January 28, 2025

[CNC, MOH, ARDT, UHS, ENSG, ADUS]: Medicaid Funding & Best Bet on OMB Funding Memo

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We lean against yesterday's OMB directive for temporarily pausing federal funding for grants, loans and programs applying largely to Medicaid's payments to the states for **Medicaid insurers (CNC, MOH, ELV, UNH, CVS)** or for reimbursements or supplemental payments to **hospitals (ARDT, UHS, CYH, THC, HCA), nursing homes (ENSG, private Providence Group, OHI, SBRA), home care agencies (ADUS, BTSG, AMED)**, etc.

We think it is important to acknowledge that the extent to which this Administration appears to be testing the bounds of its legal authorities is largely unprecedented, which in all likelihood will need to be resolved by the courts. As it relates to Medicaid, however, the confusion stemming from the OMB memo's vague wording, specific exemptions for Medicare, Social Security benefits, and direct assistance to individuals, will likely require greater clarity in the near future.

Regardless, given that OMB's temporary funding pause calls for such action to be done "to the extent permissible under applicable law," we tend to think it does not freeze funding that is mandatory, like the federal Medicaid match (aka FMAP), and not subject to appropriations. Therefore, we view that the order does not freeze the Medicaid dollars paying for most medical and certain administrative costs under the state plan amendments, section 1115 waivers, and state directed payment programs (DPPs also known as SDPs).

However, we wouldn't be surprised to see a pause on federal Medicaid funding related to transgender care, abortion-adjacent care, and DEI goals, even if financed though mandatory streams, due to the policy lenses cited in memo (i.e., "financial assistance for foreign aid, non-governmental organizations, DEI, woke gender ideology, and the green new deal"). It is not clear to us if this would even be legal.

If we are wrong and a broader temporary pause does apply, we would expect states, hospitals, insurers, or patients to sue to block and reverse the action and we think stakeholders are likely to prevail, since such a freeze could pose immediate harm and since the underlying federal financing is mandatory and not discretionary.

Where this directive could temporarily pause Medicaid-related funding would likely be Medicaid grants to states authorized by other statutes and financed via other means. Potential examples would include planning Medicaid / CHIP grants to state agencies to develop programs for promoting continuity of care to eligible incarcerated inmates or state grants to implement, enhance and expand Medicaid/CHIP school-based services.

Centene Corp (CNC)

Price:	$65.16
52-Week High:	$81.42
52-Week Low:	$55.03

Molina Healthcare Inc (MOH)

Price:	$309.98
52-Week High:	$423.92
52-Week Low:	$272.69

Ardent Health Partners, Inc. (ARDT)

Price:	$15.04
52-Week High:	$20.72
52-Week Low:	$13.63

Universal Health Services Inc (UHS)

Price:	$190.82
52-Week High:	$243.25
52-Week Low:	$152.68

The Ensign Group Inc (ENSG)

Price:	$140.35
52-Week High:	$158.45
52-Week Low:	$110.71

Addus HomeCare Corporation (ADUS)

Price:	$133.00
52-Week High:	$136.72
52-Week Low:	$85.94

Notwithstanding our view on the application of this OMB memo on the bulk of Medicaid spending, we maintain our previous view (here, here) that Medicaid remains in the crosshairs by Congress and the administration, particularly as a likely reconciliation offset. At this time, the top ones that we believe have the most appeal include: 1) some version of Medicaid work requirements; 2) playing around with the FMAP – for certain states, populations or costs like medical vs administrative; and 3) lowering states' allowed provider tax thresholds.

However, we note two other Medicaid savings ideas are gaining more attention and for now likely will remain on the list even though we are skeptical about ultimate enactment due to concerns from the states (including red states) and legislators from purplish areas: Medicaid per-capita caps by eligibility category / overall Medicaid block grants and limits on DPPs' total provider payments.

Congress converting Medicaid match funding to per-capita caps or overall block grants is not a new idea, has long been an idea pushed by conservatives, and was one of the pillars in the failed 2017 ACA repeal-and-replace reconciliation bill. Various right-leaning think tanks staffed with former Trump officials continue to back the concept as do some nominated to the administration. Included in the recently circulated potential reconciliation offset list, it has been cited by House Energy and Commerce Chairman Brett Guthrie (R-KY) (recently) and Senate HELP Chairman Bill Cassidy (R-LA) (at least, Cassidy back in 2017). Clearly, what keeps this idea in the fold is the maximum hundreds of billions in ten-year legislative savings.

For this idea to gain more meaningful traction and get over the opposition of congressmen and Senators from purplish districts / states or secure the backing from red states, the devil will be in the details. Specifically, legislators will have to assure on the two biggest pressure points of: 1) federal funding to the states won't actually be cut (as opposed to growing at a slower rate); and 2) indexing of the caps or block grants needs to keep up with projected medical cost growth, especially for those with long-term care needs.

Restricting supplemental payments to certain Medicaid providers in DPPs has similarly been suggested by right-leaning think tanks and included in the reported offset list. A legislative limit would also invite serious pushback by the states and providers because it would be seen as arbitrary and would not be undergirded by data and because it would take chip away at state agency and flexibility over their Medicaid programs long pushed by conservatives. However, the sizable federal spending and DPP growth over the years and the suspicion that DPPs inappropriately gins up funding keeps it on the agenda for the following policies:

- Congress outright repealing the May 2024 finalized Medicaid managed care rule that codified current CMS practice of allowing states to pay providers in Medicaid insurer networks at rates up to the average commercial rate (ACR) as well as imposing disclosure requirements. Repeal would leave the decision up to CMS about whether to approve individual state applications for DPPs, which until it has more information to evaluate these programs, we suspect CMS would keep its current allowance, potentially resulting in a distinction without much of a difference.
- Congress *actually* setting a lower ceiling on total provider payments under a DPP at rates less than ACR or even at a percentage of Medicare, though we have not seen any proposals or suggestions about where that line should be drawn or data supporting such a specific limit.

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