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Impact of Potential Federal Medicaid Changes on Kansas

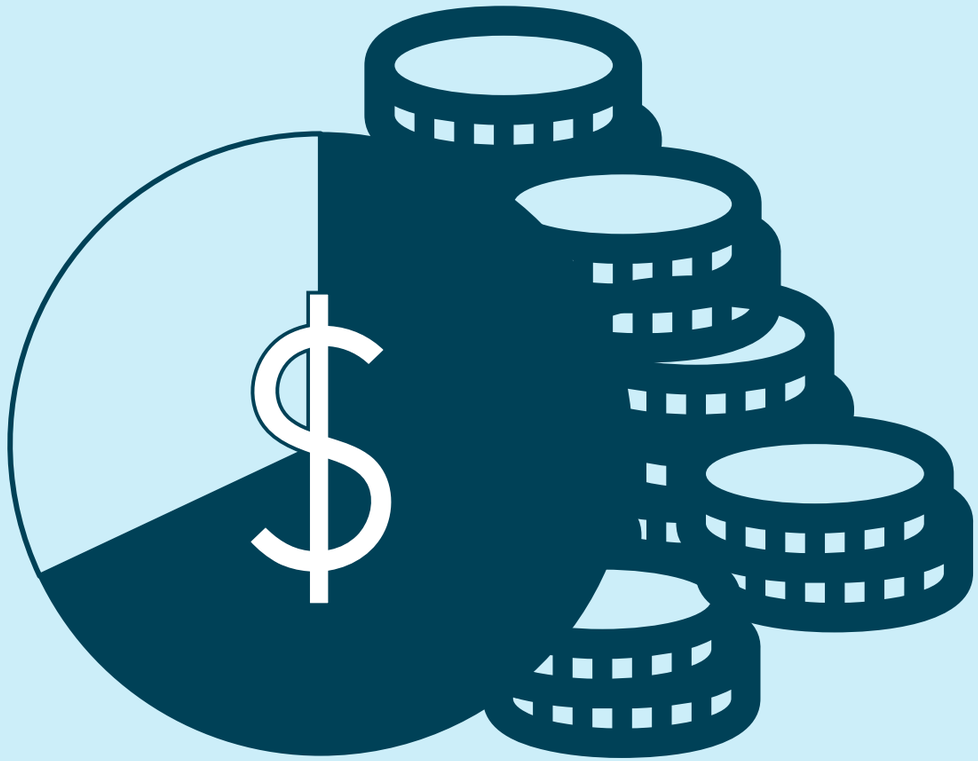
April 28, 2025

What's At Stake for Kansas?

Congress is considering deep cuts in Medicaid – in the House, the cuts could be at least $800 billion over ten years.

Federal Medicaid funds finance more **than two-thirds of Kansas' Medicaid program.**

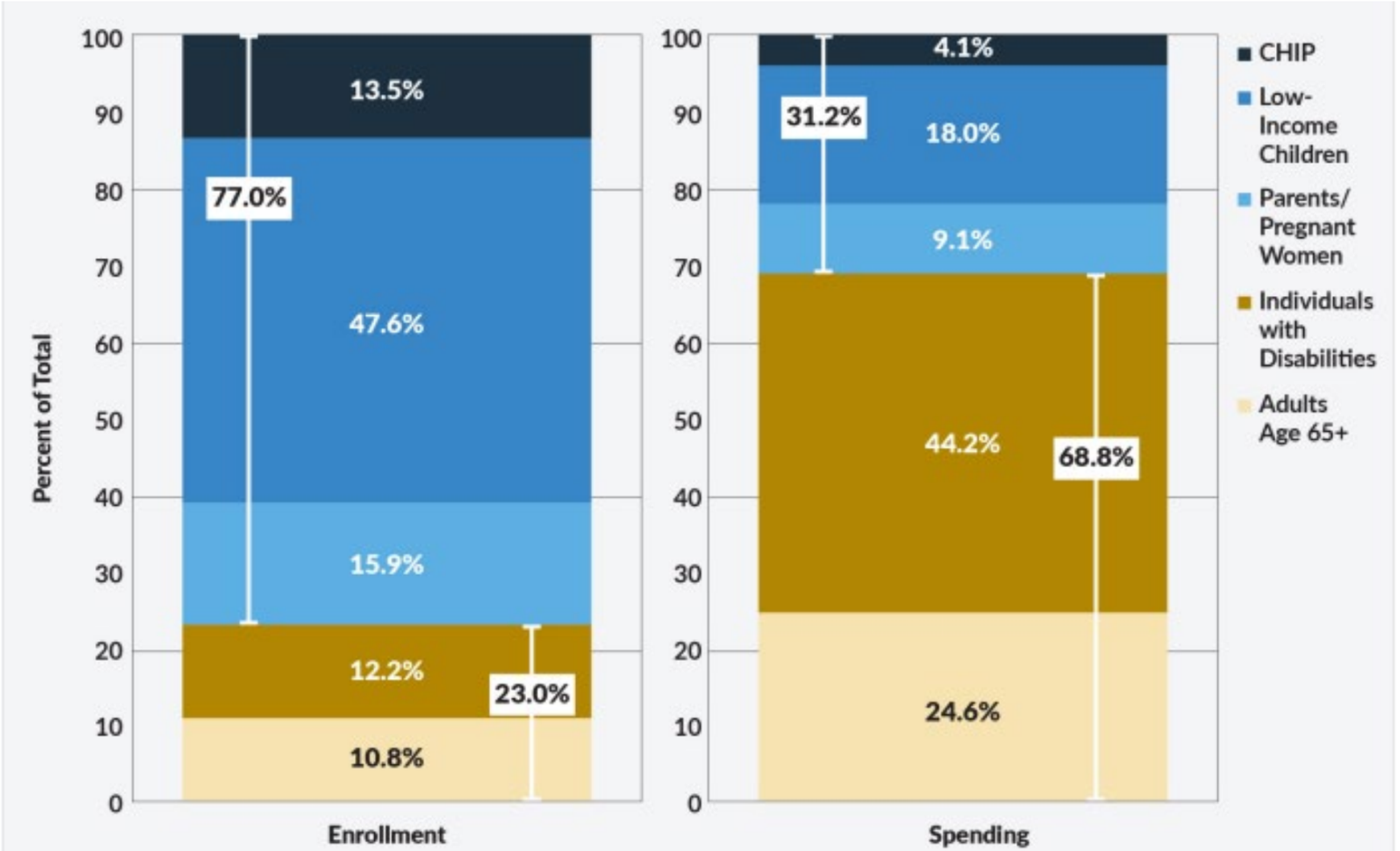
Deep cuts in federal Medicaid funding would require Kansas to either **sharply increase state spending** just to maintain coverage, **cut services**, **terminate coverage**, and/or reduce **provider payments** and access to care, not just for those enrolled in Medicaid.



Source: House Resolution; NASBO, 2024 State Expenditure Report; CBO Analysis (March 5, 2025).

No Group of Enrollees Would be Shielded from Cuts

- **Children account for the largest proportion of enrollment and 18% of spending**.
- **Enrollees eligible based on disability or age (65+) comprise 23% of all enrollees but account for over two-thirds of total spending**.
- Medicaid is the largest source of funding in Kansas for **long term care services and supports and behavioral health**.



Note: Low-income children include those enrolled in Medicaid based on household income. Enrollment and spending do not include the following populations: foster care/adoption, the sixth Omnibus Budget Reconciliation Act (SOBRA) program, tuberculosis, breast and cervical cancer and the AIDS Drug Assistance Program (ADAP). Figures may not sum to 100 percent because of rounding. Additional information on populations begins on page 26.

Source: Kansas Health Institute analysis of Kansas Medical Assistance Report (MAR), FY 2023, and additional data from the Division of Health Care Finance, Kansas Department of Health and Environment.

Source: KHI, Medicaid Primer 2024

Rural Communities Would Be Hit Hard

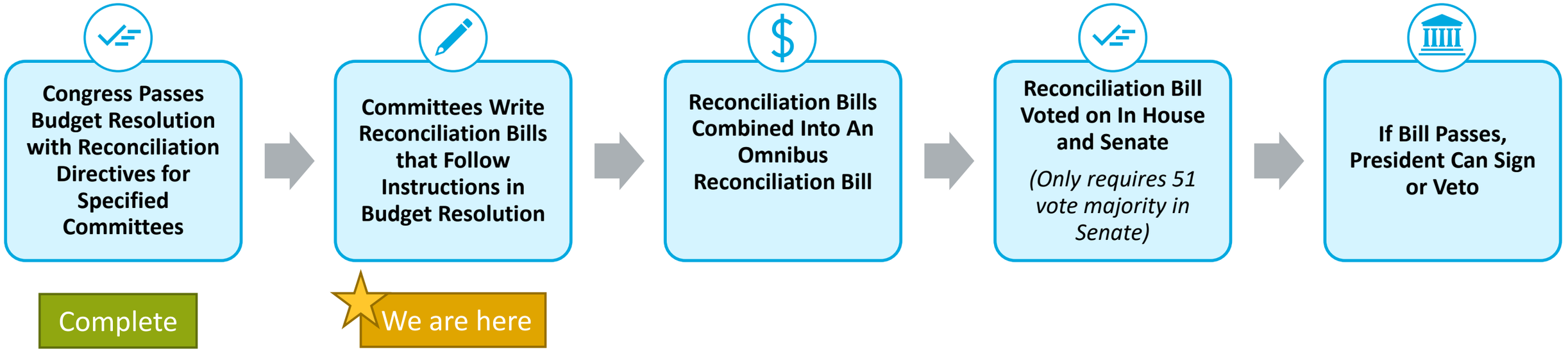
- Rural hospitals are already financially fragile and struggling to survive; losing **Medicaid dollars could devastate them and further reduce access to care in small towns.**
- 64% of Kansas' rural hospitals, which rely heavily on Medicaid funding, are at risk of closure. **One-quarter of rural hospitals, are at immediate risk of closing—the highest of any state.**
- **More than 70% of hospitals already had a negative operating margin in 2022 and 2023.**
- Given higher unemployment rates, more variable work, and transportation and infrastructure challenges, **work reporting requirements will have an outsized impact on Kansans living in rural communities.**

Source: Rural Hospitals at Risk of Closing; Kansas Rural Health Association; Kansas Hospital Association; CBPP, Medicaid Work Requirements Will Harm Rural Residents

Federal Medicaid Changes and Budget Reconciliation

Status of Congressional Budget Reconciliation

Congress is using the budget "Reconciliation" process to extend the 2017 tax cuts; Medicaid cuts have been proposed to offset the impact of the tax cuts on the federal deficit.



Source: Senate Resolution; House Resolution; CBO Analysis (March 5, 2025).

Congressional Proposals to Reduce Federal Medicaid Funding

Congress is considering these and other proposals to reach their "targets" for cuts in federal Medicaid funds:

- **Limiting states' use of provider taxes** which Kansas relies on to fund its share of Medicaid costs
- **Cutting special payments** Kansas relies on to supplement payments hospitals receive when they treat a Medicaid patient, making up for low Medicaid base rates
- **Requiring work reporting requirements** that have led to large coverage losses, due to paperwork, in every state that has implemented them
- **A per capita cap** that would put Kansas at risk for all costs above the caps
- Other changes that could **create new administrative barriers to enrollment** for eligible people

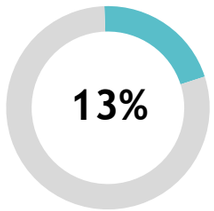
Kansas Medicaid (KanCare)

Kansas Medicaid: Who is Covered?

Medicaid in Kansas is administered by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services. Kansas contracts with managed care organizations (MCOs) to provide coverage for most Medicaid enrollees through KanCare. KanCare currently provides health care coverage to over 366,000 Kansans.*

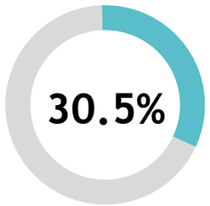
KanCare

Covers



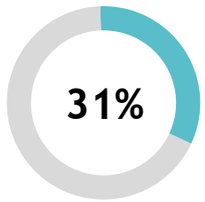
of women ages 15 to 49

Covers



of Kansas' children

Pays for



of all births in the state

Covers

1 in 4 working-age adults with disabilities

Covers

4 in 7 nursing home residents

KanCare is critical for rural Kansans:

- Nearly **1 in 3 children (32%)** covered by Medicaid live in rural areas
- More than **1 in 10 adults (11%)** covered by Medicaid live in rural areas
- More than **1 in 10 seniors (12%)** covered by Medicaid live in rural areas

Kansas has not expanded Medicaid to individuals making less than 138% of the federal poverty level (FPL, $21,597 for an individual in 2025).

* This excludes CHIP / M-CHIP enrollees.

Source: KanCare, Spending and Enrollment Reports; KFF, Medicaid in Kansas; Georgetown, Kansas Children's Health Report Card; Georgetown, Medicaid's Role in Small Towns and Rural Areas

Kansas Medicaid: Who Pays?

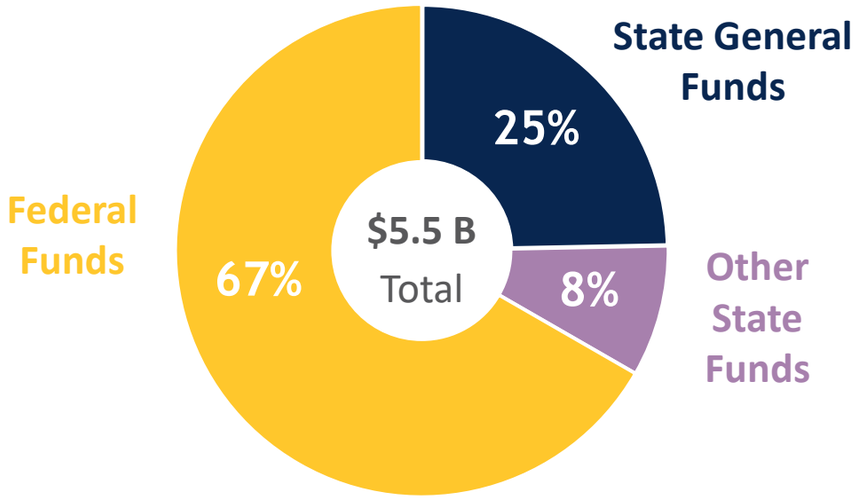
In FY 2023, Kansas spent nearly $5.5 billion on Medicaid, over two-thirds of which was federal funds. Medicaid is the largest source of federal funds in the state.

Currently, the federal government shares the cost of all Medicaid spending, without any pre-set limit.

Federal Share of Costs (2026)

Type of Cost	Federal Share
Most Medicaid Services	60.67%
Children's Health Insurance Program (CHIP) Funding (In Medicaid and Kansas' separate CHIP program)	72.47%
Administrative Costs*	50%

Kansas Medicaid Budget (FY 2023)



* Federal match for administrative activities does not vary by state and is held at 50%. States may receive a higher match rate for certain administrative activities.

Source: NASBO, 2024 State Expenditure Report; Federal Register, Fiscal Year 2026 FMAP

Kansas Medicaid: Source of Care for Vulnerable Populations

KanCare is a key source of coverage and care for women, people with behavioral health needs, children and (in very low-income families and their parents), and seniors and people with disabilities who need long term care at home or in nursing homes.

Women make up around 64% of adult Medicaid enrollees in Kansas. In 2023, KanCare covered nearly 10,700 births.

KanCare pays for nearly one-third of all behavioral health care in the state.

KanCare covers low-income children whose families already face financial stress.
1 in 10 Kansans already struggle with medical debt.

Long-term care services, including home-and community-based services (HCBS), account for 40% of all KanCare spending.

Source: KFF, Births Financed by Medicaid; Kansas Legislature, Overview of Community Mental Health System; KHI, Medicaid Expansion Impact on BH; KFF, Burden of Medical Debt; KHI, Medicaid Primer 2024

Impacts of Federal Medicaid Changes on Kansas

Manatt Health Model

- **Manatt evaluated the impact in Kansas of "pre-legislative" policy proposals under consideration in Congress,** aligning the policy parameters with recent federal bills and options developed by the Congressional Budget Office (CBO).
- Manatt's **50-state model is built "from the bottom up"** relying on publicly available state data and hospital data from the Kansas Hospital Association and informed by CBO's projections of enrollment / costs over time.
- Estimates will be **updated and interactions considered when there is legislative language.**
- See appendix for **data sources.**

Provider Taxes and State Directed Payments

Medicaid Provider Tax Reductions

States levy taxes on health providers (e.g., hospitals, nursing homes, managed care plans) to help finance the state share of Medicaid costs. Under federal rules, taxes generally may not exceed 6% of net patient revenues for the class of providers subject to the tax.

Potential Federal Policy Change

- Federal proposals would **reduce the amount of provider taxes states could raise**, by lowering the allowable rate to 5, 3 or 2.5 %
- To make up for the loss in provider taxes, states would need to rely on other sources of state funding (e.g., general funds) or make cuts to accommodate the loss of state and associated federal funding.

Kansas-Specific Context

- **Kansas assesses a 3% provider tax on hospitals and nursing homes**.** As of 2024, Kansas received $180 million in annual revenue from the hospital tax which, when invested into Medicaid, allows the state to receive $315 million in federal aid.
- In 2024, Kansas' legislature enacted **an increase in the hospital provider tax to 6%** to boost Medicaid rates to Kansas hospitals; that increase is not yet in effect.

*In addition to hospitals and nursing homes, Kansas also assesses provider taxes on continuing care retirement communities, facilities with no more than 45 skilled nursing beds, and high Medicaid volume facilities providing multiple levels of care.
**Due to a lack of data, the impact of the reduction in provider taxes on nursing homes was not modeled.

Source: KHI, Impacts of Federal Policy Decisions on Medicaid; Kansas Reflector, House Passes Budget; ; Kansas Division of Budget; HB 2250

Medicaid Provider Tax Reductions: Impact Based on Current Tax

For more information on Manatt's model and potential state responses and associated impacts, see appendix

If Kansas did not replace its lost revenue, reducing the provider tax limit to 2.5% would cut federal funding for KanCare by:

↓ **$60 million** ***(in one year)****

↓ **$636 million** ***(over ten years)***

Kansas' Medicaid state funds would decrease by		Kansas' total Medicaid funding would decrease by
$39 million *(in one year)**	**AND**	**$98 million** *(in one year)**
$413 million *(over ten years)*	**AND**	**$1.1 billion** *(over ten years)*

The projected loss in federal funding in one year is nearly comparable to all KanCare spending on dental services in FY 2023 ($76 million).

* Reflects first year of estimated implementation in 2026
- Totals may not sum exactly due to rounding

Source: KHI Medicaid Primer 2024

State Directed Payment (SDP) Reductions

SDPs allow states to direct Medicaid managed care plans to supplement base payments to state-identified categories of providers to improve access and quality of care.

Potential Federal Policy Change

- **Federal proposals could curtail or eliminate SDPs**
- Current federal rules allow states to increase SDPS **up to the average commercial rate** paid in the state/region.
- One proposal would **cap SDPs at Medicare-equivalent rates.**
- In most states, the nonfederal share of the cost of SDPS is financed through **provider taxes.**

Kansas-Specific Context

- In 2024, Kansas' SDPs approved by CMS totaled $508 million. The state's share is financed by provider taxes.
- Kansas' SDPs are set **at 93% of the average commercial rate (ACR) for inpatient services** at general hospitals, well above Medicare rates. The rate is lower for outpatient and critical access hospitals.
- Along with the recent increase in the state's hospital provider tax, Kansas' legislature approved **an increase in the SDP rate paid to hospitals.**

Source: Kansas Reflector, House Passes Budget; HB 2250

SDP Reductions: Impact on Hospitals Based on Current SDP

For more information on Manatt's model and potential state responses and associated impacts, see appendix

If Kansas did not replace its lost revenue, limiting SDPs from current levels to Medicare-equivalent rates would cut federal funding for Kansas hospitals by:

↓ **$209 million** ***(in one year)****

↓ **$ 2.2 billion** ***(over ten years)***

<u>State</u> Medicaid funds for hospitals would decrease by		<u>Total</u> Medicaid funding for hospitals would decrease by
$135 million ***(in one year)****	**AND**	**$344 million** ***(in one year)****
$1.4 billion ***(over ten years)***	**AND**	**$3.7 billion** ***(over ten years)***

The projected loss in federal funding in one year is nearly twice the amount of all KanCare spending on hospital outpatient services in FY 2023 ($107 million).

* Reflects first year of estimated implementation in 2026
- Totals may not sum exactly due to rounding

Source: KHI Medicaid Primer 2024

Provider Tax and SDP Reductions: Impact on State Revenue Increases

If Congressional proposals to reduce provider taxes and SDPs are enacted, Kansas would lose some and perhaps all of the revenue and federal match expected from the new tax and SDP.

- Kansas is expected to receive **nearly double the funding** under its new 6% provider tax on hospital inpatient and outpatient services.
- Reducing provider taxes to 5%, 4% and 3% are not applicable under Kansas' current 3% provider tax on hospitals. Any of these scenarios would **force the state to forgo the additional revenue from the increased provider tax and SDP** already approved by the legislature.

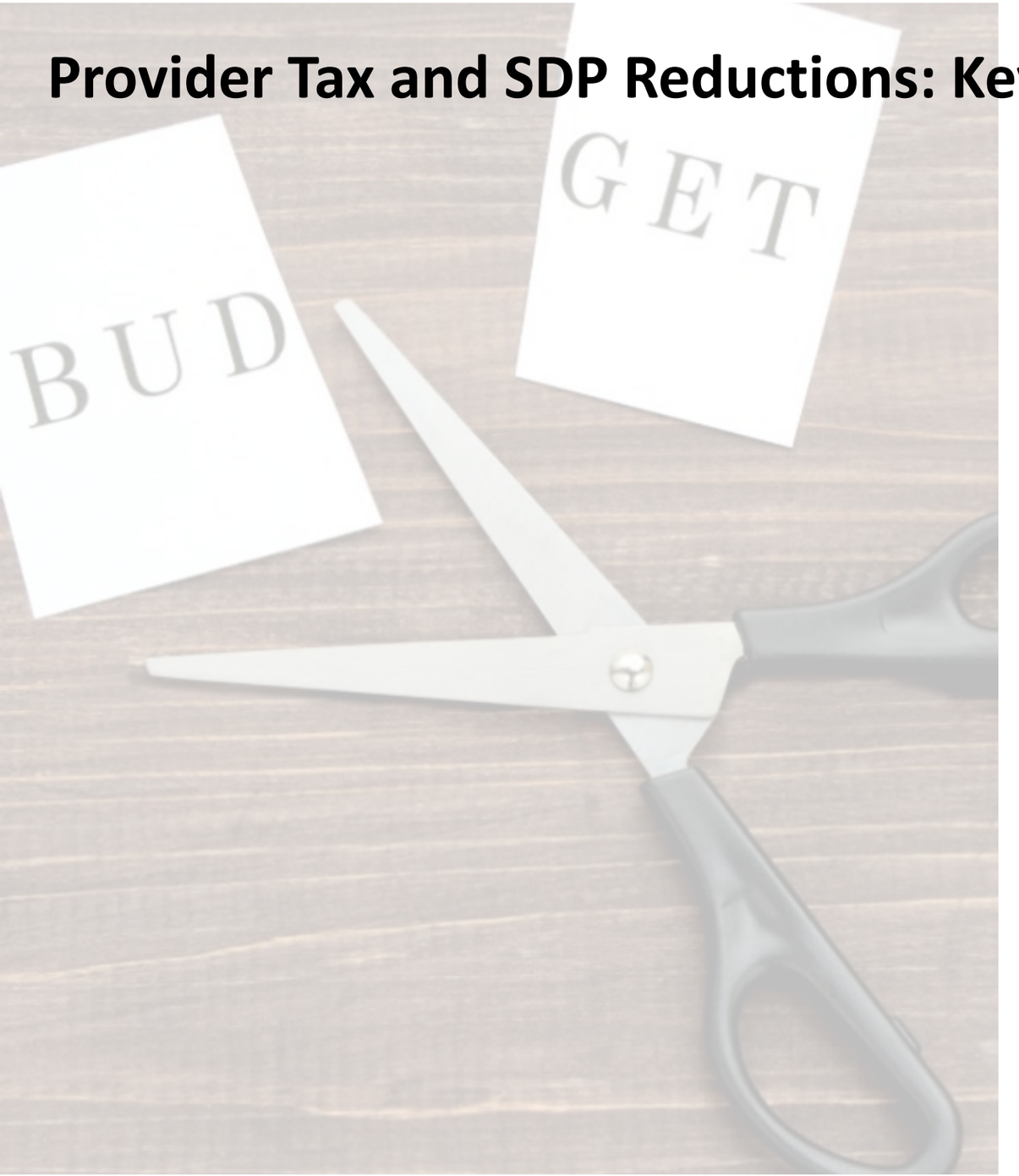
The increased provider tax passed by the Kansas legislature is expected to bring in an additional:

↑ **$180 million**
in annual revenue

↑ **$315 million**
in federal aid annually, when invested in Medicaid

Source: Kansas Reflector, House Passes Budget; Kansas Division of Budget; HB 2250

Provider Tax and SDP Reductions: Key Takeaways



- **Kansas has highest number of rural hospitals at risk of closing of any state.**
- Efforts to curtail or eliminate provider taxes and/or SDPs would push many of these hospitals to close, hurting not just Medicaid enrollees but all rural Kansans that rely on these hospitals for care.
- Kansas' legislators have determined that hospitals need a financial boost, enacting a larger SDP, financed with a provider tax, but Congressional action could undo some or all of this relief to Kansas' hospitals.

Work Reporting Requirements

Medicaid Work Reporting Requirements

Potential Federal Policy Change

- **Congress is considering mandating states to impose work reporting requirements**, where Medicaid eligibility for adults is conditioned on regularly reporting to show compliance or qualification for exemption.
- Work requirement Medicaid waivers were approved under the first Trump Administration. One (Georgia) is currently in place.
- The waivers that were implemented led to large losses in coverage due to paperwork burdens.

Kansas-Specific Context

- In its 2017 waiver proposal, Kansas proposed a work requirement in KanCare. The state later deferred consideration of this portion of its waiver.
- The COVID-19 pandemic and Biden Administration actions put work requirements off the table.
- In 2023, Governor Laura Kelly proposed legislation, which was not enacted, to expand the state's Medicaid program with work requirements for certain enrollees. If Congress includes a mandate, Kansas will no longer have a say in whether or how to adopt these measures.

Medicaid Work Reporting Requirements: Modeling Coverage Impacts

Because coverage losses from work requirements have been driven by paperwork barriers, Manatt's model estimates the potential for coverage loss in Kansas under 3 scenarios based on the level of automation in the three states' that implemented work requirements.

A

Minimal Automation

Georgia has not automated tracking of either compliance or exemptions, and covered just 2% of the population subject to work requirements. Adjusting for a planned exemption that could be automated, its experience translates to a 92% coverage loss.

B

Some Automation

*New Hampshire was able to automate exemptions and compliance tracking affecting 50% of the people subject to the requirements. Of those who whose compliance / exemptions, were not automated, 82% lost coverage.**

C

More Automation

Arkansas automated exemptions and compliance tracking for 60% of the people subject to work requirements. Of those not automatically exempted / determined compliant, 72% lost coverage.

* New Hampshire put a hold on actually terminating individuals because of large number of people slated to lose coverage.

Medicaid Work Reporting Requirements: Impact

For more information on Manatt's model and potential state responses and associated impacts, see appendix

Implementing work requirements on non-elderly and non-disabled adults would cut federal funding for KanCare by:

↓ **$111 to 192 million**

(in one year)*

↓ **$1.2 to 3.6 billion**

(over ten years)

Thousands of Kansans will have their coverage terminated

18,600 to 56,600
people will lose coverage**

Including

900 to 2,800
Children****

The highest projected loss in enrollment is comparable to all Kansans with disabilities enrolled in KanCare in FY 2023 (61,000). The highest projected loss in federal funding in one year is in the ballpark of all KanCare costs of running the Medicaid program in FY 2022 ($250 million).

- 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, which assumes Kansas does not automatically exempt or determine compliant adults from work reporting requirements. We assume that 92% of those subject to work requirements would lose coverage. These figures reflect Georgia's experience implementing work requirements.
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation in 2026.

**Enrollment figures reflect average annual enrollment declines from FY2026-2034.

***Research shows that coverage losses for parents lead to coverage losses for children. See: Health Affairs, Medicaid Work Requirements in Arkansas

Source: KHI Medicaid Primer 2024

Work Reporting Requirements: Key Takeaways

- Experience with Medicaid work requirements consistently show large coverage losses due to paperwork.
- Work is valued by Kansans, but work requirements have not led to an uptick in employment, just a loss of coverage. **Without access to health care, people are less able to work or stay employed.**
- Research shows that coverage **losses for parents will also lead to coverage losses for children.**
- Adding new, complex work reporting requirements would create new **administrative burdens and costs on the state.**

Source: Health Affairs, Medicaid Work Requirements in Arkansas

Per Capita Caps

Per Capita Caps

Potential Federal Policy Change

- Congress is considering imposing **caps on federal funding based on a pre-set amount designed to reduce federal spending.**
- Caps are set by eligibility group (e.g., kids, people with disabilities). **States would not be at risk for enrollment growth but would have to fully pay (without federal support) for health costs above the cap.**
- Congress is considering proposals to impose a cap on most or all populations or possibly limited to the Medicaid expansion group.

Kansas-Specific Context

- **Currently, Kansas receives its full share of federal costs for all program spending**. If costs rise (e.g., because of new prescription drugs), the federal government shares those new costs.
- Since Kansas has not taken up Medicaid expansion, a cap limited to the expansion group would not affect the state now but would if it adopts the expansion in the future.

Per Capita Cap: Impacts

For more information on Manatt's model and potential state responses and associated impacts, see appendix

A per capita cap would cut federal funding for KanCare by:

↓ **$347 million**
(in one year)*

↓ **$3.2 billion**
(over ten years)

Kansas could respond by spending only state dollars matched by federal dollars, leading to a decrease in total Medicaid funding of:

$573 million
(in one year)*

$5.2 billion
(over ten years)

The projected loss in federal funding in one year is more than half the amount of all KanCare payments to physicians, mid-level practitioners, and clinics in FY 2023 ($627 million).

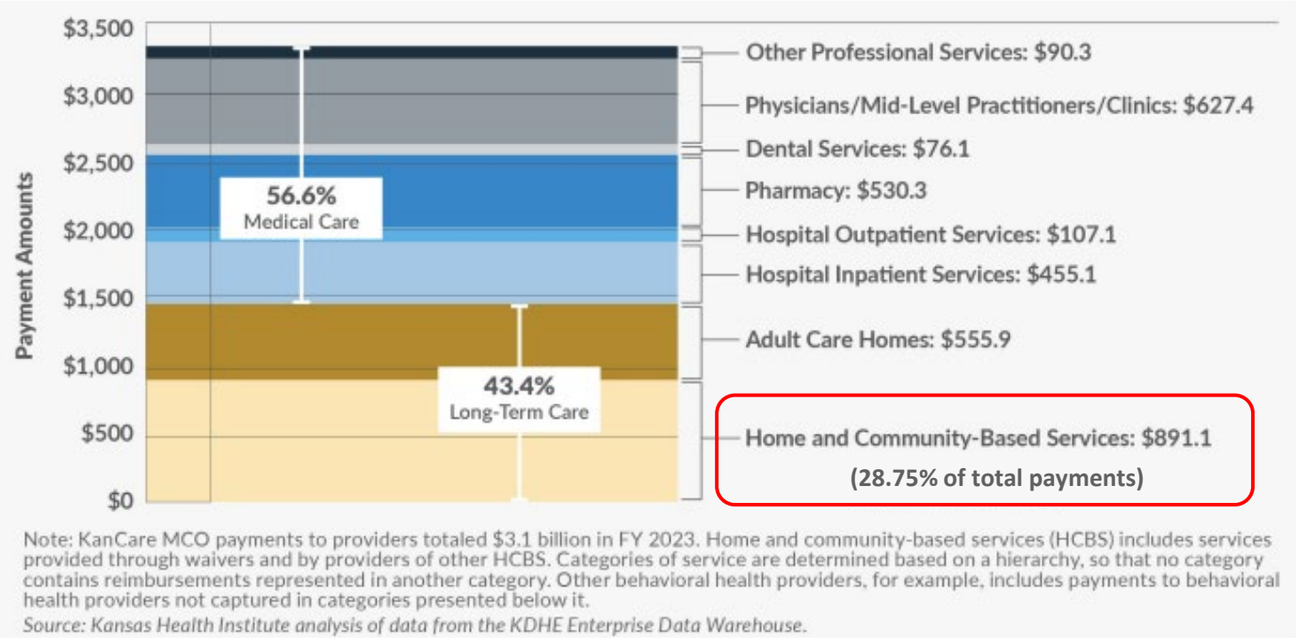
- Reflects first year of estimated implementation in 2028
- Totals may not sum exactly due to rounding

Source: KHI Medicaid Primer 2024

Per Capita Cap: Key Takeaways

- A cap on federal funding undoes the fundamental financial partnership between states and the federal government.
- Deep reductions in federal funding would shift new costs onto the state, putting Kansas at risk for health care costs above the caps.
- To limit that risk, the state would likely look for ways to reduce coverage or benefits, with a focus on optional services and the most costly enrollees.

KanCare Payments to Providers in FY 2023 ($ millions)



Note: KanCare MCO payments to providers totaled $3.1 billion in FY 2023. Home and community-based services (HCBS) includes services provided through waivers and by providers of other HCBS. Categories of service are determined based on a hierarchy, so that no category contains reimbursements represented in another category. Other behavioral health providers, for example, includes payments to behavioral health providers not captured in categories presented below it.

Source: Kansas Health Institute analysis of data from the KDHE Enterprise Data Warehouse.

HCBS at Risk Under Medicaid Cuts

Home and Community-Based Services (HCBS), which are optional but costly services, account for nearly 30% of total KanCare payments and are critical for seniors and people with disabilities. Historically, when faced with financial pressure, states have cut HCBS.

Source: KHI Medicaid Primer 2024; KFF, Medicaid in Kansas; Health Affairs, Faced with Medicaid Cuts States Reduced Support For Older Adults And Disabled People

What’s At Stake for Kansas?

What’s at Stake for Kansas?

Kansas Medicaid is the backbone of Kansas’ health care system. While the policies may evolve, if they add up to deep cuts to federal Medicaid, they will have major ripple effects on people and providers and will further weaken rural health care

Federal funding accounts for about two-thirds of Kansas’ Medicaid spending. If Congress makes deep cuts to that funding, Kansas will have few options other than to reduce or terminate coverage and benefits and lower reimbursement rates, all leading to more uninsured people, higher uncompensated care, and increased medical debt.

The depth of cuts proposed in the House budget will likely mean that no one – not children, seniors in need of long-term care, people with disabilities, pregnant women – will escape the impact. Because of the fragility of rural health care in Kansas, rural communities may be hit the hardest.

Medicaid work requirements would jeopardize enrollees' ability to access needed health care and create added administrative burden for the state and Medicaid enrollees. They would have an outsized impact on rural Kansans.

Appendix

Manatt Health Modeling Data Sources

Manatt Health is using a range of data sources to inform its modeling:

Medicaid financial management report (FMR) data, collected from "CMS-64" reports that provides information on aggregate Medicaid spending by state, currently available through FY 2023.

Quarterly Medicaid enrollment and expenditure data for Medicaid expansion enrollees collected through the Medicaid Budget and Expenditure System (MBES), available through December 31st, 2023.

Enrollment by eligibility group from FFY 2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Tabulations from the Medicaid and CHIP Payment and Access Commission (MACPAC) of FFY 2022 T-MSIS data on per capita expenditures by eligibility group.

SDP preprint data published by CMS.

Enrollment and expenditure growth projections from the Congressional Budget Office (CBO).

State-specific data derived from state web sites and/or discussions with state Medicaid and budget officials when there are gaps in otherwise publicly-available data.

Medicaid Provider Tax Changes*: 1-Year* KanCare Impacts

Scenario	Change in Medicaid Spending Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	TOTAL	
Scenario A: Reduction of Provider Tax Limit to 5%	-	-	-	Not applicable under Kansas' current 3% provider tax. Any of these scenarios would force the state to forgo the additional revenue from the increased provider tax already approved by the legislature.
Scenario B: Reduction of Provider Tax Limit to 4%				
Scenario C: Reduction of Provider Tax Limit to 3%				
Scenario D: Reduction of Provider Tax Limit to 2.5%	**-$60M**	**-$39M**	**-$98M**	Would decrease federal funding for Kansas Medicaid by **$60 million** overall (2% compared to expected federal Medicaid funding under current law).

Notes:

- 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.
- Totals may not sum exactly due to rounding.

* Reflects first year of estimates implementation

Medicaid Provider Tax Changes*: 10-Year* KanCare Impacts

Scenario	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	TOTAL	
Scenario A: Reduction of Provider Tax Limit to 5%	-	-	-	Not applicable under Kansas' current 3% provider tax. Any of these scenarios would force the state to forgo the additional revenue from the increased provider tax already approved by the legislature.
Scenario B: Reduction of Provider Tax Limit to 4%				
Scenario C: Reduction of Provider Tax Limit to 3%				
Scenario D: Reduction of Provider Tax Limit to 2.5%	**-$636M**	**-$413M**	**-$1.05B**	Would decrease federal funding for Kansas Medicaid by **$636 million** (2% compared to expected federal Medicaid funding under current law).

Notes:

- 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.
- Totals may not sum exactly due to rounding.

State Directed Payment Changes: KanCare Impacts

Scenario	Change in Medicaid Spending Over 1-Year Period (2026)*			Key Takeaway
	Federal	State	Total	
Reduce State Directed Payments from Current Levels to Medicare-Equivalent Rates	**-$209M**	**-$135M**	**-$344M**	Total Medicaid funding for Kansas hospitals would decrease by up to $344 million in FY2026 (22% decline compared to expected total Medicaid hospital funding in Kansas under current law).

Scenario	Change in Medicaid Spending Over 10-Year Period (2025-2034)			Key Takeaway
	Federal	State	Total	
Reduce State Directed Payments from Current Levels to Medicare-Equivalent Rates	**-$2.22B**	**-$1.44B**	**-$3.67B**	Total Medicaid funding for Kansas hospitals would decrease by up to $3.67 billion over ten years (22% decline compared to expected total Medicaid hospital funding in Kansas under current law).

Notes:
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Medicaid Work Reporting Requirements: KanCare Impacts

Scenario	Changes Over 1-Year Period (2026)**				Key Takeaway
	Total	Federal	State	Enrollment Impact	
Work Requirements on All Adults Eligible Through Non-Disability Pathways* Ages 18-64	**-$182M to -$317M**	**-$111M to -$192M**	**-$72M to -$125M**	**-19,000 to -32,000**	Total Medicaid enrollment would decline by 5%-9% and total Medicaid spending would decline by 3%-6%. As many as 1,600 children would lose coverage.

Scenario	Changes Over 10-Year Period (2025-2034)				Key Takeaway
	Total	Federal	State	Enrollment Impact (Average annual)	
Work Requirements on All Adults Eligible Through Non-Disability Pathways* Ages 18-64	**-$1.9B to -$5.9B**	**-$1.2B to -$3.6B**	**-$759M to -$2.3B**	**-19,000 to -57,000**	Total Medicaid enrollment would decline by 5%-15% and total Medicaid spending would decline by 3%-10%. As many as 2,800 children would lose coverage.

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

Per Capita Caps *(All Enrollees): 1-Year* KanCare Impact

State Response	Changes in Medicaid Spending Over 1-Year Period (2028)*			Key Takeaway
	Federal	State	TOTAL	
Option A: Kansas Only Spends State Dollars that are Matched by Federal Dollars	-$347M	-$225M	-$573M	Total Medicaid spending would decrease by **$573 million** (10%).
Option B: Kansas Maintains Prior State Funding Levels Regardless of Federal Match	-$347M	-	-$347M	Total Medicaid spending would decrease by **$347 million** (6%).
Option C: Kansas Fully Replaces Lost Federal Funding	-$347M	+$347M	-	Kansas would need to increase its own Medicaid spending by **$347 million**—an increase of 15%—to maintain existing total Medicaid spending levels.

There is growing momentum around a per capita cap on only Medicaid expansion enrollees. While this does not directly impact Kansas as the state has not expanded Medicaid, it would make it harder for the state to receive the financial benefits from expanding Medicaid in the future (e.g., $509 million in additional funding).

Note:
- See appendix for additional details on per capita cap modeling assumptions
- Totals may not sum exactly due to rounding.

* Reflects first year of estimated implementation.

Source: KHI, Impacts of Federal Policy Decisions on Medicaid

Per Capita Caps *(All Enrollees): 10-Year* KanCare Impact

State Response	Change in Medicaid Spending Over 10-Year Period (2024-2035)			Key Takeaway
	Federal	State	TOTAL	
Option A: Kansas Only Spends State Dollars that are Matched by Federal Dollars	-$3.15B	-$2.04B	-$5.19B	Total Medicaid spending would decrease by **$5.19 billion** (11%).
Option B: Kansas Maintains Prior State Funding Levels Regardless of Federal Match	-$3.15B	-	-$3.15B	Total Medicaid spending would decrease by **$3.15 billion** (7%).
Option C: Kansas Fully Replaces Lost Federal Funding	-$3.15B	+$3.15B	-	Kansas would need to increase its own Medicaid spending by **$3.15 billion**—an increase of 17%—to maintain existing total Medicaid spending levels.

Note: Totals may not sum exactly due to rounding.

Source: KHI, Impacts of Federal Policy Decisions on Medicaid