**Primer: Medicaid Reforms Provide Savings Without Cutting Benefits**

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The prospect of including Medicaid reforms as part of a budget reconciliation bill has outraged leftist groups, who claim that Congress and the Trump Administration want to "cut" the program. But the reforms to Medicaid put forth in this primer would do nothing of the sort. Instead, they would result in significant savings while still allowing the program to grow substantially.[1]

According to the most recent baseline estimates from the Congressional Budget Office (CBO), the federal government will spend $656 billion on Medicaid during the current fiscal year.[2] If that spending level were to remain constant, Washington would spend a total of $6.56 trillion on Medicaid during the years 2026–2035. But CBO projects federal spending on Medicaid to reach $8.58 trillion over that period—more than $2 trillion higher than level funding.[3]

Even if all of the House Energy and Commerce Committee's $880 billion in directed savings for budget reconciliation comes from Medicaid, spending on the program would still increase by more than $1 trillion in the coming decade. Only in the twisted world of Washington, where people assume that government programs have an inherent right to grow indefinitely, does an increase in spending of over $1 trillion constitute a "cut."

Just as importantly, an $880 billion reduction in Medicaid spending would only reduce its funding to roughly the levels of eight months ago. In its January fiscal update, CBO raised its estimate of federal Medicaid spending by $817 billion compared to its estimates from just this past June. Most of that increase in spending comes, either directly or indirectly, from various regulatory actions taken in the final months of the Biden administration that will raise program spending.[4]

Not only will the savings proposals discussed here not "cut" the program; in many instances, they will merely undo changes finalized by the Biden administration less than a year ago. At a time when the federal debt continues to climb, the notion of returning Medicaid spending to that of a few years ago has the same logic as returning federal spending to pre-COVID levels. It looks radical only in Washington.

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[1] "Who's Afraid of Medicaid Reform?" *The Wall Street Journal*, February 27, 2025, https://www.wsj.com/opinion/medicaid-reform-republicans-democrats-entitlement-healthcare-40fc7701.
[2] Congressional Budget Office, "The Budget and Economic Outlook: 2025 to 2035," January 17, 2025, https://www.cbo.gov/system/files/2025-01/60870-Outlook-2025.pdf, Table B-4, p. 23.
[3] Ibid.
[4] Ibid., Appendix A, pp. 16-17.

The Center for Renewing America's Fiscal Year 2023 budget contemplated structural changes to Medicaid, including repeal of the Obamacare expansion to the able-bodied and changes to the state-federal match mechanism.[5] These proposals are major cost-savers, but other proposals could also generate significant budgetary savings. In a program whose ten-year estimated costs jumped by $817 billion in just the last few months, there are many potential reforms that would benefit taxpayers and reserve its use for those most in need.

Contrary to claims that these proposals will cut benefits for Medicaid recipients, many policy changes will increase its efficiency while cracking down on waste and fraud. The proposals outlined below—which can work either in conjunction with the larger reforms in the CRA budget or separate from them—focus on 1) preserving coverage for those most in need, 2) ending unfunded mandates that the Biden administration imposed on state programs, and 3) eliminating various funding gimmicks that states use to increase the amount of federal matching funding they receive.

These changes would ensure that Medicaid coverage remains available and accessible to those who qualify for benefits rather than retaining actions from the Biden administration that expanded the welfare state to unsustainable levels. They would also restore the proper state-federal balance within the program, both eliminating onerous requirements for states and responding to states' financing abuses.

## Preserving Coverage for Those Most in Need

**Citizenship Verification**: In 2005, a Republican Congress codified a requirement that state Medicaid programs verify both the citizenship and identity of individuals applying for benefits to prevent illegal immigrants from receiving taxpayer-funded benefits.[6] Subsequently, Democrats enacted provisions that rely on merely matching an applicant's name to a Social Security number.[7]

While this verification regime, which Democrats incorporated into Obamacare, can confirm an individual's citizenship, it does nothing to verify that said individual is the person applying for benefits.[8] Given the way in which this system effectively encourages identity fraud, policymakers should consider repealing its lax verification regime and instead reverting back to the regime established by the Republican Congress nearly twenty years ago.

*Potential Savings*: CBO estimated savings from enactment of the original verification regime in 2005 at $735 million over ten years.[9] While current estimates of the fiscal savings of this proposal are unclear, this change would both support program integrity and, by ensuring that

[5] Documents available at https://americarenewing.com/issue/budget/.
[6] Section 6036 of the Deficit Reduction Act, P.L. 109-171, codified at 42 U.S.C. 1396b(x).
[7] Section 211 of the Children's Health Insurance Program Reauthorization Act, P.L. 111-3, codified at 42 U.S.C. 1396a(ee).
[8] Section 1411 of the Patient Protection and Affordable Care Act, P.L. 111-148, codified at 42 U.S.C. 18081.
[9] Congressional Budget Office, cost estimate for the conference report to accompany S. 1932, the Deficit Reduction Act, January 27, 2006, https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/costestimate/s1932conf0.pdf, p. 36.

only verified citizens can receive taxpayer-funded benefits, bolster the work the Trump administration is doing to secure the nation's borders.

**Eligibility Redeterminations**: Enrollment in the Medicaid program exploded during COVID, during which a provision passed by Congress prevented states from removing individuals from the program except in limited circumstances. While those restrictions have since lapsed, enrollment remains significantly above pre-COVID levels. In January, CBO raised its estimate for 2025 Medicaid enrollment from 79 million last June to 84 million—the largest factor contributing to the estimated $817 billion increase in program spending over the decade.[10]

The increase in enrollment comes at the same time that the Biden administration finalized rules prohibiting states from redetermining Medicaid eligibility more than once per year.[11] Requiring or encouraging more regular determinations by states would ensure that scarce taxpayer dollars go only to individuals who are actually eligible for the program. This basic reform would prevent fraudulent enrollment and greatly reduce improper payments.

*Potential Savings*: The Committee for a Responsible Federal Budget (CRFB) estimates that repealing the Biden administration's limits on eligibility redeterminations would save $75 billion over a decade and encouraging states to increase the frequency of their eligibility redeterminations would save $40 billion.[12]

**Presumptive Eligibility**: Section 2202 of Obamacare permitted hospitals to make presumptive eligibility determinations for all Medicaid-eligible individuals.[13] In practice, this provision has allowed hospitals to enroll individuals based on as little as a verbal attestation of income, with those individuals receiving taxpayer-subsidized coverage for up to two months. One study found that in 2018, 70 percent of individuals initially determined eligible in this way were later found to be ineligible, or never to have bothered to complete a full application—meaning that more than two in three of those who qualified for Medicaid through presumptive eligibility did so through questionable, if not outright fraudulent, means.[14]

*Potential Savings*: CRFB estimates the savings from "restrict[ing] Medicaid retroactive coverage" at $10 billion over a decade.[15] Restricting, or even eliminating, presumptive eligibility for the able-bodied adult population will generate savings for the federal government and states

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[10] Congressional Budget Office, "Budget and Economic Outlook," pp. 16-17.
[11] Centers for Medicare and Medicaid Services, "Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," *Federal Register*, April 2, 2024, https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf, pp. 22780-22878.
[12] Committee for a Responsible Federal Budget, "Medicaid Savings Options," December 12, 2024, https://www.crfb.org/blogs/medicaid-savings-options.
[13] Section 2202 of the Patient Protection and Affordable Care Act, codified at 42 U.S.C. 1396a(a)(47)(B).
[14] Cited in Sam Adolphsen and Jonathan Bain, "Eligible for Welfare Until Proven Otherwise: How Hospital Presumptive Eligibility Pours Gasoline on the First of Medicaid Waste, Fraud, and Abuse," Foundation for Government Accountability, September 21, 2020, https://thefga.org/wp-content/uploads/2020/09/How-Hospital-Presumptive-Eligibility-Pours-Gasoline-Medicaid-Fraud.pdf.
[15] Committee for a Responsible Federal Budget, "Medicaid Savings Options."

alike while preventing fraud and ensuring that scarce resources remain available for the most vulnerable.

**Penalties for Improper Payments**: As Medicaid expansion has expanded the number of beneficiaries on the government rolls, so too have the levels of improper payments within Medicaid grown. The inability of states to check beneficiaries' eligibility during COVID did not stop the escalation of improper payments. Far from it: One recent study estimated the total amount of improper payments within Medicaid at nearly $1.1 trillion over the last decade.[16]

The same study that calculated the $1.1 trillion total noted that the Secretary of Health and Human Services has the authority to withhold Medicaid payments from states with eligibility errors exceeding 3 percent.[17] A similar proposal to withholding payments entirely would reduce the federal matching rate for states with high levels (either by rate or gross amount) of improper payments and so would encourage states to take program integrity more seriously. This would cut off what some states regard as a limitless supply of "free" federal money.[18]

*Potential Savings*: Various proposals to penalize states with high improper payment rates could save taxpayers billions of dollars. More importantly, by encouraging states to take additional measures to crack down on waste, fraud, and abuse, these proposals could yield more significant savings over time.

**Waiting Periods**: Medicaid and other government-funded health-care programs create the problem of "crowd-out," wherein individuals drop privately funded insurance to go on the government rolls. One famous study, by MIT professor Jonathan Gruber, estimated crowd-out levels of 60 percent, meaning that three in every five individuals in government programs had dropped private coverage to receive benefits on the taxpayers' dime.[19]

To combat the "crowd-out" phenomenon, some states had previously imposed waiting periods that prevented individuals with private coverage from going immediately on to the government rolls. But a Biden administration final rule issued last year prohibited states from imposing waiting periods, encouraging further expansion of the welfare state at the expense of private coverage.[20]

*Potential Savings*: The Biden administration estimated that the provisions in this rule would collectively increase federal Medicaid spending by $22 billion between 2024 and 2028, along

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[16] Brian Blase and Rachel Greszler, "Medicaid's True Improper Payments Double Those Reported by CMS," Paragon Health Institute, March 3, 2025, https://paragoninstitute.org/wp-content/uploads/2025/03/Medicaids_True_Improper_Payments_FOR-RELEASE_V4.pdf.
[17] 42 U.S.C. 1396b(u).
[18] Blase and Greszler, "Medicaid's True Improper Payments."
[19] Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research Working Paper No. 12858, January 2007, https://www.nber.org/system/files/working_papers/w12858/w12858.pdf.
[20] Centers for Medicare and Medicaid Services, "Medicaid Program: Streamlining."

with over $23 billion in new unfunded mandates on state Medicaid programs.[21] Repealing the rule entirely would save around $50 billion over a decade, and repealing the prohibition on waiting periods could generate savings in the billions.

**Work Requirements**: Most conservatives support provisions that would either permit or require state Medicaid programs to ensure that able-bodied adults of working age are working, or engaging in activities likely to lead to employment, as a condition of receiving benefits. During the first Trump administration, a total of thirteen states received approval to impose work requirements. But judicial rulings, the onset of COVID, and revocations of approvals by the Biden administration have led to Medicaid work requirements being removed in all states except Georgia.

Medicaid work requirements would encourage economic growth by expanding the labor supply while giving beneficiaries important skills and experience that promote self-sufficiency. But some states have thus far declined to participate in Obamacare's expansion of Medicaid to the able-bodied, largely because the program lacks work requirements.[22] There is some concern, therefore, that work requirements may have the unintended consequence of giving these non-expansion states the political cover they need to embrace an ill-advised Medicaid expansion.

*Potential Savings*: In April 2023, CBO estimated that legislation directing states to implement work requirements in Medicaid would save the federal government $109 billion over ten years.[23] CRFB estimates that *requiring* states to implement work requirements would save $140 billion over a decade, while *permitting* states to do so would save only $35 billion.[24] If work requirement legislation leads additional states to embrace Medicaid expansion, however, those federal savings could decline or disappear entirely.

**Lottery Winners**: In prior Congresses, lawmakers introduced legislative proposals that would include large-scale lottery, gambling, or other lump-sum payments (those over $80,000) when determining eligibility for benefits.[25] These bills were introduced after stories emerged of beneficiaries remaining on food stamps even after winning a multi-million-dollar jackpot.[26]

Congress has yet to enact these proposals despite their common-sense approach. Ensuring that benefits remain available for the most vulnerable requires restricting benefits for those who have received large financial windfalls.

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[21] Ibid., Tables 24-25, pp. 22863-64. Federal spending estimate reflects an increase in federal Medicaid spending of $36.2 billion, an increase in CHIP spending of $1.2 billion, and a decrease in federal spending on Exchange subsidies of $15.4 billion; state spending estimate includes $22.7 billion in state Medicaid spending and $490 million in state CHIP spending.

[22] Emily Wagster Pettus, "Medicaid Expansion Effort Collapses in Republican-Led Mississippi Legislature," Associated Press, May 2, 2024, https://apnews.com/article/mississippi-medicaid-expansion-31678a582c4f9de38b3f2323f1811e9f.

[23] Congressional Budget Office, Letter to Rep. Frank Pallone regarding Medicaid work requirements, April 26, 2023, https://www.cbo.gov/system/files/2023-04/59109-Pallone.pdf.

[24] Committee for a Responsible Federal Budget, "Medicaid Savings Options."

[25] H.R. 829 (115th Congress) and S. 2209 (115th Congress), Prioritizing the Most Vulnerable over Lottery Winners Act of 2017.

[26] "Michigan Man Still Receives Food Stamps After Winning $2 Million Jackpot," Fox News, May 18, 2011, https://www.foxnews.com/us/michigan-man-still-receives-food-stamps-after-winning-2-million-jackpot.

*Potential Savings*: CRFB estimates that restricting benefits for illegal aliens, prisoners, and lottery winners would generate approximately $5 billion in combined savings over ten years.[27]

**Durable Medical Equipment**: A previously proposed policy included in the president's budget would limit Medicaid reimbursement of durable medical equipment (DME) to no more than Medicare rates. Given that much DME purchased via Medicare is acquired through competitive bidding contracts, this provision would introduce more market forces into a similar government program in Medicaid.

*Potential Savings*: CRFB estimates that this provision could generate approximately $5 billion in savings over a ten-year period.[28]

**Eliminating Unfunded Mandates**

**Unfunded Mandate on Prescription Drugs**: When explaining its reasons for the $817 billion increase in its Medicaid baseline, CBO noted increased costs for prescription drugs, "particularly the use of anti-obesity medications known as glucagon-like peptide-1 agonists, or GLP-1s."[29] That development came shortly after the Biden administration proposed requiring all Medicaid programs, most of which do not currently cover GLP-1s, to do so.[30] While it is prudent to support measures that increase wellness among beneficiaries, GLP-1s are not that. Further, it would be unwise to levy a multi-billion-dollar unfunded mandate on states by requiring them to cover this category of prescription drug.

*Potential Savings*: The Biden administration's proposal estimated that the federal government would spend $11 billion, and states $4 billion, on this unfunded mandate over the coming decade.[31]

**Nursing Home Rule**: Last spring, the Biden administration finalized a rule to impose staffing and various other requirements on nursing homes receiving federal funds.[32] The new mandates

[27] Committee for a Responsible Federal Budget, "Medicaid Savings Options."
[28] Committee for a Responsible Federal Budget, "Medicaid Savings Options."
[29] Congressional Budget Office, "Budget and Economic Outlook," p. 17.
[30] Elizabeth Williams, Robin Rudowitz, and Clea Bell, "Medicaid Coverage of and Spending on GLP-1s," Kaiser Family Foundation, November 4, 2024, https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-and-spending-on-glp-1s/; Alejandra O'Connell-Domenech, "Biden Proposes Medicare, Medicaid Coverage of Obesity Drugs," *The Hill*, November 26, 2024, https://thehill.com/policy/healthcare/5010254-biden-administration-proposes-obesity-drug-coverage-medicare-medicaid/.
[31] Juliette Cubanski and Elizabeth Williams, "Proposed Coverage of Anti-Obesity Drugs in Medicare and Medicaid Would Expand Access to Millions of People with Obesity," Kaiser Family Foundation, November 26, 2024, https://www.kff.org/policy-watch/proposed-coverage-of-anti-obesity-drugs-in-medicare-and-medicaid-would-expand-access-to-millions-of-people-with-obesity/.
[32] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," *Federal Register*, May 10, 2024, https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08273.pdf, pp. 40876-41000.

came despite the fact that existing federal law already imposes certain staffing requirements on nursing facilities.[33]

These new requirements, which have been subject to a legal challenge, come as many facilities face staffing shortages.[34] The mandates likely will force state Medicaid programs to increase payment rates. Otherwise, the cost of the requirements could jeopardize facilities' financial viability, threatening access to care.

*Potential Savings*: In the final rule, CMS estimated that if the $43 billion cost of the rule were allocated proportionately to various nursing-home payers, the rule would raise federal Medicaid spending by $16.5 billion over a decade while imposing $11.7 billion in unfunded mandates on state Medicaid programs.[35] CRFB estimated that repealing the regulation would result in $25 billion in Medicaid savings.[36]

## Ending State Financing Abuses

**State-Directed Payments**: A managed care rule issued by the Biden administration last spring permitted states for the first time to make supplemental payments to certain providers that exceed Medicare payment rates and can equal the average payment rates paid by commercial insurance plans.[37] The rule blessed a financing arrangement that had heretofore remained in a legal gray area. It will encourage states to increase spending so that they can receive additional federal matching dollars.

CBO in January cited this rule as one of the reasons that it raised its baseline for Medicaid spending by a total of $817 billion over the coming decade.[38]

This policy could raise *private* health-care costs as well. Linking maximum Medicaid payment levels to the average rates paid by commercial insurance doubly incentivizes hospitals to demand even higher reimbursements from commercial payers. Policymakers should consider repealing this inflationary mechanism, which will raise both federal and private health-care costs.

*Potential Savings*: The Biden administration's rule estimated that the state-directed payments provision included in the managed care rule would increase federal spending by at least $17.6 billion through 2028 and admitted that a "high-cost" scenario would raise federal spending by $83.9 billion through the same period.[39] CRFB estimates that repealing this provision would save

[33] Section 1819(b)(4)(C) of the Social Security Act, codified at 42 U.S.C. 1395i-3(b)(4)(C), and Section 1919(b)(4)(C) of the Social Security Act, codified at 42 U.S.C. 1396r(b)(4)(C).
[34] American Health Care Association et al. v. Xavier Becerra and Chiquita Brooks-LaSure, amended complaint available at https://www.ahcancal.org/News-and-Communications/Press-Releases/Documents/2024-05-23%20AHCA%20Complaint.pdf.
[35] Ibid., Table 23, p. 40972, and Table 24, p. 40974.
[36] Committee for a Responsible Federal Budget, "Medicaid Savings Options."
[37] Centers for Medicare and Medicaid Services, "Medicaid Program: Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality," *Federal Register*, May 10, 2024, https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, pp. 41002-41285.
[38] Congressional Budget Office, "Budget and Economic Outlook," p. 17.
[39] Centers for Medicare and Medicaid Services, "Medicaid Program: Managed Care Access," Table 10, p. 41260.

$140 billion over a decade and that further reforming Medicaid to reduce supplemental payments could generate much higher savings of $500 billion.[40]

**Bonuses for States to Expand to Able-Bodied Adults**: As part of the American Rescue Plan Act in 2021, the Democratic Congress and the Biden administration enacted a temporary, two-year increase in the Medicaid match rate for their existing populations to those states that had yet to expand coverage to able-bodied adults, if and when those states should decide to participate in Obamacare's Medicaid expansion.[41] Federal incentives such as these function as bribes for states to expand the entitlement risk, thus transforming Medicaid from a program to help the needy into an unsustainable benefit hammock. Further, most expansion states suffer sizable cost overruns, which should be avoided.[42]

*Potential Savings*: One leftist think tank estimated that if all non-expansion states accepted expansion, bonus provisions would result in $13.1 billion in additional federal Medicaid spending.[43]

**Budget Neutrality for Medicaid Waivers**: The Government Accountability Office (GAO) has for many years called for stricter criteria to ensure that state Medicaid waivers are budget-neutral to the federal government. These waivers, under Section 1115 of the Social Security Act, are designed to give states additional flexibility to manage their Medicaid programs.[44]

While federal policy has intended that waivers operate in a budget-neutral manner, the Medicaid program has lacked specific requirements in law or regulations mandating this approach. This lack of specificity has allowed presidential administrations to abuse the waiver process in ways that could leave federal taxpayers on the hook for additional spending. For instance, the Obama administration approved Medicaid waivers that permitted Iowa and Arkansas to adjust their program spending levels higher than without the waiver because the administration wanted to compel politically red states to participate in Obamacare's expansion of Medicaid to able-bodied adults.[45]

In September 2022, the Biden administration changed its approach to calculating budget neutrality. Among other changes, the new policies reduced the assumed inflation growth of Medicaid when calculating a state's cap on expenditures under a waiver and limited the amount

[40] Committee for a Responsible Federal Budget, "Medicaid Savings Options."
[41] Section 9814 of the American Rescue Plan Act, P.L. 117-2, codified at 42 U.S.C. 1396d(ii).
[42] Hayden Dubois and Jonathan Ingram, "An Unsustainable Path: How Obamacare's Medicaid Expansion Is Causing an Enrollment and Budget Crisis," Foundation for Government Accountability, January 19, 2022, https://thefga.org/wp-content/uploads/2022/01/Medicaid-Enrollment-and-Cost-Hikes-2.0.pdf.
[43] Laura Harker and Breanna Sharer, "Medicaid Expansion: Frequently Asked Questions," Center for Budget and Policy Priorities, June 14, 2024, https://www.cbpp.org/sites/default/files/6-16-21health_series3-18-24.pdf.
[44] Section 1115 of the Social Security Act, codified at 42 U.S.C. 1315.
[45] Government Accountability Office, "Medicaid Demonstrations: HHS' Approval Process for Arkansas' Medicaid Expansion Waiver Raises Cost Concerns," Report GAO-14-689R, August 8, 2014, https://www.gao.gov/assets/gao-14-689r.pdf.

of "roll-over" savings states could assume during the waiver renewal process.[46] This policy change was announced via an August 2024 letter to state Medicaid directors, not via legislation or even regulations adopted subject to notice-and-comment rulemaking. As such, another administration could simply modify or revoke these policies.

*Potential Savings*: GAO's recent update on federal "high-risk" programs quoted the Centers for Medicare and Medicaid Services as saying that its September 2022 policy change regarding budget neutrality would save a total of $106 billion in Medicaid spending between 2023 and 2027, including $60 billion in federal funds.[47] Codifying these policy changes in law would lock in these savings, which could exceed $100 billion in federal funds over a decade.

**Provider Taxes**: The CRA budget proposed repealing provider taxes, a system whereby states agree to impose levies on categories of providers (hospitals, managed care plans, etc.). After receiving additional matching dollars from Washington, states turn around and send those dollars back to the same providers that agreed to the assessments in the first place. Little wonder, then, that provider taxes are the one form of government levy that states short on funding strongly support: The assessment amounts to "a tax no one really pays" because most providers get all their funds back, and then some, after the state receives Medicaid matching funds from Washington.[48]

While serving as vice president, Joe Biden reportedly called the provider tax mechanism a "scam" that lawmakers should outlaw.[49] But more recently, leftist groups have advertised this "scam" as a way for states to fund Medicaid expansion—using a sham accounting gimmick to promote Obamacare rather than general fund revenues, which would require state lawmakers to cut funding from other priorities (education, corrections, transportation, etc.) to fund coverage for able-bodied adults.[50]

*Potential Savings*: A CBO list of various fiscal reform proposals released in December stated that repealing provider taxes entirely, as proposed in the CRA budget, would save $612 billion over ten years.[51] Other policies short of full repeal would also generate significant savings. For instance, the same CBO document stated that lowering the permissible provider tax level from 6

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[46] Centers for Medicare and Medicaid Services, "Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects," State Medicaid Director Letter #24-003, August 22, 2024, https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf.
[47] Government Accountability Office, "High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness," Report GAO-25-107743, February 25, 2025, https://www.gao.gov/assets/gao-25-107743.pdf, p. 291.
[48] Rachel Bluth, "California Medical Lobby Ask Voters to Guarantee Billions in Annual Funding," *Politico*, October 31, 2024, https://www.politico.com/news/2024/10/31/california-ballo-prop-65-health-care-00186322.
[49] Quoted in Brian Blase, "Biden Was Right: Medicaid Provider Taxes a 'Scam' That Should Be Scrapped," *Forbes*, February 16, 2016, https://www.forbes.com/sites/theapothecary/2016/02/16/biden-was-right-medicaid-provider-taxes-a-scam-that-should-be-scrapped/?sh=7873604a1c6c.
[50] Families USA, "Options to Generate the State Share of Medicaid Expansion Costs," January 2019, https://familiesusa.org/wp-content/uploads/2019/09/MCD_States-Share-10-Percent_Fact-Sheet.pdf, p. 5.
[51] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024, https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf, p. 12.

percent to 2.5 percent would yield a net of $241 billion in savings, while reducing the 6 percent level to 5 percent would generate $48 billion in deficit reduction over a decade.[52]

Similar policies could also limit states' abuses of the federal Medicaid match. Restricting the use of intergovernmental transfers—another category of sham transactions designed largely so states can receive additional matching funds from Washington—could generate $50 billion in savings.[53] Even legislative provisions that simply halt any new provider taxes or intergovernmental transfers by states would guard against further or future abuses of the system and would likely generate billions of dollars in savings by doing so.

**District of Columbia and Federal Territories**: Since 1997, the District of Columbia has had a statutorily determined federal matching rate of 70 percent for Medicaid and the State Children's Health Insurance Program (SCHIP). Likewise, statutory changes made in 2023 increased the Medicaid matching rates for Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.[54] Equalizing the treatment of all states and territories under the same Medicaid formula such that no individual territory receives special carveouts in statute would provide some savings, and would also level treatment across the board.

*Potential Savings*: CBO estimated that the changes to territorial match rates would cost $7.5 billion in its first five years.[55] Removing explicit statutory carveouts in favor of a match rate formula that does not give special treatment to certain territories would equalize treatment while saving the federal government money.

## Conclusion

Opponents of reform claim that any changes to the Medicaid program are massive "cuts" that will cause beneficiaries harm. In reality, the opposite is true: Failing to change a program with such rapidly exploding costs will only result in the unsustainability that ultimately harms its recipients. If Washington attempts to provide "free" benefits to everyone, it will be able to afford benefits for no one—including the people who need them most.

The reforms described above will begin to refocus Medicaid on the needy and vulnerable populations it is meant to serve and rebalance the proper state-federal funding mechanism. These changes will make Medicaid stronger and more fiscally sustainable and help both program beneficiaries and taxpayers in general.

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[52] Ibid.
[53] Committee for a Responsible Federal Budget, "Medicaid Savings Options."
[54] Cited in Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures," *Federal Register*, November 29, 2024, https://www.govinfo.gov/content/pkg/FR-2024-11-29/pdf/2024-27910.pdf, pp. 94742-46.
[55] Congressional Budget Office, cost estimate for H.R. 2617, the Consolidated Appropriations Act, 2023, https://www.cbo.gov/system/files/2023-01/PL117-328_1-12-23.pdf, Table 7, p. 21.