ACOG Guide: Medicaid Matters

Purpose: An explanation of 2025 proposed Medicaid cuts. For internal ACOG use, including ACOG District and Sections legislative chairs and lobbyists.

Talking Points:

- Medicaid is a medical assistance program funded jointly by the federal government and state governments
- Nationally, there are nearly 80 million individuals (around 20% of Americans) enrolled in Medicaid or the Children's Health Insurance Program (CHIP)
- Medicaid finances 41% of births nationally
- In Maryland, 19.8% are covered by Medicaid and CHIP and 42% of births are financed by Medicaid.
- Any reduction in federal funding forces Maryland to either shift funds from other state programs or cut benefits.
    - Individuals most in need of health care will lose access to safety net coverage
    - Cuts to Medicaid would shift health care costs onto rural families and reduce or eliminate essential services at rural hospitals
    - Cuts to the Medicaid program will result in delays of preventive services, treatment for chronic conditions, and prenatal care putting undue strain on emergency rooms and increasing negative health outcomes
- The current (as of 5/13/25) bill text out of the House Energy and Commerce committee cuts $880 billion from health care programs with estimates of anywhere between 8 million and 13 million people losing health coverage.
- With the loss of Medicaid expansion, over 20 million Americans could lose access to Medicaid assistance
- Work requirements don't work
    - Most Medicaid adults under the age of 65 are already employed
    - Work requirements increase administrative burdens and costs for States and fail to increase employment rates (example: Georgia)
- Provider taxes support state Medicaid financing
    - Provider taxes are paid by institutional providers
    - Provider taxes are used to reimburse Medicaid providers
    - Changes to provider taxes threaten physician payment, which is already lower than the cost of providing care
    - A recent CBO report found that limits on provider taxes would lead to an increase of 3.9 million uninsured individuals
- State directed payments (SDP) are a financing mechanism states use to direct managed care organizations to pay providers according to specific rates or methods. Congress is proposing to cap these payments at 100% of the Medicare rate.
    - To help sustain the obgyn profession and access to care in rural areas, the Medicare rate should be the floor for payments and there should be no cap on SDPs.

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- Reducing federal funding threatens to increase fraud, waste and abuse in Medicaid
    - The federal government supports states through funding and training for fraud, waste and abuse
    - In 2024, the Medicaid improper rate was 5.1%, the lowest rate since the COVID-19 pandemic began

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Medicaid Background

Signed into law in 1965, Medicaid is a medical assistance program funded jointly by the federal government and state governments.[i] Medicaid is administered by the states, giving them flexibility on how care is delivered, what services are covered, and how much providers are reimbursed. The federal government uses income to determine eligibility for most pregnant people, parents, adults, and children. However, those who are 65 and older, are blind, or have a disability can become Medicaid eligible qualifications through Social Security Administration. Additionally, to be eligible for Medicaid, individuals must generally reside in the state they receive Medicaid in and must either be citizens or qualified non-citizens in the United States.[ii] States determine the income thresholds for pregnant people, parents, and children to be eligible for Medicaid.[iii]

Nationally, there are over 79 million individuals enrolled in Medicaid or the Children's Health Insurance Program (CHIP), with enrollment numbers higher post-pandemic in 41 states.[iv] 77% of Americans hold favorable views on Medicaid.[v] Medicaid programs are crucial to improving health and mortality, to reducing poverty rates by limiting out-of-pocket medical expenditures, and to acting as a safety net during public health crises, such as the COVID-19 pandemic, in which 92 million Americans were able to receive access to healthcare services.[vi,vii,viii]

Medicaid finances 41% of births nationally, making it the largest payer of maternity care in the United States.[ix,x] In the American Rescue Plan Act of 2021, states were given the option to extend Medicaid postpartum coverage from 60 days to 12 months through a State Plan Amendment (SPA) rather than through an 1115 demonstration waiver. This extension was created to address and improve racial disparities and coverage stability in maternal health and took place on April 1, 2022. As of January 2025, 49 states and DC have implemented a 12-month Medicaid postpartum coverage extension through either an 1115 demonstration waiver or SPA.[xi]

Maryland:

Total Enrollment in Medicaid	1.4 million
Percent of Births Financed by Medicaid	42%
Extension of Postpartum Coverage to 12 Months	Yes

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Cuts to the Program

The Trump administration and Congress are trying to push through approximately $880 billion in cuts to Medicaid over the next 10 years. Proposals to cut Medicaid include reducing the Medicaid Expansion Federal Medical Assistance Percentage (FMAP), implementing work requirements, restricting provider taxes, and implementing per capita caps.

Cuts to the Medicaid program mean that millions of Americans will lose Medicaid health coverage. Individuals most in need of health care will lose access to safety net coverage or will experience reduced services covered. Cuts to Medicaid would shift health care costs to rural families and reduce or eliminate essential services at rural hospitals.[xii] Cuts to the Medicaid program will result in delays in preventive services and treatment for chronic conditions, putting undue strain on emergency rooms. Cuts to the Medicaid program would result in increased long-term costs as a large uninsured population leads to prolonged gaps in accessing lifesaving care and uncompensated care for providers. Evidence shows that for low-income pregnant patients, disruptions in health insurance coverage are associated with lower levels of recommended pregnancy-related care.[xiii]

The majority of the public, including both Democrats and Republics oppose major cuts to Medicaid.[xiv]

Maryland:

Estimated Change in Enrollment (Per Capita Cap)	-18%
Estimated Number of People who would Lose Coverage with Medicaid Cuts (FMAP)	421,000 people
Rural Maternity Care Access (% of Rural Hospital L&D Units Closed)	0%

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Medicaid Expansion

Medicaid expansion, permitted by the Affordable Care Act, allowed states to expand coverage to adults with incomes up to 138% of the federal poverty level, allowing dramatic reductions in uninsured rates in the states that have adopted Medicaid expansion.[xv] As of 2025, 40 states and DC have adopted and implemented Medicaid expansion.[xvi] Over 20 million Americans have gained access to health care services under the Medicaid program due to Medicaid expansion. [xvii]

- **Medicaid expansion has resulted in better health outcomes and state budget savings.** Since the implementation of Medicaid expansion in 2010, studies have found an increase in access and utilization of care, financial security, increases in coverage, increases in provider capacity, and greater positive health outcomes. Studies have shown that Medicaid expansion leads to state budget savings through offsetting costs in other areas. Additionally, expansion has been shown to reduce uncompensated care costs for hospitals and clinics.[xviii]
- **Trigger laws could result in the loss of healthcare for 20 million Americans.** States that have expanded Medicaid have a 90% federal match rate (FMAP), meaning that 90% of the costs for enrollees are paid for by the federal government.[xix] Twelve states have trigger laws in place that dictate that expansion would automatically end or require significant changes if the FMAP were to drop, increasing the risk of losing coverage for Medicaid for enrollees in those states.[xx] With the loss of Medicaid expansion, over 20 million Americans could lose access to Medicaid assistance, leading to poorer health outcomes, a loss of safety net hospitals, and catastrophic financial hardships due to out-of-pocket healthcare costs.[xxi,xxii]
- **Current proposals (as of 5/13/25) are to reduce the Medicaid Expansion FMAP to 80 percent only for states that use state funds to cover undocumented immigrants.**

Maryland:

Medicaid Expansion Status	Yes
Trigger Law Impacting Expansion Population	No
State Covers Undocumented Immigrants with State Only Funds	No
For more, read Maryland's **KFF State Fact Sheet**	Maryland Medicaid

Work Requirements/Work Reporting Requirements

- Medicaid eligibility is determined primarily based on income. However, work or community engagement requirements are added conditions of eligibility that tie coverage to working, volunteering, engaging in educational activities, or employment search opportunities for a pre-determined number of hours.[xxiii]
- **Work requirements don't work.** In June 2018, Arkansas became the first state to implement work and community engagement requirements in Medicaid, requiring adults ages 30-49 to work twenty hours a week, participate in community engagement activities, or qualify for an exemption to maintain coverage.[xxiv] By April 2019, when a federal judge put the policy on hold, 18,000 adults had already lost coverage.[xxv] Additionally, a study published in the *New England Journal of Medicine* found no evidence that Arkansas' work requirement policy increased employment.[xxvi]
- **Pregnant, postpartum people, and caregivers should be exempt from work and community engagement requirements.** No individual who is pregnant, twelve months postpartum, or a caregiver should have their health coverage terminated under the work requirement. States should have specific exemptions for individuals who are pregnant, twelve months postpartum, or caregivers. There are several reasons a pregnant person may decide not to work or may need to stop working. For example, with the cost of childcare and transportation, it may not be financially expedient for a person with multiple children to be employed and meet the health, developmental, educational and social needs of their children.
- **Even with the exception, states should not implement work requirements.** Medicaid work requirements will lead to a massive loss of coverage for Medicaid enrollees, prolonged gaps in care, churn between insurance types, and uncompensated care. Additionally, and most importantly, work requirements are not commensurate with the objectives of the Medicaid program to ensure health care coverage and promote health outcomes. Additionally, most Medicaid adults under the age of 65 are already employed, meaning the reporting requirements will put unnecessary administrative burdens on Medicaid enrollees.[xxvii]
- **Work requirements should not be imposed on the expansion population**. Work requirements for the expansion population cause disproportionate harm for vulnerable groups such as people with mental health conditions, caregivers, and rural residents with limited job access. If federal work requirements were required for Medicaid expansion enrollees ages 19 to 55, 4.6 million to 5.2 million people would lose coverage.[xxviii] This would lead to barriers in care, increased uncompensated costs for hospitals and providers, and large gaps for states to fill. Additionally, it is estimated that there will be roughly 15,400 avoidable deaths due to coverage losses from work requirements.[xxix]
- **Work requirements will create barriers for patients. They increase cost and administrative burdens for States.** The proposal to require work and community

engagement activities would unravel the gains made by the state's Medicaid expansion by reducing access to health care for those most in need, while increasing administrative burdens and costs for States and failing to increase employment rates. For example, Georgia spent more than $86 million to implement its Medicaid work requirement waiver with less than 75 percent of eligible participants enrolled.[xxx]

Maryland:

Status of Work Requirements	No
Estimated number of people that would lose coverage with a federal work requirement	95,000–109,000

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Per Capita Caps

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- Medicaid is currently financed by the federal government and states through a federal match for states based on the state's per capita income, certain services, and the ACA expansion group. Proposals for a per capita cap involve a capped payment per enrollee versus funding based on costs.
- **Per capita caps do not account for patients with complex or costly needs.** Rather, the Federal government makes a flat payment for each enrollee that doesn't account for increased costs of providing care. This means states would either have to fill in the budget for increased costs of complex or costly health needs or reduce benefits. This could mean that pregnant and postpartum individuals could lose coverage for critical preventive, diagnostic, or treatment services.
- **Per capita caps do not account for state spending.** Per capita caps are unaffected by state spending, leaving states to continue financing largely on their own or to reduce eligibility levels. This could result in pregnant or postpartum people no longer qualifying for health care coverage because of reduced eligibility or the elimination of coverage enhancements such as presumptive eligibility and postpartum coverage extension.

Provider Tax

- To help finance the state share of Medicaid, 49 states use provider taxes, where 85% of the tax burden falls on health care items, services, or entities that provide or pay for health care items or services and fund Medicaid "base" rates and supplemental payments.[xxxi]
- **Provider tax revenues benefit both providers and patients.** States use provider tax revenues for base payments to providers, supplemental payments to providers, and Medicaid coverage expansion. Provider taxes are beneficial to providers who serve Medicaid patients.[xxxii]
- **Restrictions or elimination of provider taxes will result in challenges maintaining current, or increased, Medicaid spending.** In order to continue financing their Medicaid program, states will have to make cuts to Medicaid eligibility, benefits, and payment rates. Alternatively, states would have to raise taxes or cut other budgets such as education.[xxxiii]
- **Congress is considering reducing the 6% safe harbor limit which will impact physician payment.** The "hold harmless" provision of provider taxes prohibits states from directly or indirectly guaranteeing providers will receive their tax revenues back.[xxxiv] However, this provision does not apply if the tax revenue is 6% or less of patient revenues from treating patients (often called the "safe harbor" limit").[xxxv] This allows for revenues to fund payments back to the taxed providers. revenues may fund payments back to the providers being taxed.[xxxvi]

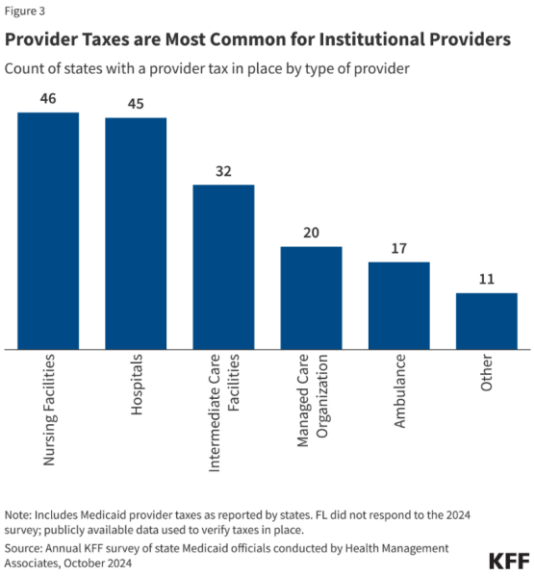

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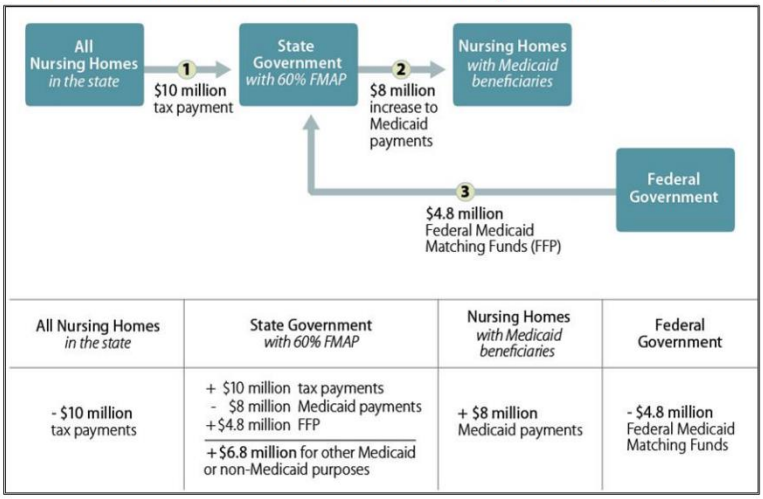
Figure 1. Provider Tax Example for a State with 60% FMAP Using Nursing Home Provider Tax Revenue to Increase Medicaid Payments to Nursing Homes



All Nursing Homes *in the state*	State Government *with 60% FMAP*	Nursing Homes *with Medicaid beneficiaries*	Federal Government
- $10 million tax payments	+ $10 million tax payments - $8 million Medicaid payments + $4.8 million FFP + $6.8 million for other Medicaid or non-Medicaid purposes	+ $8 million Medicaid payments	- $4.8 million Federal Medicaid Matching Funds

Maryland:

Use of Provider Taxes to Fund Medicaid	Yes

Addressing Fraud and Waste

- **Cutting Medicaid will increase fraud, waste and abuse.** The Trump administration and Congress are trying to push through approximately $880 billion in cuts to Medicaid over the next 10 years. Speaker Johnson has called Medicaid problematic due to fraud, waste, and abuse and has alluded to $50 billion in annual fraudulent payments, concepts that have been reiterated by the White House as well. The White House has cited "improper payments" as a form of fraud, while not clarifying that these payments are NEITHER fraud nor abuse and are due to missing documentation or missing administrative steps.[xxxvii]
    - **Fraud** is "the intentional act of deception and misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another person". Medicaid fraud is a criminal act. **Fraud is not unique to Medicaid.** Fraud also occurs in Medicare and private health insurance.[xxxviii]
    - **Abuse** refers "to provider practices that are inconsistent with acceptable business and medical practices that result in unnecessary cost to the program.
    - **Waste** is "the inappropriate utilization of services and misuse of resources that result in unnecessary cost to the program". This is an unintentional and non-criminal act.
- **Improper payments are at their lowest rate.** In 2024, the Medicaid improper rate was 5.1%, the lowest rate since the COVID-19 pandemic began.[xxxix]
- **There are checks for fraud, waste, and abuse at the federal and state levels – without federal funding, training and program integrity will be threatened.** Routine oversight and specific activities are embedded into Medicaid programs to investigate and combat fraud and abuse and mitigate different risks. While states are responsible for day-to-day program integrity, the federal government supports states through funding and training.[xl] The GAO and MACPAC have made recommendations to reduce fraud by investing in oversight and transparency, NOT by reducing federal funding.[xli]

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For more information, contact us at stateleg@acog.org

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