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What Matters for States:
Capitalizing on Reforms in the One Big Beautiful Bill

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Medicaid Needs Reform

1) One-in-four Americans is enrolled in Medicaid.

2) It is the largest and fastest growing part of state budgets.

3) About 60% of all federal funding states receive comes through Medicaid.

4) The federal share of Medicaid has grown from a historic 60% to 75% today.

5) It is increasingly a corporate welfare program for big hospital systems and insurers.

6) Medicaid is riddled with perverse incentives that fail to prioritize the truly needy and result in states devoting resources to developing financial schemes to obtain more federal money.

7) There are massive levels of waste, fraud, abuse, and improper payments

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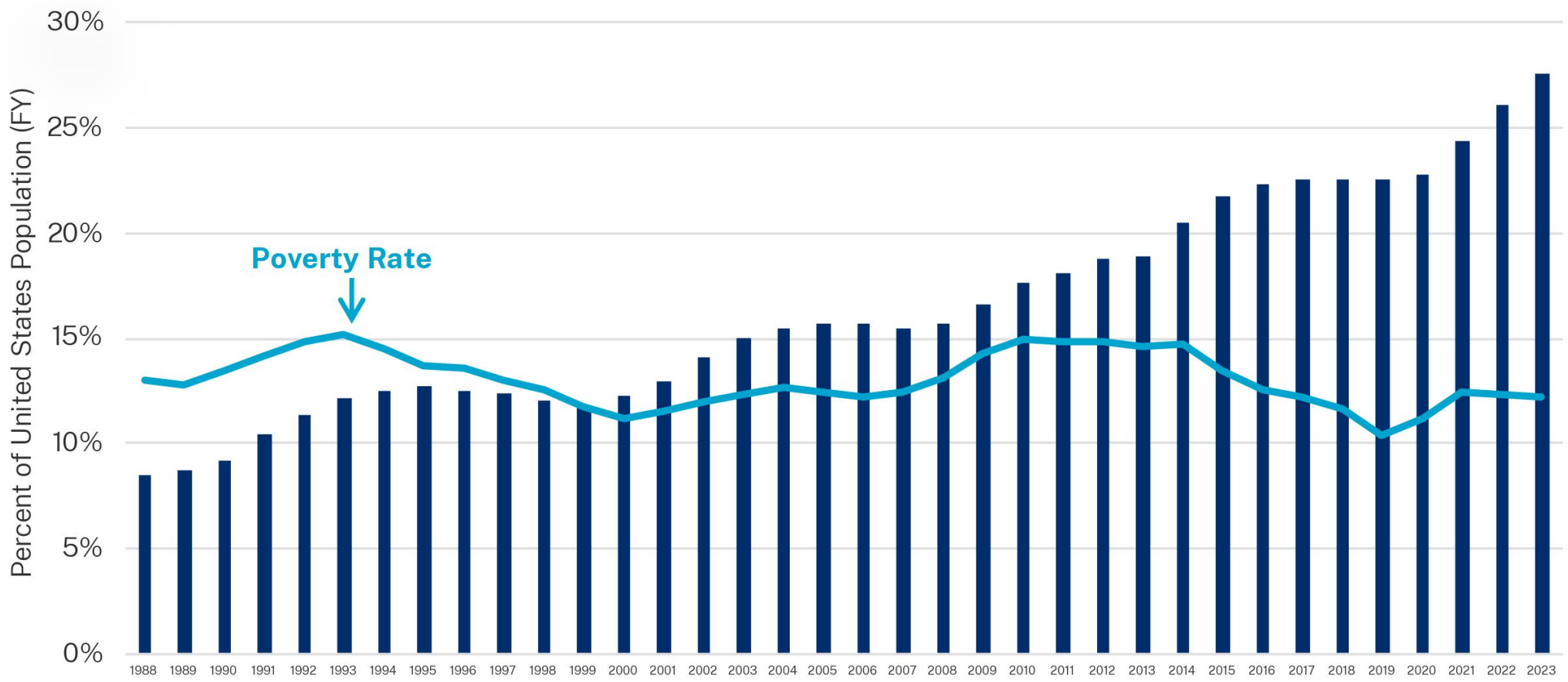
Medicaid is No Longer for the Poor

Enrollment Has Tripled over Last Three Decades as Enrollees Now Double People in Poverty



Source: MACStats - Medicaid and CHIP Databook 2023 Edition, Census Bureau, Centers for Medicare & Medicaid Services

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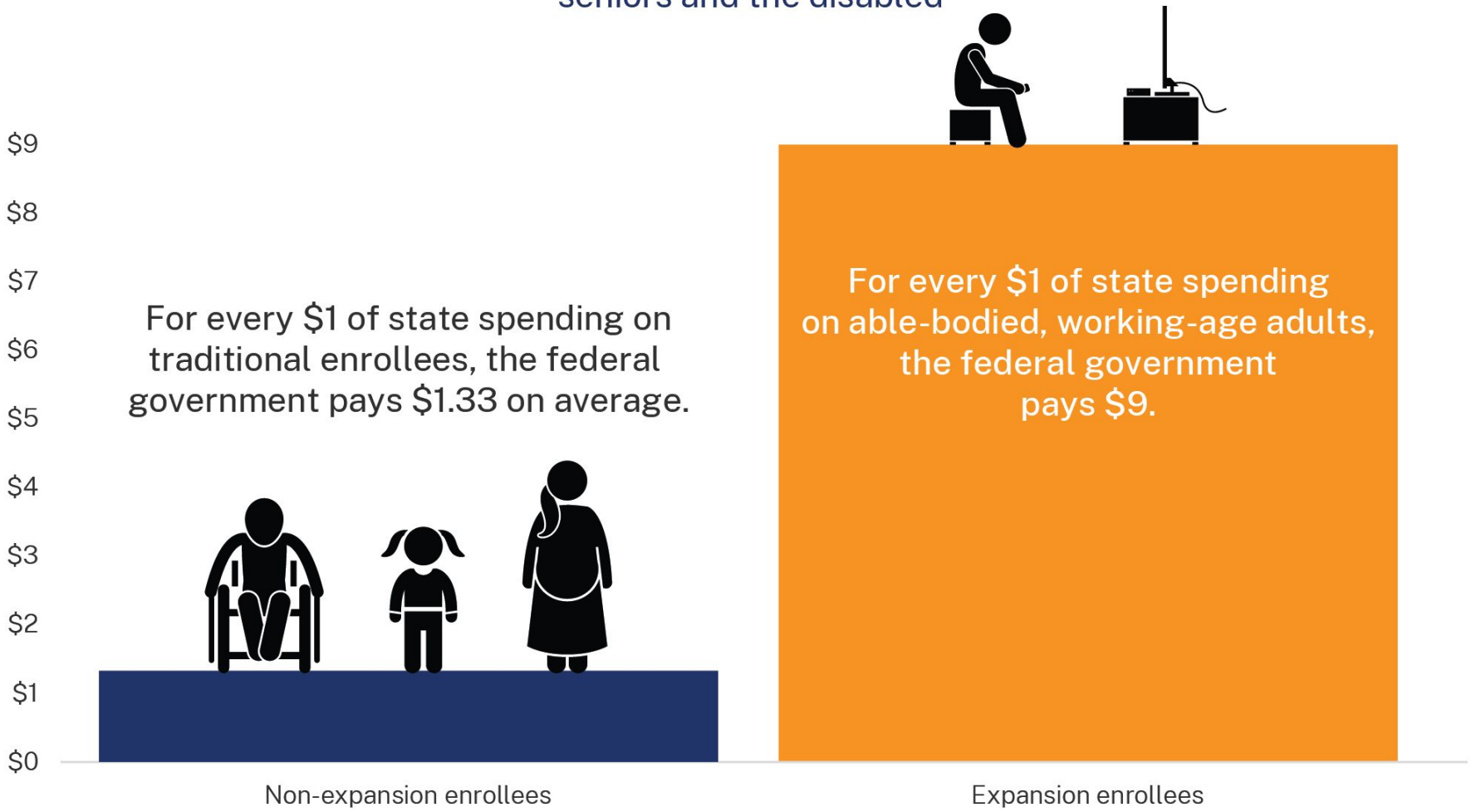
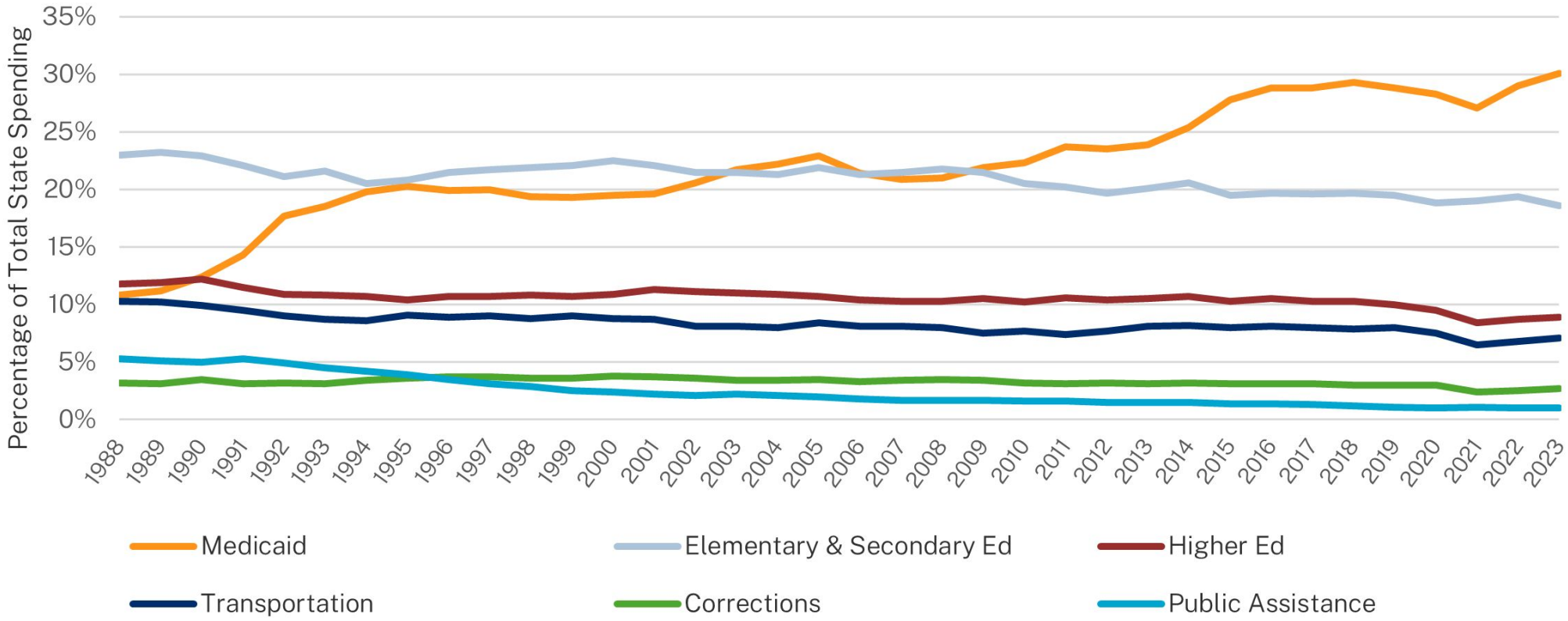
Medicaid's Broken Math:
$9 For the Able-Bodied, $1.33 for the Truly Needy

The federal government gives states 7x more for able-bodied, working-age adult enrollees than for kids, pregnant women, seniors and the disabled



Brian Blase and Niklas Kleinworth, "Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform," Paragon Health Institute, March 2025, https://paragoninstitute.org/medicaid/addressing-medicaid-money-laundering-the-lack-of-integrity-with-medicaid-financing-and-the-need-for-reform/

Medicaid as Pac-Man: Nearly 30% of State Spending on Medicaid as Other Areas Decline



Notes: This figure excludes the category of all other state spending, which is typically about 30% of total state spending.
Source: National Association of State Budget Officers' Annual Expenditure Reports

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Medicaid Improper Payment Rate Exceeded 25% in 2019 and 2020 - the Only Recent Years CMS Did Full Program Audits

Year	FFS	Managed Care	Eligibility*	Overall**
2015 - Cycle 3	18.63%	0.08%	N/A	N/A
2016 - Cycle 1	9.78%	0.49%	N/A	N/A
2017 - Cycle 2	10.55%	0.38%	N/A	N/A
2018 - Cycle 3	23.91%	0.02%	N/A	N/A
2019 - Cycle 1 *	15.12%	0.00%	20.60%	**26.18%**
2020 - Cycle 2 ***	12.67%	0.16%	22.32%	**27.47%**
2021 - Cycle 3	13.91%	0.00%	9.27%	**13.68%**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place. In relation to 2021 eligibility rates, the PERM program is unable to access data
containing Federal Tax Information (FTI) as part of the eligibility reviews. For income verification, states have the option to use the Federal Data Services Hub (Hub) or other data sources for income verification. However, IRS statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including CMS improper payment measurement programs. Since requesting FTI from states is statutorily prohibited, PERM did not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source for
Medicaid income eligibility.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.
***Due to the COVID-19 Public Health Emergency, CMS suspended all improper paymentrelated engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the public health emergency impact, the Cycle 2-specific rates may not
be comparable to other cycles.

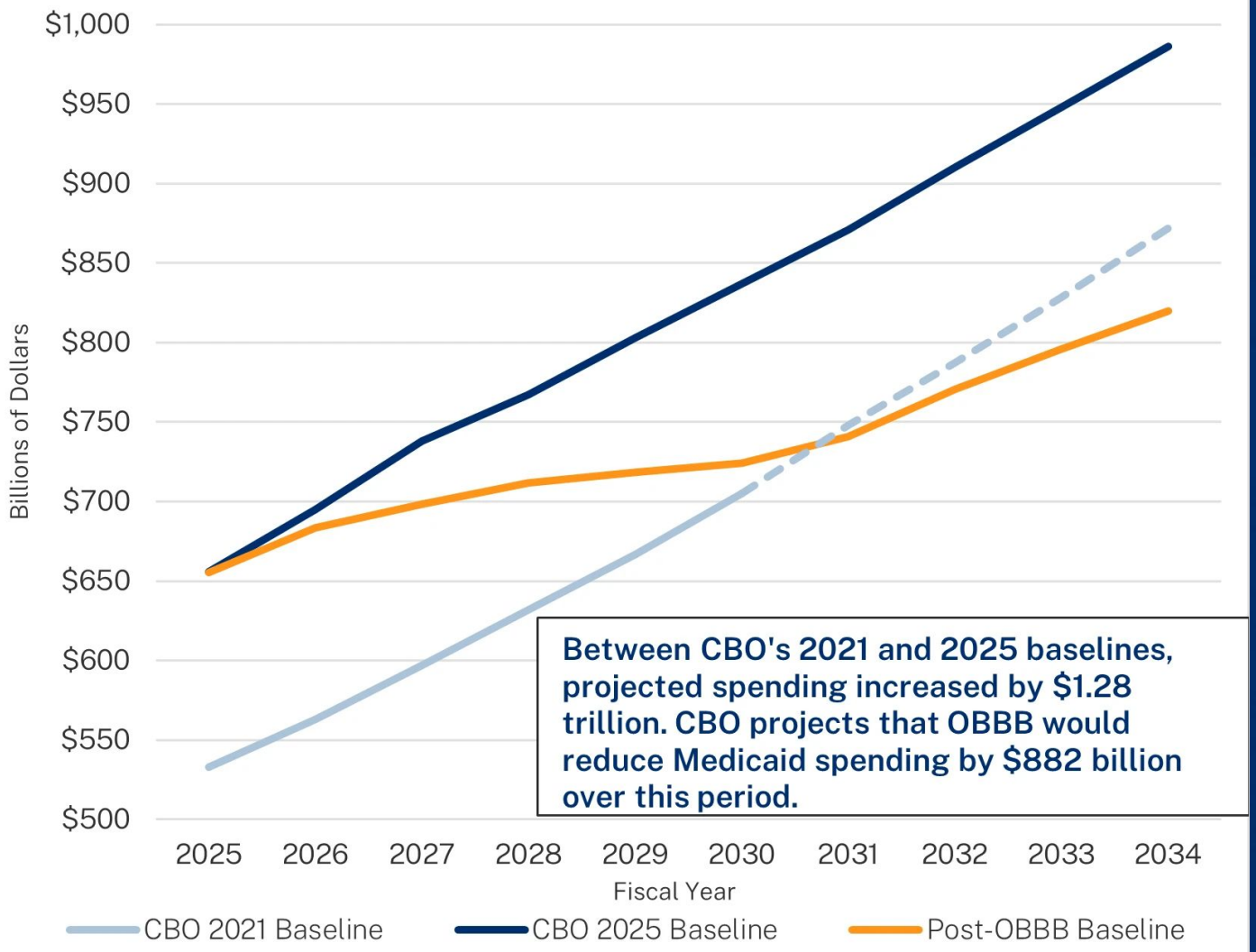
Source: Center for Medicaid and Medicare Services. "2021 Medicaid & CHIP Supplemental Improper Payment Data," https://www.cms.gov/files/document/2021-medicaid-chip-supplemental-improper-payment-data.pdf-1

Poor or nonexistent eligibility reviews are the main driver of improper payments in Medicaid.

CMS completed full audits in only two years over the past decade. In each of those years, the improper payment rate exceeded 25%.

- Obama paused eligibility audits during the first four years of Medicaid expansion.
- Biden paused eligibility audits during the COVID public health emergency.

The OBBB Would Reduce the Biden-Era Medicaid Spending Binge, Restoring Spending to the Pre-Biden Baseline by 2031



NOTE: This figure is built on CBO's estimates of OBBB, including the rural transformation program, as of July 1.

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The One Big Beautiful Bill's Medicaid Reforms

Goals: Prioritize the most vulnerable and reduce waste, fraud, and abuse within the program.

1) Implement work & community engagement requirement for able-bodied, working-age enrollees without dependents under 14

2) Places limits on the legalized Medicaid money-laundering machine by reducing states' ability to use the provider tax scheme and capping Medicaid payments (made through insurers) at Medicare levels

3) Takes steps to ensure only those eligible are enrolled and reduce waste, fraud, and abuse within the program

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Rural Health Transformation Program

- **OBBB Requirements**
  - Creates the Rural Health Transformation Program (RHTP) five-year $50 billion fund focused on rural communities.
  - Prioritizes one-time investments that improve access and sustainability.
  - Ties funding to removal of long-standing barriers, pushing states to address regulatory limits that distort rural health markets.
  - Encourages states to commit to policy reforms:
    - States receive half credit for commitments in their applications
    - Full credit once reforms are enacted.

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Expanding short-term limited duration (STLDI) Plans

- **STLDI has long provided an affordable coverage option for individuals priced out of traditional insurance.**
- **Research shows these reforms benefited enrollees and improved market stability by offering lower-cost alternatives.**
- **In 2018, the Trump administration expanded STLDI flexibility:**
  - 364-day initial terms
  - Renewals up to 36 months in total duration.
- **A 2023 Biden rule restricted STLDI sharply:**
  - Limiting contracts to 3 months and total duration to 4 months
  - The Trump administration announced it will not enforce this rule and encourages states not to enforce it
- **States should:** Bolster insurance options by expanding STLDI plans to at least Trump-era flexibilities.

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Repealing CON Laws

- **CON laws require providers to prove to regulators that new services or facilities are "needed."**
  - 38 states and D.C. still enforce CON, restricting new entrants and innovations.
  - CON laws raise per-capita health care costs by approximately 10.5% by artificially limiting supply and driving consolidation.
  - Consolidates market power among incumbents who often sit on CON boards and deny would-be competitors' applications.
- **These rules block growth in high-need areas such as nursing homes, psychiatric services, and rural hospitals.**
- **States should repeal CON laws altogether, allowing rural communities to meet demand for services.**

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Expanding Scope of Practice

- **Non-physicians (NPs, PAs, pharmacists) face arbitrary, government-imposed limits despite credentialing comparable to physicians.**
- **These laws:**
  - Create provider shortages
  - Drive patients into higher-cost physician settings
  - Duplicate care and payments
  - Reinforce physician-centered care monopolies
- **Several states are rolling back restrictions, such as expanding pharmacists' prescriptive authority.**
  - These states include: CO, ID, IN, IA, MT
- **States should** allow health care professionals to practice at the top of their license by removing t arbitrary scope-of-practice barriers

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