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The Threatened Medicaid Catastrophe: What Boards Should Know and Do

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The landscape of issues that keep hospital board members and management awake at night has changed dramatically in the last several weeks. Regardless of party identification or ideological persuasion, healthcare leaders will need to accept the fact that many of the policies and proposals being discussed in our nation's capital today have profound implications for hospitals and the patients and communities that rely on them. Even issues seemingly unrelated to healthcare, like the immigration crackdown, can have significant implications for the ability of hospitals to hire and retain highly qualified doctors, nurses, and other clinicians, or to protect the privacy of their patients and the confidentiality of patient records.

The cancellation of hundreds of federal health-related grants, contracts, and programs—along with the layoff of thousands of federal employees—has already led to chaos and slowed the pace of medical and scientific breakthroughs. Over time this could reduce quality and access to care, resulting in worse outcomes for patients. The erosion of many aspects of the social safety net, including housing, nutrition programs, and education, will also impact the most vulnerable patient populations. Tariffs and the trade wars have already begun to disrupt the health industry supply chain. Threats to the tax-exempt status of hospitals, universities, and other health-related entities will also prove to be disruptive, even if the threats are not carried out.

However, nothing is frightening public and non-profit hospital management and boards today quite as much as the prospect of major cuts in the Medicaid program. While Medicare appears for now to be safe, it is beginning to look like open season on

Medicaid. The recently enacted Congressional budget resolution tasks the House Energy and Commerce Committee with finding $880 billion in budget cuts in the programs within the committee's jurisdiction that are subject to appropriations—and Medicaid accounts for 95 percent of those programs.

The federal budget reconciliation process was initially enacted by the Congressional Budget and Impoundment Control Act of 1974 and created a process that permitted Congress to consider "reconciliation" of tax and spending rules under an expedited procedure. Most notably, the law permits Congress to adopt such legislation under certain circumstances without it being subject to a filibuster in the Senate. The process has been used often in the last half-century to cut spending, increase or reduce taxes, and even to develop sweeping reforms. Reconciliation was used, for example, to enact major provisions of the Affordable Care Act.

This year, Republican leadership in both houses of Congress are hoping to use reconciliation to extend expiring tax cuts and make major changes to federal spending on programs, including Medicaid. In February, the Senate and House each passed separate budget resolutions, and on April 5, the Senate passed a revised resolution attempting to reconcile the differences. This version, which was adopted by the House on April 10, provides "reconciliation instructions" for enacting tax, energy, border security, and other policies as well as federal spending reductions.

The revised budget framework establishes different rules for reconciliation in the House and Senate. House committees are required to offset the cost of extending the tax cuts by at least $1.7 trillion, where the Senate sets a savings floor of just $4 billion.[1] As a result, the House Energy and Commerce Committee, which has jurisdiction over Medicaid, is directed to reduce spending "by not less than $880 billion" over 10 years, whereas the Senate version includes no such instructions.

Although the House version of the budget resolution does not mention Medicaid, that program comprises $8.2 trillion out of the $8.6 trillion in mandatory 10-year spending from which the House Energy and Commerce Committee must come up with spending reductions. As a result, major cuts to Medicaid are the only way to meet the House's budget resolution goal. Assuming that the $880 billion in cuts over a decade are spread uniformly across 10 years, or $88 billion a year, this represents around 16 percent of federal Medicaid funding in FY 2024. If that level of funding is extracted from Medicaid—whether through reduced eligibility or other budget-cutting mechanisms—it could prove disastrous for many hospitals, especially safety net, rural, and teaching hospitals, potentially putting them out of business or forcing them into insolvency.

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1 Andrew Lautz and Rachel Snyderman, "What's in the FY2025 Budget Resolution," Bipartisan Policy Center, April 5, 2025.

Possible Medicaid Budget Reconciliation Proposals

- Establish Medicaid work requirements as a condition of Medicaid eligibility.
- Eliminate the enhanced matching rate for "Medicaid-expansion" states.
- Reduce incentives for "non-expansion" states to expand their Medicaid programs.
- Lower the minimum federal Medicaid matching rate.
- Eliminate Medicaid and Children's Health Insurance Program (CHIP) eligibility for certain legal immigrants.
- Restrict state use of provider taxes to finance state Medicaid costs.
- Limit or eliminate state-directed supplemental payments to providers.
- Convert federal Medicaid funding to a per capita cap structure.
- Standardize Medicaid administrative matching rate.
- Biden Administration rules that could be repealed to generate savings:
  - Medicaid Eligibility and Enrollment Rule
  - Ensuring Access to Medicaid Services Rule
  - Medicaid, CHIP Managed Care Access, Finance, and Quality Rule
  - CMS Nursing Home Minimum Staffing Rule

Now that both houses have passed their respective versions of reconciliation instructions, the House leadership has directed its committees to produce legislation implementing the proposed cuts by no later than May 9. This has created a sense of urgency for healthcare industry leaders, including hospital management and governing boards, to try to minimize (or mitigate) the impact of the proposed cuts. In that regard, there are several points for board members to take into account during this critical period.

Be Prepared to Play the Long Game

Almost since the enactment of the Medicaid program, there have been legislative efforts to undermine it, many of which also sought to use the budget reconciliation process. In 1981, incoming President Ronald Reagan sought to replace Medicaid with a block grant that would have effectively terminated it as an entitlement. Republicans (who controlled the Senate) and Democrats alike worked together to preserve Medicaid as an entitlement. However the Reagan administration did succeed in passing legislation in the Omnibus Budget Reconciliation Act of 1981 that granted states greater flexibility in setting hospital payment rates—a process that also gave birth to the requirement that if a state chose to adopt a different payment methodology, it nonetheless would be required to "take into

account the situation of hospitals that serve a disproportionate number of low-income patients with special needs." In other words, the first iteration of what came to be known as the disproportionate share hospital (DSH) requirement in Medicaid grew out of the efforts of a new President to gut the program. In addition, despite the expressed intention of the House leadership to move rapidly to pass a reconciliation bill, history clearly tells us that it is likely to take months rather than weeks to achieve such a goal. The need to play the long game was underscored on May 1, when the White House released a "skinny budget" proposal for the next fiscal year, which begins October 1, 2026. That proposal—lacking in many details—proposes to further cut the Department of Health and Human Services budget by over 26 percent in the new fiscal year.

Accept that Medicaid Needs Reform—But Not with a Chain Saw

It is safe to say that if we were trying to reinvent Medicaid, we would not necessarily design the program we have today. Most notably, when Congress broke the link between Medicaid and Medicare reimbursement principles and permitted states to adopt their own payment methodologies, most states adopted methodologies that were guaranteed to pay hospitals and other providers significantly less than Medicare or commercial payers. As a result, the program began to rely on "workarounds" to make up for the losses and provide at least some assurance that Medicaid recipients would have access to providers.

These workarounds have taken various forms over the years, including DSH payments and other forms of supplemental fee-for-service payments or state-directed payments made through managed care organizations. Currently, over 40 percent of all Medicaid payments to hospitals flow through these mechanisms annually.[2]

In addition, because many states were unable or unwilling to support the non-federal share of these additional payments, states also looked to providers themselves to make up the difference, through such mechanisms as inter-governmental transfers from public providers and provider taxes or assessments from private providers. These supplemental payments and non-federal funding mechanisms have been under attack for years, and as a result they are also listed among the possible budget cuts on the table during the current reconciliation process.[3] However, these mechanisms currently support many billions of dollars in Medicaid payments to providers in all 50 states and play an essential role in supporting the otherwise under-reimbursed care provided by many Medicaid providers. They cannot simply be eliminated without a devastating impact of providers and patients alike.[4]

2 "Medicaid Base and Supplemental Payments to Hospitals," Medicaid and CHIP Payment and Access Commission Issue Brief, April 2024.

3 "Directed Payments in Medicaid Managed Care," Medicaid and CHIP Payment and Access Commission Issue Brief, October 2024.

4 "States With At Least One Provider Tax in Place," KFF Medicaid Policy Action Trends, 2025.

Medicaid Is Not Strictly a Partisan Issue

The devastating impact of many of the proposed Medicaid cuts would fall equally on red states and blue states, and a number of House and Senate Republicans have expressed their opposition to dismantling the Medicaid program as we know it. These individuals, particularly in the House, have been warning leadership about how far they are willing to go in cutting Medicaid.

Some GOP lawmakers say they are willing to block the final reconciliation package if it goes too far, an unusual show of defiance from the centrist wing. Rep. Don Bacon (R-Neb.) has been quoted as saying he would vote against a final bill if it includes "massive spending cuts that harm Medicaid." Rep. Bacon has said, "I reflect about 20 people. I think there's a bunch of us that don't want to see cuts to the quality of healthcare and reimbursements to hospitals. We think $880 [billion] would force that."[5] Rep. Nicole Malliotakis (R-N.Y.) has been quoted as saying, "There's a clear understanding between many of us and the speaker. We will not vote for something that takes away eligibility from our constituents, period."

On April 29, House Rep. Chip Roy (R-TX) responded to the House Speaker's attempt to set a May 9 deadline for committee action on reconciliation by stating that he does not "see deadlines as sacrosanct." And on May 1, House Appropriation Committee Chair Tom Cole (R-OK) also pushed back on the new White House "skinny budget" proposal.[6]

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There Is Safety in Numbers—Board Members Should Reach Out to Build Local and Regional Coalitions

While these expressions of support for Medicaid are positive signs, boards should not take that support for granted once the legislative process begins to gather momentum. House members in particular will face substantial arm-twisting to support an omnibus reconciliation bill in which it may be possible to "hide" many harmful provisions. It is therefore still imperative that board members work together with management to reach out to potential allies, particularly locally and regionally, to educate legislators about the impact of significant Medicaid cuts.

Board members can make common ground with existing organizations representing hospital interests. The Washington State Hospital Association recently told its members that "legislative advocacy is the most important step hospital leaders can take right now. Medicaid is a safety net for the most vulnerable members of our community, and cuts are likely to lead to service reductions that impact all patients—not just patients who rely on Medicaid.... There are likely to be patients who are unable to overcome the

5 "The Red Lines Begin: A Dozen House Republicans Say No to Big Medicaid Cuts," Punchbowl News, April 16, 2025.

6 See "Donald Trump's budget may cut too close to the bone even for Republicans," Bloomberg Government Afternoon Briefing, May 2, 2025.

barriers presented by these cuts. We and our members are sharing this information with members of our congressional delegation."[7]

It is also important to take advantage of the role and respect many board members enjoy in their communities and reach out to other governing boards and representatives of the patient population, the physician community, and others.

Key Board Takeaways

- Be prepared to play the long game.
- Accept that Medicaid needs reform—but not with a chain saw.
- Medicaid is not strictly a partisan issue.
- There is safety in numbers—board members should reach out to build local and regional coalitions.
- Don't shy away from contingency planning.

Don't Shy Away from Contingency Planning

Hospitals in states most vulnerable to Medicaid funding reductions are already preparing for what some leaders describe as a financial reckoning. If federal proposals to roll back Medicaid expansion move forward, hospitals could see a $31.9 billion loss in revenue and $6.3 billion in additional uncompensated care, according to an analysis from the Urban Institute and the Robert Wood Johnson Foundation.[8]

The Washington State Hospital Association also encouraged "hospital governing boards to begin having conversations about what services may need to close. With the potential cuts at the state and federal levels for hospitals in our state, services will be lost. We are urging board members and hospital leaders to start now so they can do closures in a planful way with time to consider options."[9]

A recent article quoted Elaine Batchlor, M.D., CEO of MLK Community Healthcare, a safety-net health system based in South Los Angeles, as sharing "that her strategy has been dominated by proposed cuts to Medicaid funding—and what they could mean for the community and for the survival of the system's 131-bed Martin Luther King Jr. Community Hospital. We've talked about which services we might have to stop providing to our community. Unfortunately, labor and delivery is always vulnerable when finances are stressed, because most hospitals lose money on labor and delivery services."[10]

7 Alan Condon and Madeline Ashley, "Health Systems 'Proactively' Planning for Range of Medicaid Scenarios," *Beckers Hospital Review*, April 9, 2025.
8 *Ibid.*
9 *Ibid.*
10 Kelly Gooch and Kristin Kuchno, "8 Health System CEOs on the Turbulence Defining 2025," *Becker's Hospital Review*, April 21, 2025.

In conclusion, the current threats to the future of one of the nation's most important safety net programs are very real and should be taken seriously by hospital governing boards. But board members are not without tools to head off the most serious threats or at least mitigate their impact—especially if you draw upon the leadership qualities and stature in your communities that led to your appointment in the first place.

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