over 10-year period (2025-2034)***

SCENARIO D: Reduction of provider tax limit for hospitals to 2.5%		
Federal	**State**	**TOTAL**
-$636 million	-$413 million	**-$1.05 billion**

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

KEY POINT:

This policy change would significantly decrease federal funding for Kansas Medicaid by $60 million overall over 1 year and $636 million over 10 years.

When combined with the state match, this loss climbs to a loss of $98 million over 1 year and $1.05 billion over 10 years in total Medicaid funding.

STATE DIRECTED PAYMENTS

State directed payments (SDP) are an important mechanism for funding health care providers that care for Medicaid enrollees. With approval from the Centers for Medicare & Medicaid Services (CMS), states can direct managed care organizations to supplement base payments to groups of providers to improve access and quality of care. In 2024, Kansas' SDPs approved by CMS totaled $508 million. Kansas' SDPs bring Medicaid managed care payments up to 93% of the average commercial rate (ACR) for inpatient services at general hospitals and bring rates up to lower percentages of the ACR for outpatient services at general hospitals and for Critical Access Hospitals. Along with the increase in the state's hospital provider tax, Kansas is planning to increase the amount of SDPs paid to hospitals. Federal proposals could curtail or eliminate SDPs used by states to supplement payments to hospitals, boost essential providers, or promote delivery system reform. One proposal is to reduce the current levels of SDPs to Medicare-equivalent rates.

1-YEAR KANCARE IMPACT

*Changes in spending over 1-year period (2026)**

SCENARIO: Reduce state directed payments from current levels to Medicare-equivalent rates

Federal	State	TOTAL
-$209 million	-$135 million	**-$344 million**

10-YEAR KANCARE IMPACT

*Changes in spending over 10-year period (2025-2034)**

SCENARIO: Reduce state directed payments from current levels to Medicare-equivalent rates

Federal	State	TOTAL
-$2.22 billion	-$1.44 billion	**-$3.67 billion**

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

KEY POINT:
Total Medicaid funding for Kansas hospitals would decrease by up to $344 million over 1 year and up to $3.67 billion over 10 years. **This is a 22% decline compared to expected total Medicaid hospital funding in Kansas under current law.**

WORK REPORTING REQUIREMENTS

To receive benefits from Medicaid, Kansas enrollees are not currently required to work as a condition for eligibility. Kansas, which is one of only 10 states not to expand its Medicaid eligibility, already has one of the most restrictive income eligibility requirements in the country. Most people eligible for Medicaid are pregnant women, children, the elderly and disabled populations. Congress could implement work requirements as a condition for Medicaid eligibility that applies to all non-elderly, non-disabled adults ages 18-65 enrolled in Medicaid. Administrative costs to the state to implement and monitor work requirements are not included in these calculations. Drawing on the experiences of three states that have implemented work requirements approved by CMS — Arkansas, New Hampshire and Georgia — Manatt developed three coverage loss scenarios for Kansas.

1-YEAR KANCARE IMPACT

*Changes in spending over 1-year period (2026)***

SCENARIO: Work reporting requirements apply to adults eligible through non-disability pathways ages 18-64*

Federal	State	TOTAL	ENROLLMENT IMPACT
-$111 million to -$192 million	-$72 million to -$125 million	**-$182 million to -$317 million**	**-19,000 to -32,000 (inc. 900-1,600 children)**

10-YEAR KANCARE IMPACT

*Changes in spending over 10-year period (2025-2034)**

SCENARIO: Work reporting requirements apply to adults eligible through non-disability pathways ages 18-64*

Federal	State	TOTAL	ENROLLMENT IMPACT
-$1.2 billion to -$3.6 billion	-$759 million to -$2.3 billion	**-$1.9 billion to -$5.9 billion**	**-19,000 to -57,000 (inc. 900-2,800 children)**

*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. The 10-year enrollment impacts are average annual enrollment impacts for FY26-34.*

KEY POINT:
Medicaid enrollment would be greatly reduced. It's estimated to decline by 5-9% over 1 year and by 5-15% over 10 years, impacting up to 57,000 Kansans — including 2,800 children.

KEY TAKEAWAYS

1. MEDICAID IS A CRITICAL SOURCE OF HEALTH CARE COVERAGE FOR KANSANS.

Hundreds of thousands of Kansans rely on Medicaid for health insurance. Medicaid in Kansas does not provide coverage for working-age adults who are not parents or caregivers. Therefore, Kansans relying on Medicaid for health care include children, pregnant women, parents and caregivers, seniors in nursing homes, people with disabilities, and people with behavioral health needs.

Medicaid is also critical to Kansas' rural communities and the future of their hospitals. Higher percentages of rural children and adults rely on Medicaid than in urban areas. With 26% of Kansas' rural hospitals already at immediate risk of closure, any cuts to Medicaid could force closures and further reduce access to health care for rural communities.

2. KANSAS WILL PAY THE PRICE FOR FEDERAL CUTS TO MEDICAID.

Deep cuts to Medicaid will shift costs to the state and cause significant downstream impacts on health plans, providers and enrollees. **As members of Congress look for ways to cut $880 billion from Medicaid costs, the modeling shows no matter what method is used, Kansas will stand to lose billions in total funding over 10 years.**

Implementing per capita caps would cause Kansas to lose $3.15 billion in federal funds over 10 years. Should Kansas only spend dollars matched by federal funding, then that total loss in Medicaid spending increases to $5.19 billion over 10 years. Provider taxes and SDPs play a significant role in supporting providers and hospitals, many of which are already at risk of closing due to financial instability. Cuts of this magnitude could result in Kansas hospitals losing $1.08 billion over 10 years in total provider assessment dollars. As for SDPs, funding for Kansas hospitals would decrease by 22% compared to expected funding under current law. That equates to a loss of $3.67 billion over 10 years in federal and state funding. Proposals to add work requirements for conditions of Medicaid eligibility would result in a coverage loss for up to 57,000 Kansans over 10 years and a total loss in funding up to $5.9 billion over 10 years.

Such cuts would greatly impact Kansas' current budget, of which Medicaid currently makes up the greatest portion of federal funding. It would leave a substantial gap in funding to cover the health care costs of enrollees, leaving state officials to determine how to make up for billions in losses.

3. PROPOSED CHANGES WOULD FORCE KANSAS TO REDUCE ITS MEDICAID PROGRAM.

No matter the method of cuts used, Kansas will be forced to make changes to its Medicaid program. It will have to cut core functions, such as benefits, rates and services, or change eligibility requirements. Such changes would terminate health care coverage for Kansas' lowest-income residents, who already face significant challenges. These changes also would increase medical debt, create more uncompensated care for providers and hospitals, reduce reimbursements to providers, and force already struggling hospitals to close their doors.

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United Methodist HealthMinistryFund
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