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Testimony of
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Committee on the Budget

"Medicaid: The Reality"

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Good morning, Chairman Johnson, Ranking Member Merkley, and members of the Committee.

My name is Andy Schneider and I am a Research Professor of the Practice at the Georgetown University McCourt School of Public Policy and the Center for Children and Families. I have 50 years of experience with the Medicaid program as a Congressional staffer, Executive Branch employee, private consultant, legal services attorney and now as a researcher at Georgetown University's McCourt School of Public Policy.

I have a long-standing interest in ensuring the integrity of the Medicaid program. As a House staffer, I worked on the anti-fraud amendments in the Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) and the Patient Protection and Affordable Care Act (P.L. 111-148). During my time as a consultant my clients included Taxpayers against Fraud, for which I analyzed the effectiveness of the False Claims Act at reducing fraud against Medicaid. Prior to coming to Georgetown University, I served in the Obama Administration as a Senior Advisor at the Centers for Medicare & Medicaid Services (CMS), where I focused in part on program integrity issues in Medicaid.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

CCF is responsible for raising external funding to conduct our work; the full list of our current funders is available on our website. CCF does not accept any government, foreign, or corporate funding; our work is primarily funded by philanthropies.

The testimony and views I am presenting today are my own and not those of Georgetown University or the McCourt School of Public Policy.

Medicaid's Role in Our Health Care System

It is hard to overstate the importance of the role that Medicaid plays in our health care system. Medicaid is our nation's second largest health insurance program, covering

66.7 million Americans as of April, 2026.[1] An additional 7.1 million people (largely children) are covered by the Children's Health Insurance Program (CHIP),[2] and the majority of these children are enrolled in Medicaid.[3] It accounts for nearly one fifth of all national health care spending.[4] It is the primary payer for long-term care in the U.S., covering three-fifths of total spending[5] and 6 in 10 nursing home residents.[6] It is the largest payer for behavioral health and substance use disorder services.[7] It fills in the gaps in Medicare coverage of long-term care, vision, and dental benefits for about 9 million low-income Medicare beneficiaries as well as premiums and cost-sharing for another 3 million.[8] It is a major source of financing for care delivered by safety net hospitals and clinics to uninsured and low-income Americans.[9]

It should come as no surprise, then, that Medicaid is very popular with the American people. A January 2025 KFF Tracking Poll found that 77% of voters had very or somewhat favorable views about Medicaid, including 63% of Republicans and 81% of Independents. Reducing federal funding for Medicaid was literally the least popular of eleven health policy priorities that were tested in this poll.[10]

Medicaid provides essential financial protections and access to care for America's families and children, including children under age 6.[11] A recent study in *JAMA* found that 61% of all children in the U.S. had enrolled in Medicaid or CHIP at some point by

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[1] Center for Medicaid and CHIP Services, "April 2026 Medicaid & CHIP Enrollment Data Highlights," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights

[2] Ibid

[3] MACSTATS, Exhibit 32 Child Enrollment in CHIP and Medicaid by State, 2024 https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-32.-Child-Enrollment-in-CHIP-and-Medicaid-by-State-FY-2024.pdf

[4] MACPAC, "Medicaid 101," https://www.macpac.gov/medicaid-101/

[5] Alice Burns et al. "10 Things to Know About Medicaid," KFF, February 18, 2025. https://www.kff.org/medicaid/10-things-to-know-about-medicaid/

[6] Priya Chidambaram, Alice Burns, Tricia Neuman, and Robin Rudowitz, "5 Key Facts About Nursing Facilities and Medicaid," KFF, May 28, 2025, https://www.kff.org/medicaid/5-key-facts-about-nursing-facilities-and-medicaid/.

[7] MACPAC, "Behavioral Health in the Medicaid Program" June 2015, https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/

[8] Abby Wolk et al., "Five Key Facts About Spending and Enrollment for People with Medicare and Medicaid (Dual Eligible Individuals)," KFF, July 15, 2026, https://www.kff.org/medicaid/five-key-facts-about-spending-and-enrollment-for-people-with-medicare-and-medicaid-dual-eligible-individuals/

[9] MACPAC, "Medicaid 101," https://www.macpac.gov/medicaid-101/

[10] Ashley Kirzinger et al."KFF Health Tracking Poll: Public Weighs Health Care Spending and Other Priorities for Incoming Administration," KFF, January 17, 2025, https://www.kff.org/health-costs/kff-health-tracking-poll-public-weighs-health-care-spending-and-other-priorities-for-incoming-administration/

[11] CCF Fact Sheet, "Medicaid Matters for Young Children and Their Families," June 1, 2026, https://ccf.georgetown.edu/2025/06/03/medicaid-matters-for-young-children-and-their-families/

the time they turned 18.[12] Similarly, Medicaid is vital for maternal and infant health—covering 41% of all births nationwide and almost half of births (47%) in rural areas and small towns.[13] Also thanks in large part to the ACA's Medicaid expansion, Medicaid is a crucial source of coverage for child care workers covering 26% of the child care workforce in 2024.[14]

Medicaid is particularly important to children and families in rural America and to the hospitals and physicians serving rural communities. Non-elderly adults and children in small towns and rural areas are more likely than those living in metro areas to rely on Medicaid/CHIP for their health insurance.[15] Medicaid also covers a larger share of women of reproductive age (23.3%) in rural areas as compared to metro areas (20.5%),[16] thanks largely to the Affordable Care Act's Medicaid expansion. Already, rural clinics and hospital units have closed citing cuts from H.R. 1 as an unsustainable loss of revenue.[17]

The high cost of medical care facing working families today means that the economic protection that Medicaid provides for parents and their children is essential. If one member of the family is uninsured, the entire family is at risk of unsustainable medical debt and even bankruptcy.

Medicaid coverage of children also provides long-term benefits for children and families and for our nation. Research shows that children covered by Medicaid have better

[12] Ye Shen et al., "Insurance Dynamics During Childhood in the Fragmented US Health System," *JAMA*, September 24, 2025, doi:10.1001/jama.2025.15488.
[13] Births Financed by Medicaid by Metropolitan Status, KFF, 2024, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[14] Nancy Kaneb and Elisabeth Wright Burak, "Early Childhood Educators Still Need Medicaid - Now More than Ever," Georgetown University Center for Children and Families, July 31, 2026, https://ccf.georgetown.edu/2026/07/31/early-childhood-educators-still-need-medicaid-now-more-than-ever/.
[15] Joan Alker, Aubrianna Osorio, and Edwin Park, "Medicaid's Role in Small Towns and Rural Areas" Georgetown Center for Children and Families, January 15, 2025 https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/
[16] Joan Alker and Aubrianna Osorio, "Medicaid Plays a Key Role for Maternal and Infant Health in Rural Communities," Georgetown University Center for Children and Families, May 15, 2025, https://ccf.georgetown.edu/2025/05/15/medicaid-plays-a-key-role-for-maternal-and-infant-health-in-rural-communities/.
[17] Adam Searing, "Rural Hospitals and Communities Feeling Impact of H.R. 1 Medicaid Cuts" Georgetown Center for Children and Families, May 1, 2026 https://ccf.georgetown.edu/2026/05/01/rural-hospitals-and-communities-feeling-impact-of-h-r-1-medicaid-cuts-rural-health-fund-falls-short/

health as adults, are more likely to graduate from high school and go on to college, and have higher earnings in adulthood.[18]

Medicaid Enrollment for Children Is Falling Precipitously

One data point that we at CCF are closely tracking is child enrollment in Medicaid/CHIP. We know from past experience that when Medicaid enrollment of children declines, the uninsured rate for children goes up. This is because many children losing Medicaid or CHIP do not have another source of affordable, comprehensive coverage.

It is troubling that adults are losing Medicaid, but it is even more concerning for children because they are more likely to remain eligible for Medicaid or CHIP when they lose it. This is for two reasons. First, the median eligibility level for children in Medicaid/CHIP is 255% of the federal poverty line (about $5,800 per month for a family of 3), so children are always eligible at higher income levels than their parents.[19] Second, offers of affordable, comprehensive dependent coverage for low and moderate wage workers are scarce.[20] As a result, Medicaid/CHIP are often the best and only option for children.

As a consequence of the "Medicaid unwinding" (the post-pandemic redetermination of every Medicaid enrollee's eligibility), the child uninsured rate went up from 5.1% in 2022 to 6.0% in 2024—an increase of approximately 700,000 uninsured children.[21] This is the highest uninsured rate for children that the U.S. has seen in nearly a decade. Especially concerning is that the uninsured rate for young children under 6 rose more quickly than it did for older children.[22]

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[18] Edwin Park, Joan Alker, and Alexandra Corcoran, "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," Commonwealth Fund, December 8, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm and Congressional Budget Office, "Exploring the Effects of Medicaid During Childhood on the Economy and the Budget: Working Paper 2023-07," November 1, 2023, https://www.cbo.gov/publication/59231.

[19] Jennifer Tolbert et al., "An Early Look at Policy Decisions as States Get Ready to Implement Work Requirements," KFF, April 30, 2026, https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/.

[20] Gary Claxton et al., "How employers support lower-waged workers' access to health insurance options," Peterson-KFF Health System Tracker, April 20, 2026, https://www.healthsystemtracker.org/chart-collection/how-employers-support-lower-waged-workers-access-to-health-insurance-options/#Distribution%20of%20worker%20contributions%20for%20health%20insurance%20coverage,%20by%20firm%20size,%20for%20single%20or%20family%20coverage,%202025.

[21] Joan Alker, ""Progress for Children is Eroding as Child Uninsured Rate Spikes to Highest Level since 2014," Georgetown University Center for Children and Families, September 12, 2025, https://ccf.georgetown.edu/2025/09/12/progress-for-children-is-eroding-as-child-uninsured-rate-spikes-to-highest-level-in-decade/.

[22] Elisabeth Wright Burak, Aubrianna Osorio and Joan Alker, "Uninsured Rate for Young Children Rose More Sharply than for Older Children from 2022-2024," Georgetown University Center for Children and

The unwinding process was largely concluded in 2024–with the exception of North Carolina and Kentucky, which accepted CMS's offer of additional time to complete children's renewals in order to protect children's coverage[23]--so it does not explain declines in Medicaid/CHIP enrollment of children since January 2025.

We at CCF believe that the child uninsured rate has continued to rise since President Trump took office. While we await data from the U.S. Census Bureau this fall that will examine uninsured rates for 2025, we are closely monitoring Medicaid enrollment. *Our latest tracking finds that 2.3 million fewer children are enrolled in Medicaid since January 2025[24]—an extremely sharp decline that is happening much more quickly than a similar decline that we saw during President Trump's first term*.[25]

This is a statistic that should ring alarm bells for every policymaker who cares about the well-being of children. Consider that 2.3 million children are more than the entire population of children under 18 in ten states and the District of Columbia: Alaska, Delaware, Maine, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming.[26]

Why are children losing Medicaid? Once we know more about who these children are and how many of them are becoming uninsured, we will have more definitive answers, but we are confident, based on prior experience and anecdotal evidence, that the likely causes include:

- One in four children lives in a mixed-status family where the child is a citizen but the parent is not.[27] Due to the Trump Administration's extreme deportation

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Families, June 1, 2026, https://ccf.georgetown.edu/2026/06/01/uninsured-rate-for-young-children-rose-more-sharply-than-for-older-children-from-2022-2024/.

[23] Kentucky began regular renewals for children again in July 2025. See https://khbe.ky.gov/Enrollment/PHEUnwinding/Child%20Renewal%20Communication%20Packet_April%202025.pdf. North Carolina's timeline is available here: https://www.northcarolinahealthnews.org/wp-content/uploads/2023/11/JLudlam_SOsborne_Deputy-Secretaries_Pre-Medicaid-Expansion-Launch-Ltr-to-Counties.docx.pdf

[24] Our tracker is available here: https://ccf.georgetown.edu/feature/state-by-state-medicaid-enrollment-data/

[25] Joan Alker, "Two Million Fewer Children and Enrolled in Medicaid Since Trump Took Office," Georgetown University Center for Children and Families, May 28, 2026 https://ccf.georgetown.edu/2026/05/28/two-million-fewer-children-are-enrolled-in-medicaid-since-trump-took-office/

[26] Annie E. Casey Foundation, Kids Count Data Center, https://datacenter.aecf.org/data/tables/99-total-population-by-child-and-adult-populations#detailed/2/2-53/false/575/39,40,41/416,417

[27] Pillai D. Pillai A. and Artiga, S. "Children in Immigrant Families: Key Facts on Health Coverage and Care" KFF, May 19, 2026 https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/

agenda and Medicaid data sharing practices, these families are terrified about interacting with the federal government and enrolling in or renewing their child's Medicaid even though the child is a citizen.

- Cuts to outreach and tax credits for Marketplace coverage, as well as newly enacted state laws such as S.B. 2 in Indiana which are already adding more red tape, create an "unwelcome mat" effect. It is well documented that when parents gain coverage their children do too[28] – and the opposite is likely true as well. When parents lose coverage, their children often do because of confusion or administrative errors -- even though the children remain eligible.
- The federal government is not enforcing protections for children such as 12 months of continuous eligibility in Medicaid and CHIP.[29]

Layered on top of the current troubling declines will be further declines over the next decade. CBO is projecting that child Medicaid enrollment will decline even further, largely as a consequence of the 2025 budget reconciliation law, H.R. 1.[30]

How H.R. 1 Harms Medicaid

H.R. 1 included the largest Medicaid cuts in history. According to CBO estimates issued after final passage, the law will cut federal Medicaid spending by nearly $1 trillion over ten years (fiscal years 2025-2034) (see Figure 1).[31] The law will also increase the number of uninsured people by 10 million by 2034, of which 7.5 million are the result of H.R. 1's Medicaid cuts (see Figures 2 and 3), according to CBO estimates.[32]

[28] Hudson, Julie and Asako Moriya. "Medicaid Expansion for Adults Had Measurable "Welcome Mat' Effects on Children" *Health Affairs* September 2017 https://pubmed-ncbi-nlm-nih-gov.proxy.library.georgetown.edu/28874493/

[29] Alker, J. "Florida Leaders Have Failed to Implement Bipartisan Plan" Georgetown University Center for Children and Families, November 25, 2025 https://ccf.georgetown.edu/2025/11/25/florida-leaders-have-failed-to-implement-bipartisan-plan-approved-over-2-years-ago-to-help-families-afford-health-insurance-for-their-children/

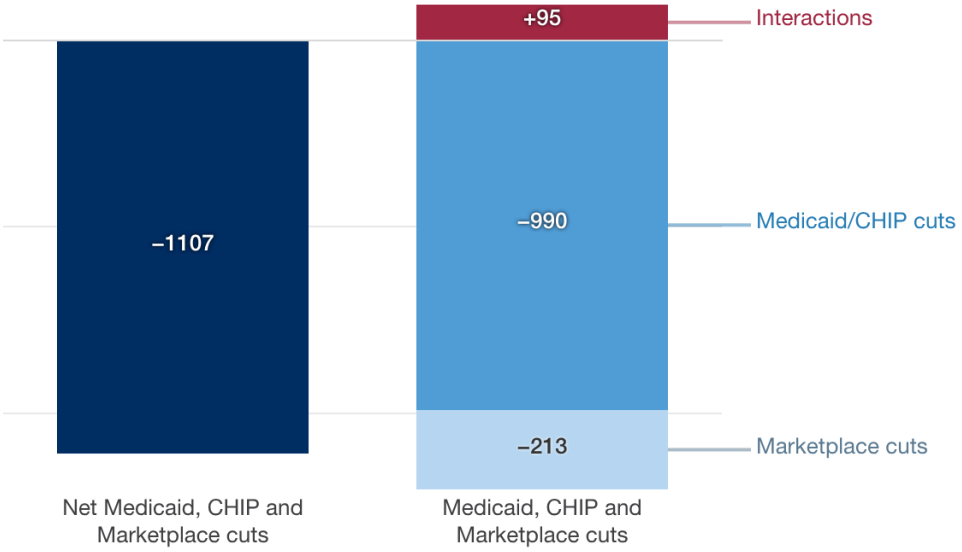
[30] Congressional Budget Office, "Federal Subsidies for Health Insurance: 2026-2036," July 2026, https://www.cbo.gov/publication/62539. H.R. 1 is P.L. 119-11. Colloquially referred to as the "One Big Beautiful Bill Act (OBBBA)" and "The Working Families Tax Cut" legislation

[31] Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," July 21, 2025, https://www.cbo.gov/publication/61570.

[32] Congressional Budget Office, "CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, Public Law 119-21," August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

Figure 1

Federal Health Program Cuts under H.R. 1 (in billions)

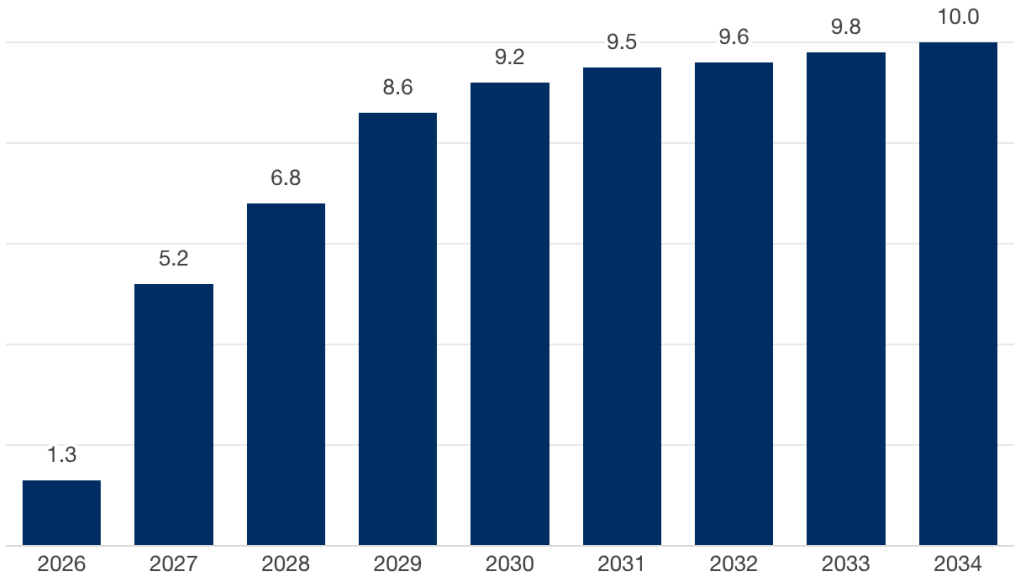


Cuts shown as negative values; interactions offset impact.

Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline" (July 2025).

Figure 2

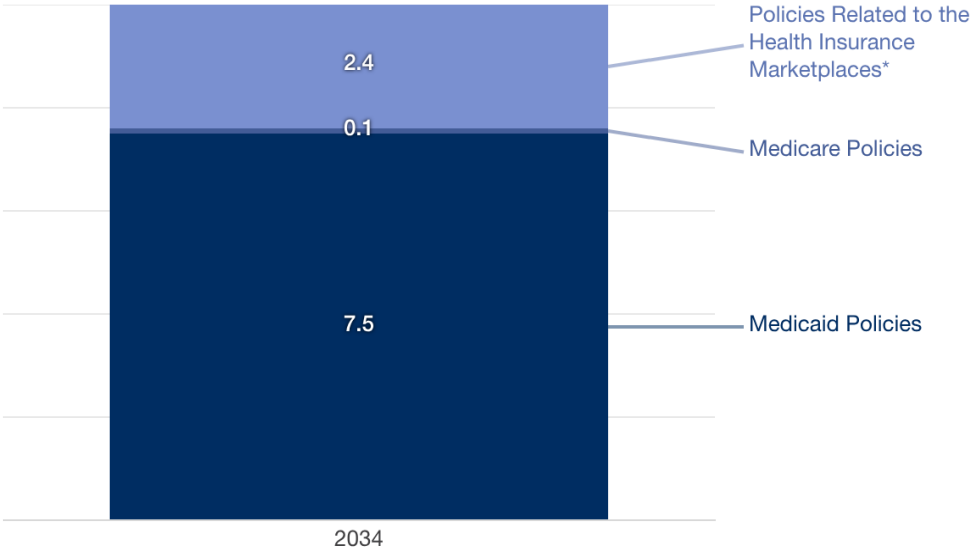
CBO Estimate of Increase in Uninsured by Year under H.R. 1 (in millions)



Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Distributional Effects of Public Law 119-21" (August 2025).

Figure 3

CBO Estimate of Increase in Uninsured by 2034 under H.R. 1 (in millions)



** Includes interaction effects of a 0.3 million increase in the uninsured.*

Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Distributional Effects of Public Law 119-21" (August 2025).

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The vast majority of the federal spending cuts from H.R. 1's 21 Medicaid provisions—94% of its gross cuts — are due to five types of provisions:[33]

- Reducing enrollment and access to needed care among people eligible for the Affordable Care Act's Medicaid expansion through work reporting requirements as well as more frequent renewals and increased cost-sharing.
- Shifting costs to states by restricting states' use of provider taxes to finance their Medicaid programs, including a prohibition on new taxes or increases in existing taxes, a ban on certain types of "uniformity waiver" taxes, and a phasedown in the permissible size of provider taxes only in expansion states.
- Eliminating eligibility of many lawfully present immigrants and shifting the costs of emergency hospital care to expansion states.

[33]Edwin Park and Sabrina Corlette, "Medicaid, CHIP, and Affordable Care Act Marketplace Cuts and Other Health Provisions in the Budget Reconciliation Law, Explained," Georgetown University Center for Children and Families/Georgetown University Center on Health Insurance Reforms, updated August 13, 2025, https://ccf.georgetown.edu/2025/07/22/medicaid-chip-and-affordable-care-act-marketplace-cuts-and-other-health-provisions-in-the-budget-reconciliation-law-explained/ and Georgetown CCF analysis of Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," *op cit*.

- Limiting state-directed payments in managed care, which supplement payments to hospitals and other providers and improve access to care.
- Blocking regulations that would have simplified the enrollment and renewal process and increased participation among eligible individuals, especially people with disabilities and seniors.

It is notable that only four of H.R. 1's provisions can be viewed as addressing fraud, waste, and abuse and they account for only 2.5% of H.R. 1's gross Medicaid cuts.[34] Moreover, the Centers for Medicare & Medicaid Services (CMS) is now implementing some of these cuts — state-directed payments, work reporting requirements, section 1115 waiver budget neutrality, and provider taxes — in ways that go well beyond the statutory requirements of H.R. 1 and will result in even deeper Medicaid cuts.[35]

In its most recent Medicaid baseline projections, CBO has reiterated the harm H.R. 1 is expected to wreak on the tens of millions of low-income children, parents, and other adults who rely on the Medicaid program for their health coverage. CBO's February 2026 baseline finds that average monthly enrollment of children is estimated to fall by 2 million between fiscal years 2025 and 2036. Enrollment of parents and other adults eligible under the expansion will fall by 7 million—or more than 40%—and enrollment of parents and pregnant women, who would have been eligible prior to the expansion, will fall by 1 million (see Figure 4).[36] Put another way, CBO now expects total Medicaid enrollment in fiscal year 2034 to be 11 million lower than what it projected before

[34] Andy Schneider, "Fraud and Abuse Against Medicaid: The Truth About the Budget Reconciliation Law," Georgetown University Center for Children and Families," July 25, 2025, https://ccf.georgetown.edu/2025/07/25/fraud-and-abuse-against-medicaid-the-truth-about-the-budget-reconciliation-law/.

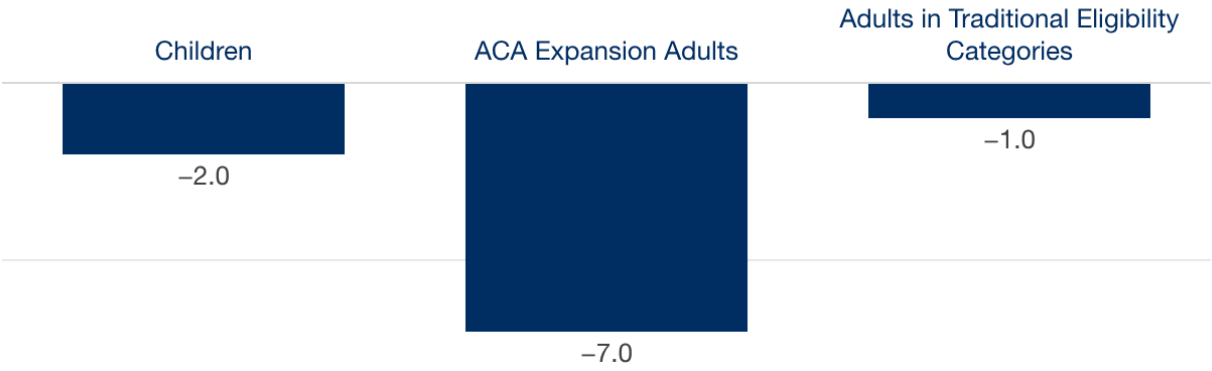
[35] See Leo Cuello, "CMS Triples Harmful Impact of HR 1 Medicaid Provider Cuts in State Directed Payment Proposed Rule, Georgetown University Center for Children and Families, May 28, 2026, https://ccf.georgetown.edu/2026/05/28/cms-triples-harmful-impact-of-hr-1-medicaid-provider-cuts-in-state-directed-payment-proposed-rule/; Tricia Brooks et al., "New Federal Medicaid Work Reporting Requirements Rule Threatens Coverage for Vulnerable Americans: An Explainer of the Interim Final Rule," Georgetown University Center for Children and Families, July 16, 2026, https://ccf.georgetown.edu/2026/07/16/new-federal-medicaid-work-reporting-requirements-rule-threatens-coverage-for-vulnerable-americans-an-explainer-of-the-interim-final-rule/; Joan Alker and Edwin Park, "Trump Administration Issues Section 1115 Medicaid Waiver Financing Guidance Which Goes Far Further Than H.R. 1 (Again)," Georgetown University Center for Children and Families, June 25, 2026, https://ccf.georgetown.edu/2026/06/25/trump-administration-issues-section-1115-medicaid-wavier-financing-guidance-which-again-goes-far-further-than-h-r-1/; and Edwin Park, "CMS Issues New Rule Again Going Beyond H.R. 1 Requirements to Further Restrict State Use of Provider Taxes," Georgetown University Center for Children and Families," July 27, 2026, https://ccf.georgetown.edu/2026/07/27/cms-issues-new-rule-again-going-beyond-h-r-1-requirements-to-further-restrict-state-use-of-medicaid-provider-taxes/.

[36] Congressional Budget Office February 2026 Medicaid Baseline, https://www.cbo.gov/system/files/2026-02/51301-2026-02-medicaid.pdf.

enactment of H.R. 1 in its June 2024 Medicaid baseline, according to a KFF analysis of CBO baselines (see Figure 5).[37]

Figure 4

CBO Baseline Estimates of Medicaid Enrollment Reductions Between 2025 and 2036 by Eligibility Category (in millions)



Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Medicaid Baseline Projections" (February 2026).

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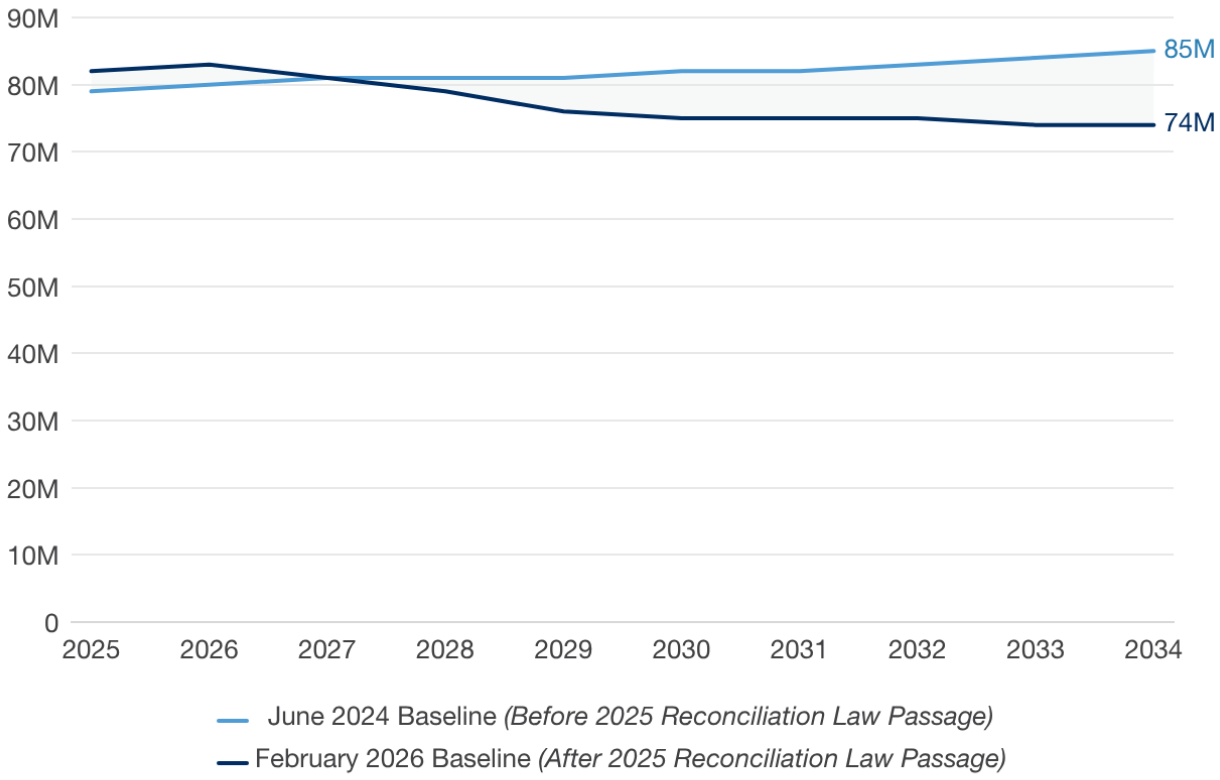
[37] Elizabeth Williams, Alice Burns, and Robin Rudowitz, "How Has Projected Medicaid Spending and Enrollment Changed Since Passage of the 2025 Reconciliation Law," July 1, 2026, https://www.kff.org/medicaid/how-has-projected-medicaid-spending-and-enrollment-changed-since-passage-of-the-2025-reconciliation-law/.

Figure 5

KFF Comparison of CBO Baseline Estimates of Medicaid Enrollment



CBO's January 2025 baseline did not include Medicaid enrollment estimates; enrollment projections from the June 2024 baseline are shown here. 2025-2034 is the period for which comparable enrollment projections are available.

Source: KFF analysis of the Congressional Budget Office's "Medicaid Baseline Projections" (February 2026).

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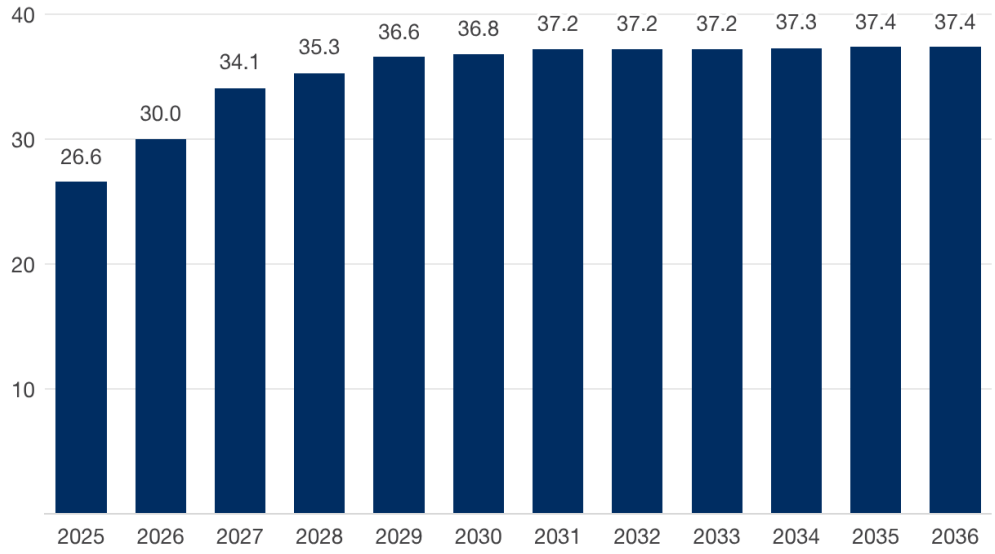
H.R. 1's Medicaid cuts and the resulting enrollment losses likely account for the large majority of the 10.8 million—or 40%— increase in the number of uninsured people between calendar years 2025 and 2036 currently estimated by CBO in a new analysis (see Figure 6).[38] As CBO states, "[t]he 2025 reconciliation act made major changes to Medicaid that, on net, are expected to decrease enrollment and reduce the federal deficit." CBO then notes that "[s]ome provisions directly affect eligibility and enrollment" like work reporting requirements, the moratoria on certain application, enrollment, and renewal rules, and more frequent redeterminations for expansion adults. Other provisions, such as the restrictions on provider taxes and state-directed payments, "lead

[38] Congressional Budget Office, "Federal Subsidies for Health Insurance: 2026-2036," July 2026, https://www.cbo.gov/publication/62539.

to lower enrollment indirectly" as "states may respond to reduced resources for financing their share of Medicaid by tightening their eligibility requirements or scaling back optional coverage."

Figure 6

CBO Baseline Estimates of the Number of Uninsured People



Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Federal Subsidies for Health Insurance, 2026 to 2036" (July 2026).

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While some of the most impactful Medicaid cuts, such as the work reporting requirements, have not yet fully taken effect, states are already instituting other cuts to their Medicaid programs due, in part, to budgetary pressures created by H.R. 1's cost-shifts in Medicaid and SNAP. These cuts include reductions to home and community-based services (HCBS), the services that allow older adults and people with disabilities to live at home and in their communities rather than in institutions.

Because HCBS are optional services under federal Medicaid law, they are among the first places states look when federal support contracts. For example, when the Great Recession created state Medicaid budget shortfalls, every state cut HCBS, with waiting lists in many states growing accordingly.[39] Early evidence suggests that history is beginning to repeat. In initial data from a tracker of state HCBS policy changes launched by researchers at George Washington University, the majority of recent state actions on HCBS were cuts (e.g., reduced waiver slots and service caps, provider rate

[39] Jessica Schubel, Alison Barkoff, H. Stephen Kaye, Marc Cohen & Jane Tavares, "History Repeats? Faced With Medicaid Cuts, States Reduced Support for Older Adults and Disabled People," *Health Affairs Forefront*, April 16, 2025, https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.

reductions, and tightened eligibility) falling heavily on people with intellectual and developmental disabilities, physical disabilities, and older adults.[40]

Medicaid Cost Growth Driven by Systemwide Health Spending Trends but Has Grown More Slowly Than Other Payors

As the Peterson Center on Healthcare and KFF explain, health care costs generally rise faster than inflation and growth in the economy. Key contributors include medical technological advances, rising prices, aging of the population, increased rates of chronic illness, and expansions in health insurance coverage, among others.[41] Consistent with these systemwide trends, CBO similarly states that there are three factors that drive growth in federal health spending in programs like Medicare and Medicaid: (1) growth in prices for health care services; (2) growth in the average spending per beneficiary; and (3) increases in enrollment. Notably, there is no mention of fraud as a factor.[42]

Research has previously shown that Medicaid costs per enrollee are significantly less than the equivalent per-enrollee costs of enrolling Medicaid beneficiaries into employer-sponsored insurance.[43] This is due, in large part, to Medicaid reimbursement rates being considerably lower than those in private insurance (and in Medicare).[44] Moreover, Medicaid costs per enrollee have also tended to grow more slowly than in Medicare and private insurance. For example, historical National Health Expenditure (NHE) data from the Office of the Actuary at CMS show that between calendar years 1987 and 2024, on average, Medicaid spending per enrollee grew 4.1% annually, compared to 5.2% in Medicare and 6.2% in employer-sponsored insurance (see Figure 7).[45]

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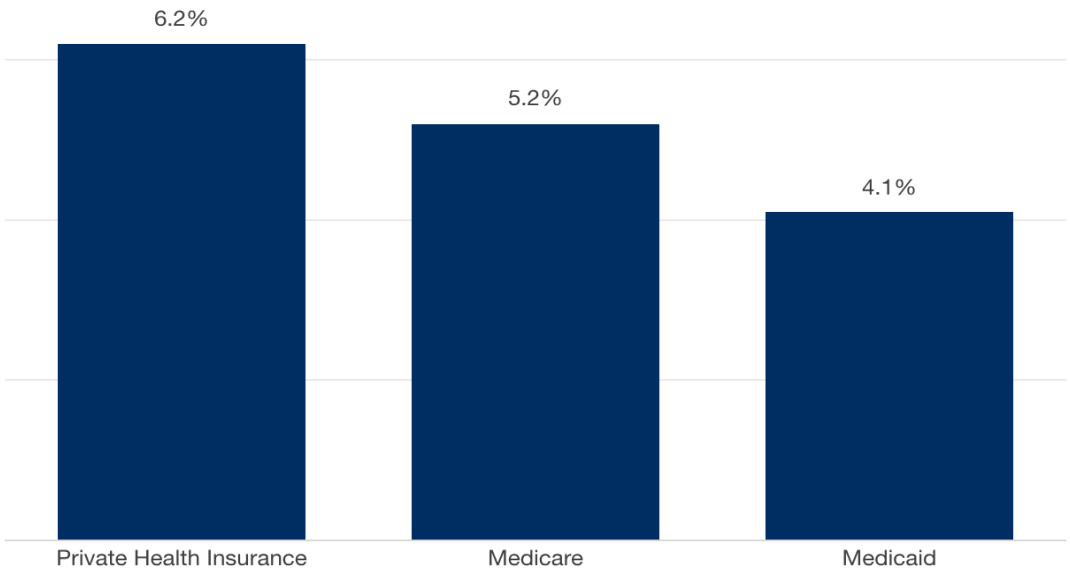
[40] HCBS Impacts Tracker Project, George Washington University Milken Institute School of Public Health, https://hpmmatters.publichealth.gwu.edu/HCBS-impacts-tracker-project (pilot data as of July 17, 2026).
[41] Cynthia Cox et al., "Health Care Costs and Affordability," KFF, October 8, 2025, https://www.kff.org/health-costs/health-policy-101-health-care-costs-and-affordability/.
[42] Congressional Budget Office, "Federal Subsidies for Health Insurance: 2026-2036," *op cit*.
[43] Teresa Coughlin et al., "What Difference Does Medicaid Make?," KFF, May 2013, https://www.kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/.
[44] See, for example, Government Accountability Office, "Comparisons of Selected Services under Fee-for-Service," July 15, 2014, https://www.gao.gov/products/gao-14-533; Adam Biener and Thomas Selden, "Public and Private Payments for Physician Office Visits," *Health Affairs*, December 4, 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749; and Stephen Zuckerman, Laura Skopec, and Joshua Aarons, "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019," *Health Affairs*, February 1, 2021, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00611.
[45] Georgetown CCF analysis of historical National Health Expenditure data, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

Figure 7

Average Annual Growth of Per-Enrollee Expenditure, 1987-2024



Source: Georgetown University Center for Children and Families analysis of the Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Data.

Looking forward, prior to enactment of H.R. 1, NHE projections showed that Medicaid cost per enrollee was expected to grow annually, on average, at 5.4%, after completion of unwinding of the pandemic-related continuous coverage requirement (2026-2033), compared to 6% in Medicare and 4.5% in employer-sponsored insurance.[46] That is similar to current NHE projections, after taking into account H.R. 1's Medicaid cuts, where average annual Medicaid per enrollee cost growth (5.3%) will be in line with growth in per-enrollee costs in employer-sponsored insurance (5.1%) and below that of Medicare (6%).[47] Similarly, CBO estimated that in 2023, prior to enactment of H.R. 1, federal subsidies per enrollee would grow at a slower pace in Medicaid/CHIP than in employer-sponsored insurance between 2023 and 2033.[48] The latest CBO projections, including the impact of H.R. 1, find that growth in real federal subsidies per enrollee in

[46] Georgetown CCF analysis of prior NHE projections in Matt McGough et al., "How much is health spending expected to grow?," Peterson-KFF Health System Tracker, August 4, 2025, https://www.healthsystemtracker.org/chart-collection/how-much-is-health-spending-expected-to-grow/#Total%20health%20spending,%20by%20service%20type,%202018-2023;%20projected%202024-2033.

[47] Jacqueline A. Fiore et al., "National Health Expenditure Projections 2025-34: Strong Utilization Growth Initially, Legislative Impacts Later," *Health Affairs*, June 24, 2026, https://www.healthaffairs.org/doi/10.1377/hlthaff.2026.00642#EX3.

[48] Congressional Budget Office, "Federal Subsidies for Health Insurance: 2022-2023," September 2023, https://www.cbo.gov/publication/59273.

Medicaid between 2026 and 2036 will be less than half (41%) of growth in employer-sponsored insurance and less than half (45%) of growth in Medicare.[49]

As these spending data and projections show, Medicaid's per-enrollee growth is driven by factors like health care prices and an aging population, not by fraud. But that does not mean fraud against Medicaid is not a serious problem. It is, and it always has been. The question before this Committee is not whether to fight fraud against Medicaid, it is how. And the answer begins with being precise about what fraud is, and what it is not.

Improper Payments Are Not the Same as Fraud

The Government Accountability Office (GAO) defines fraud as "obtaining something of value through willful misrepresentation."[50] GAO is crystal clear that improper payments are not the same as fraud: "Improper payments are any payments that should not have been made, or were made in an incorrect amount, for reasons ranging from unintentional administrative errors to fraud. Though not all improper payments are due to fraud, high rates of estimated improper payments can indicate that a program is vulnerable to fraud."[51]

In Medicaid, improper payments are measured through the Payment Error Rate Measurement program. PERM does not measure fraud. It measures compliance with statutory, regulatory, and administrative requirements under the Payment Integrity Information Act of 2019. (As GAO recognizes, improper payment estimates are "not specifically designed to detect fraud.")[52] Improper payments include payments lost to fraud, but most improper payments involve missing or insufficient documentation, payments that may well have been entirely proper, but where the paperwork to prove it was incomplete.

According to CMS's Fiscal Year 2025 Improper Payments Fact Sheet, 77.2% of Medicaid improper payments in 2025 resulted from insufficient documentation (typically a missed administrative step and in CMS's own words "generally not indicative of fraud or abuse)."[53] The remaining improper payments were payments that should not have been made. These include payments made in cases where the beneficiary was

[49] Congressional Budget Office, "Federal Subsidies for Health Insurance: 2026-2036," *op cit*.
[50] GAO, "Fraud and Improper Payments," https://www.gao.gov/fraud-improper-payments.
[51] Ibid.
[52] GAO, "Combating Fraud: Managing Risks in Federally-Funded, State-Administered Programs," July 23, 2026, https://www.gao.gov/assets/gao-26-109100.pdf
[53] CMS's supplemental data show this includes 5.6% that were merely "technically improper": payments to the right recipient in the right amount that failed a procedural requirement, which CMS does not even seek to recover. CMS, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet..

ineligible for the program, or the beneficiary was eligible but received a service that was not covered (16.7%); payments made to providers who were not enrolled in the program (1.9%); and other monetary losses (3.5%).[54]

The Medicaid improper payment rate in 2025 was 6.1%. By way of comparison, the improper payment rate in Medicare Fee-for-Service was 6.55%; in Medicare Part C, 6.09%: and in Medicare Part D, 4.0%.[55] CMS and state Medicaid agencies can and should work together to reduce these rates. But they should not be conflated with a fraud rate.

Growth in Spending Is Not Itself Evidence of Fraud

One pervasive fallacy deserves a direct response: the claim that growth in Medicaid spending on particular services, such as home and community-based services (HCBS) and behavioral health care, is in and of itself evidence of fraud. It is not. Spending growth in areas such as these often reflect deliberate, bipartisan federal and state policy choices as well as the size and needs of the populations Medicaid serves.

Consider HCBS services. For decades, Congress, on a bipartisan basis, has deliberately encouraged states to rebalance Medicaid long-term care spending away from institutional settings to home and community-based settings. These efforts have worked. HCBS grew from about 1% of Medicaid long-term care spending in 1981 to nearly two-thirds today, delivering services that decades of research show improve outcomes while reducing overall costs.[56] And the demand is real: more than 10,000 Americans turn 65 every day, and more than half of those reaching age 65 will need long-term services and supports in their lifetime.[57] Congress most recently reaffirmed this policy direction in H.R. 1, creating a brand-new HCBS authority, section

[54] CMS, 2025 Medicaid & CHIP Supplemental Improper Payment Data, January 2026, https://www.cms.gov/files/document/2025-medicaid-chip-supplemental-improper-payment-data.pdf.
[55] CMS Fiscal Year 2025 Improper Payments Fact Sheet, op. cit.
[56] Congressional Research Service, *Medicaid Section 1915(c) Home- and Community-Based Services Waivers*, R48519, April 29, 2025, https://www.congress.gov/crs-product/R48519; Jane Tavares, Alison Barkoff, Sara Rosenbaum & Marc A. Cohen, "Unfounded Fraud Allegations Threaten Vital Medicaid Home And Community-Based Services," *Health Affairs Forefront*, March 16, 2026, https://www.healthaffairs.org/content/forefront/unfounded-fraud-allegations-threaten-vital-medicaid-home-and-community-based-services; and Joe Caldwell et al., "Home and Community-Based Services Improve Outcomes While Reducing Costs," Community Living Policy Center, Lurie Institute for Disability Policy, Brandeis University, April 2026, https://heller.brandeis.edu/community-living-policy/research-policy/publications/titles/hcbs-improve-outcomes-reduce-costs.html.
[57] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Long-Term Services and Supports for Older Americans: Risks and Financing," revised August 2022, https://aspe.hhs.gov/reports/ltss-older-americans-risks-financing-2022.

1915(c)(11), that will allow states to serve people before they decline to an institutional level of care.

The same is true of behavioral health, where rising utilization follows directly from Congress's own bipartisan choices, including mental health parity requirements,[58] the Certified Community Behavioral Health Clinic expansion under the Bipartisan Safer Communities Act,[59] and support for the 988 crisis line,[60] after decades of documented underinvestment and unmet need.

When Congress builds capacity, and more people then receive care, the policy is working as intended. Treating that growth as presumptive fraud punishes states for doing exactly what federal law asked of them. The consequences are already visible: In July 2026, HHS deferred more than $1 billion in federal Medicaid payments from California and Minnesota, much of it for home-based services,[61] even as the majority of recent state HCBS actions, as discussed above, have been cuts.

Fraud Against Medicaid is Real; State-Federal Collaboration Is the Answer

As with Medicare and private health insurers, there is fraud against Medicaid, and it demands an effective response.[62] GAO explains that while fraud can be carried out by providers, managed care plans, and beneficiaries, "identified cases of fraud have most commonly been carried out by providers" [63] There is no reliable estimate of the amount of fraud against Medicaid or Medicare. In the 2026 National Health Care Fraud Takedown, the Department of Justice lists cases alleging over $6.5 billion in fraud against Medicare, Medicaid, and other federal health care programs; of those charges,

[58] Anne Dwyer, "Medicaid/CHIP Mental Health Parity: Latest Federal Actions Explained," CCF, September 19, 2024, https://ccf.georgetown.edu/2024/09/19/medicaid-chip-mental-health-parity-latest-federal-actions-explained/
[59] Anne Dwyer, "Ten New States Join the CCBHC Medicaid Demonstration; H.R. 1 Puts Its Success at Risk," CCF, June 29, 2026, https://ccf.georgetown.edu/2026/06/29/ten-new-states-join-the-ccbhc-medicaid-demonstration-h-r-1-puts-its-success-at-risk/
[60] Hannah Green and Anne Dwyer, "In-State Call Answer Rates for 988 Lifeline," CCF, https://ccf.georgetown.edu/feature/in-state-call-answer-rates-for-988-lifeline/
[61] Home Health Care News, "HHS Defers Over $1B in Medicaid Payments, Including for Home-Based Services," July 2026, https://homehealthcarenews.com/2026/07/hhs-defers-over-1b-in-medicaid-payments-including-for-home-based-services/..
[62] Andy Schneider, "The Truth About Fraud Against Medicaid," CCF, January 10, 2025, https://ccf.georgetown.edu/2025/01/10/the-truth-about-fraud-against-medicaid/
[63] Government Accountability Office, "Combating Fraud: Managing Risks in Federally Funded, State-Administered Programs," July 23, 2026, https://www.gao.gov/assets/gao-26-109100.pdf

$518 million—about 8%--involved fraud against Medicaid.[64] (These amounts represent alleged, not proven, losses).

Deterring, identifying, and prosecuting provider fraud is the job of a specific, long-established state-federal enforcement architecture: state Medicaid agencies, state Medicaid Fraud Control Units (MFCUs), state auditors, CMS, HHS-OIG, DOJ, and the FBI. When these agencies collaborate, they are much more effective. As DOJ explained in announcing its 2026 National Health Care Fraud Takedown, "Today's Takedown represents a new era in federal, state, and international cooperation to combat health care fraud: cases in 56 federal districts and 45 U.S. states and territories, with 50 state Medicaid Fraud Control Units participating, the most in Department history."[65]

Unfortunately, some recent CMS and OIG actions have been decidedly uncooperative. To date, CMS has deferred a total of over $2.76 billion in federal matching funds from California and Minnesota on the grounds that the states have not taken fraud seriously.[66] OIG has terminated federal funding for Hawaii's MFCU[67] and suspended federal funding for New York's MFCU.[68]

There is no evidence that withholding federal funds from state Medicaid programs or state MFCUs will reduce fraud against Medicaid. There is every reason to believe that it will weaken the very agencies responsible for fighting it. The partisan tilt to CMS's deferrals is certainly not the way in which CMS has addressed fraud against Medicaid in the past.[69] And it is not among the recommendations that GAO makes for addressing fraud in Medicaid and other federally-funded, state administered programs, such as

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[64] Department of Justice, "National Health Care Fraud Takedown Results in 455 Defendants Charged with Over $6.5 Billion in Alleged Fraud," June 23, 2026, https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65

[65] Ibid.

[66] Andy Schneider, "Weaponizing Fraud Against Medicaid in California and Minnesota: Another Quarter, Another Round of Deferrals," Georgetown Center for Children and Families, July 29, 2026, https://ccf.georgetown.edu/2026/07/29/weaponizing-fraud-against-medicaid-in-california-and-minnesota-another-quarter-another-round-of-deferrals/

[67] Andy Schneider, "The Administration Weaponizes Fraud Against Medicaid: HHS OIG Hammers Hawaii," Georgetown Center for Children and Families June 12, 2026, https://ccf.georgetown.edu/2026/06/12/the-administration-weaponizes-fraud-against-medicaid-hhs-oig-hammers-hawaii/

[68] HHS, OIG, "Statement on Federal Decertification of the New York Medicaid Fraud Control Unit" (July 2, 2026) https://oig.hhs.gov/fraud/enforcement/statement-on-federal-decertification-of-the-new-york-medicaid-fraud-control-unit/.

[69] Elizabeth Hinton et al."5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments," KFF,,March 18, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-program-integrity-fraud-waste-abuse-and-improper-payments/

"sharing information and leveraging relationships among and between state and federal agencies."[70]

Conclusion

The Reality of Medicaid is that it provides access to health and long-term care services for over 67 million Americans; that it protects children, pregnant women, families, seniors and people with disabilities from the high costs of health care; and that it is very popular. Over the past 7 months, CMS political leadership has spent considerable time and energy attacking the Medicaid programs in California and Minnesota for not doing enough to address fraud while it has not addressed the 2.3 million decline in enrollment of children since January 2025. The loss of Medicaid coverage by children will likely accelerate next year, when the cuts enacted by H.R. 1 begin to take effect. Congress should direct CMS to invest its resources in reversing this trend.

[70] Government Accountability Office, "Combating Fraud: Managing Risks in Federally Funded, State-Administered Programs," July 23, 2026, https://www.gao.gov/assets/gao-26-109100.pdf