The Fiscal Foundation: Federal Matching, State Shares, and the Architecture of Medicaid Finance Under OB3

The Budget That Cannot Balance

The state Medicaid director stares at a spreadsheet that refuses to reconcile. Her agency must build work requirement verification systems, exemption processing infrastructure, and navigation capacity for 340,000 expansion adults by December 2026. The estimated cost: $85 million over two years. The available funding: unclear. Provider tax increases that would have generated $40 million in state matching funds are now prohibited under OB3. DSH allotments that might have offset hospital uncompensated care are declining. The enhanced 90% expansion match that made the whole enterprise affordable will phase down starting 2029.

Her state receives 71 cents in federal funds for every dollar spent on Medicaid services. But administrative costs for work requirement systems draw only 50 cents on the dollar regardless of the state's economic circumstances. The Congressional Budget Office projects work requirements will save the federal government $326 billion over ten years. Her state must spend tens of millions to implement a policy designed to reduce federal expenditures. No dedicated federal funding exists for implementation. The fiscal math does not work.

The FMAP Formula and Its Implications

The ***Federal Medical Assistance Percentage*** determines federal contributions to state Medicaid expenditures. Unlike block grants with fixed amounts, FMAP creates an open-ended entitlement where federal payments increase proportionally with state spending. The formula compares state per capita income to national per capita income, producing matching rates ranging from the ***50% floor*** (wealthiest states) to the ***77.76% ceiling*** (Mississippi).

Fourteen states receive the minimum 50% match: California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington, Wyoming, plus Alaska and Hawaii with adjusted calculations. These floor states pay dollar-for-dollar with federal contributions for every Medicaid expenditure. Mississippi receives 77.76%, meaning the state pays only 22.24 cents for every dollar of Medicaid spending while the federal government contributes the remainder.

The formula's neutrality to population size creates implementation disparities. California must build infrastructure serving 4.7 million expansion adults. Wyoming serves 15,000. Both face identical December 2026 deadlines. Both receive the same 50% administrative match for implementation costs. California's absolute costs dwarf Wyoming's, but California's fiscal capacity also exceeds Wyoming's by orders of magnitude. The formula assumes administrative burden correlates with state wealth, but implementation complexity does not scale with per capita income.

For work requirements, FMAP differences create divergent investment incentives. Every dollar Mississippi spends on navigation infrastructure generates $3.49 in federal match for services to retained members. Every dollar New York spends generates only $1.00 in federal match. New York has less fiscal incentive to invest in retention infrastructure because each retained member costs

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the state proportionally more. Mississippi has greater incentive but less fiscal capacity. Neither alignment produces optimal outcomes.

The Enhanced Expansion Match and Its Erosion

The Affordable Care Act offered states ***100% federal funding*** for expansion populations through 2016, declining to 95% (2017), 94% (2018), 93% (2019), and settling permanently at 90% (2020 forward). This represented a historic federal financing commitment. States could extend coverage to adults up to 138% of the federal poverty level while bearing only 10% of medical costs.

OB3 fundamentally alters this compact. The law ***eliminates the 90% enhanced match*** for expansion adults effective January 1, 2029. Federal participation transitions to 80% through 2032, then returns to standard FMAP thereafter. For states that have not yet expanded, OB3 provides a temporary 80% match for expansion within two years of enactment.

The fiscal trajectory varies by state. Kentucky (FMAP 72.85%) will see its state share for every $1,000 in expansion medical spending increase from $100 under the 90% match to $200 under the 80% transition to $271.50 under standard FMAP. Over six years, state costs for the same population nearly triple. Ohio (FMAP 63.12%) faces increases from $100 to $200 to $368.80. Floor states like New York see costs rise from $100 to $200 to $500.

Late expanders face compressed timelines. Georgia expanded in 2023 and receives the 90% match for only three years before OB3's reduction takes effect. The financial calculation favoring expansion narrowed substantially, but Georgia cannot reverse its decision without sacrificing coverage for newly enrolled populations. States that expanded under ballot initiatives over legislative opposition now see those legislatures controlling implementation of requirements on populations they never wanted to cover.

Administrative Match Rates and Infrastructure Costs

Standard administrative activities receive ***50% federal match regardless of state FMAP***. Work requirement verification, exemption processing, compliance monitoring, and member outreach fall within this category. States must fund half of all administrative infrastructure from state sources, regardless of their economic circumstances or medical matching rates.

This creates a structural paradox. Mississippi's 77.76% medical FMAP reflects its limited fiscal capacity. But Mississippi's administrative FMAP drops to 50% for building verification portals and hiring eligibility workers. The formula assumes administrative capacity correlates with state wealth, but the assumption fails when federal mandates impose uniform requirements across states with vastly different resources.

Enhanced match exceptions exist for technology investments. CMS regulations allow 90% federal match for Medicaid information technology development and 75% for ongoing operations. Verification systems, data exchange platforms, member portals, and case management systems with health IT components could qualify. States pursuing enhanced match must carefully categorize spending to maximize qualification while ensuring federal compliance.

The critical limitation: ***enhanced HIT match covers technology but not human infrastructure***. Navigation staff, community partnerships, exemption clinics, provider engagement, and care coordination cannot be classified as health information technology. These human components often represent larger cost categories than technology. A state might draw 90% match for building

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an automated verification portal but only 50% match for the caseworkers who help members use it.

States building comprehensive work requirement systems must blend funding streams with different matching rates. Automated data matching technology draws 90% federal match. Ongoing system operations draw 75%. Eligibility worker time processing exemptions draws 50%. Community organization partnerships may receive no federal match at all. MCO capitation can fund contracted navigation services, but capitation rates must be actuarially justified. The complexity of assembling adequate funding from multiple streams with different rules and approval processes challenges state administrative capacity.

OB3 Federal Funding Provisions

The Rural Health Transformation Program represents OB3's primary affirmative investment in healthcare infrastructure. The law appropriates $50 billion over five years ($10 billion annually FY 2026-2030) to CMS for distribution to eligible states. States must submit applications by December 31, 2025, including detailed rural health transformation plans and expenditure certifications.

The program seeks to address CBO-predicted reductions in Medicaid spending due to OB3 provisions. Eligible uses include workforce development, telehealth infrastructure, care coordination, and rural provider financial sustainability. Several states have submitted substantial applications. Alabama seeks $100 million annually for rural healthcare infrastructure while maintaining opposition to traditional Medicaid expansion. Alaska requests approximately $200 million over five years for workforce development and telehealth in communities accessible only by air or water. Delaware proposes up to $1 billion for medical school development, mobile health units, and school-based health centers. New Mexico requests $1 billion focused on rural workforce expansion and provider sustainability.

Critical constraints limit the program's utility for work requirement implementation. The competitive grant process requires CMS approval, and states compete against each other for limited allocations. Funds cannot cover state Medicaid matching costs directly. The timeline means funds arrive too late for December 2026 implementation. The five-year sunset creates temporary relief while structural challenges persist indefinitely.

Rural Health Transformation funds cannot fund work requirement navigation directly. However, expanded healthcare touchpoints could indirectly support verification and exemption documentation if states design programs with this secondary purpose in mind. A mobile health unit visiting rural communities for primary care could also facilitate exemption documentation for members with medical conditions. The connection is indirect and depends on state implementation choices.

Notably absent from OB3: dedicated federal funding for work requirement implementation costs. States bear full responsibility for verification systems, exemption processing, navigation infrastructure, and community engagement. Only standard 50% administrative match is available, with enhanced HIT match for qualifying technology components. CBO estimates work requirements will save the federal government $326 billion over ten years, the largest single source of Medicaid savings in OB3. States must invest in infrastructure to implement requirements that generate federal savings, without dedicated federal support for those implementation costs.

Disproportionate Share Hospital Payments

DSH payments compensate hospitals serving disproportionate shares of low-income and uninsured patients. Created in 1981, DSH recognizes that some facilities bear concentrated burdens of uncompensated care. State allotments totaled approximately $14 billion in FY 2024, distributed based on statutory formulas dating to the early 1990s. These allotments create state-by-state ceilings rather than entitlements, with states deciding distribution among qualifying hospitals.

The ACA scheduled DSH reductions beginning in 2014, reasoning that coverage expansion would reduce uncompensated care needs. Congress repeatedly delayed these cuts as expansion proceeded unevenly across states. OB3 accelerates reductions that had been postponed, with cuts taking effect beginning FY 2026.

Work requirements create conditions that increase uncompensated care precisely as DSH allotments decline. Coverage losses among expansion adults will produce patients who continue seeking healthcare without insurance. Hospitals cannot refuse emergency services regardless of insurance status. When previously covered patients arrive without Medicaid, hospitals absorb costs as charity care or bad debt. DSH payments theoretically offset these costs, but allotment reductions mean hospitals receive less federal support precisely when uncompensated care increases.

Rural hospitals face particular vulnerability. Many operate at break-even or loss, depending on DSH payments for survival. The Chartis Center for Rural Health identifies approximately 300 rural hospitals at immediate closure risk nationally. Concentrated coverage losses in rural areas from work requirement non-compliance could accelerate closures that no DSH redistribution can prevent.

Provider Taxes and the OB3 Freeze

Provider taxes allow states to generate matching funds without general appropriations. A hospital tax of 3.5% on gross revenues produces state revenue that states then spend on Medicaid, drawing federal match. The state pays higher Medicaid rates back to hospitals through supplemental payments, creating a circular flow where hospitals effectively fund their own rate increases while the federal government contributes matching funds. The mechanism has been controversial but effective, enabling states to finance program expansions, rate increases, and administrative infrastructure without legislative appropriations battles.

OB3 freezes the provider tax safe harbor at 6% through 2028, then phases down to 5% (2029), 4.5% (2030), 4% (2031), and 3.5% (2032) for expansion states. Non-expansion states maintain the 6% cap through 2032 without phase-down. More significantly, OB3 caps state-directed payments at 100% of Medicare rates for expansion states and 110% for non-expansion states.

The combination prevents states from using traditional provider tax mechanisms to fund work requirement infrastructure. States needing $40 million annually for navigation systems cannot raise hospital taxes from 3.5% to 4.0% to generate the state share. The path that financed previous Medicaid expansions is closed. States must find alternative sources: general fund appropriations requiring legislative action, reallocation from other Medicaid spending triggering provider opposition, or MCO capitation increases requiring actuarial justification and federal approval.

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State exposure varies based on reliance on these mechanisms and fiscal capacity to find alternatives. California operated under a uniformity waiver allowing differential hospital tax rates, generating approximately $3.7 billion annually in state revenue. OB3 prohibits such differential structures. California must unwind this financing arrangement while simultaneously building infrastructure for 4.7 million expansion adults. New York used provider taxes aggressively, with the MCO tax alone generating over $3.7 billion annually. CMS correspondence in 2025 indicated federal approval for only $2.1 billion under new policy standards, creating a $1.6 billion shortfall before accounting for work requirement costs.

Fee-for-Service State Vulnerability

Five expansion states operate Medicaid entirely through fee-for-service without managed care organizations: Alaska, Connecticut, Maine, Vermont, and Wyoming. Each faces fundamentally different implementation challenges than MCO states. Without health plans to delegate member navigation, these states must build all compliance support infrastructure within state agency capacity.

Connecticut represents the largest FFS expansion state. The state terminated managed care contracts in 2012, citing administrative cost concerns and quality dissatisfaction. The Department of Social Services directly administers benefits for approximately 900,000 Medicaid enrollees, including roughly 280,000 expansion adults subject to work requirements.

Connecticut's FFS structure creates both advantages and disadvantages. A 2024 consultant report confirmed the program performs better than comparison states on cost control, quality, and access. Direct state administration enables consistent policy application without multi-plan coordination. However, Connecticut lacks MCO infrastructure for member navigation. Health plans in other states will bear some responsibility for helping members document compliance. Connecticut must build equivalent capacity within DSS or through community partnerships.

Connecticut's ***heavy reliance on provider taxes creates acute vulnerability*** to OB3 restrictions. Yale New Haven Health reports a $200 million annual tax liability for three hospitals. The current provider tax agreement expires July 2026, precisely as work requirement implementation begins. The state must simultaneously negotiate new provider tax arrangements under tighter federal constraints and construct work requirement infrastructure. The timeline convergence creates compounding fiscal pressure.

Alaska never implemented managed care because geography makes it impossible. Over 200 communities are accessible only by air or water. Traditional network adequacy requirements cannot function where roads do not exist. The extensive Indian Health Service and tribal health network serves substantial portions of the Medicaid population.

Alaska's work requirement exposure is significantly mitigated by ***AI/AN exemptions***. Federal law exempts American Indians and Alaska Natives from work requirements, protecting a large share of the expansion population. Additionally, 72% of Alaska's expansion adults are already working, and 15 boroughs and census areas qualify for high unemployment hardship exemptions. The combination means Alaska's non-exempt population requiring active work requirement verification is relatively small despite the state's FFS structure.

Vermont and Maine maintain FFS for smaller populations where MCO administrative overhead would consume disproportionate resources. Vermont serves approximately 35,000 expansion adults through integrated state social services. Maine serves approximately 90,000 expansion

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adults, expanded through ballot initiative in 2017 over gubernatorial opposition. Both states must construct compliance systems within state agency capacity without MCO delegation. Maine's significant rural population faces verification barriers that the state's limited administrative infrastructure may struggle to address.

Wyoming maintains FFS for the smallest expansion population among these states, approximately 15,000 adults. The state expanded recently and has minimal infrastructure for member services. Conservative political leadership may prioritize minimal implementation investment. The combination of small population, floor FMAP (50%), and limited state capacity creates vulnerability despite modest absolute numbers.

State	Expansion Adults	FMAP	Primary Vulnerability
Connecticut	~280,000	50%	No MCO infrastructure; heavy provider tax reliance
Maine	~90,000	65.89%	Rural barriers; no MCO infrastructure
Alaska	~45,000	50%	Geographic dispersion (mitigated by tribal exemptions)
Vermont	~35,000	50%	Small capacity; floor FMAP
Wyoming	~15,000	50%	Minimal infrastructure; floor FMAP

High-Vulnerability MCO States

MCO states are not immune to fiscal vulnerability. Several face convergent pressures from multiple OB3 provisions that strain implementation capacity regardless of managed care infrastructure.

New York faces among the largest absolute implementation challenges. The state serves approximately 2.7 million expansion adults with floor FMAP, meaning the highest state share requirement. Provider tax restrictions create a $1.6 billion shortfall before work requirement costs. Legacy Medicaid systems require modernization. The state's political leadership opposes work requirements but must implement federal mandates regardless. New York's fiscal exposure from work requirements may exceed $500 million in implementation and ongoing administrative costs.

California's combination of scale, FMAP, and provider tax disruption creates acute pressure. The state must build infrastructure for 4.7 million expansion adults while unwinding differential provider tax structures that generated $3.7 billion annually. California's 50% FMAP means every dollar of implementation cost requires a full dollar of state funds for matching. The state budget already faces structural deficits, and work requirement infrastructure competes with other priorities. California may face implementation costs exceeding $800 million.

Michigan expanded Medicaid and used provider taxes extensively. The state serves approximately 750,000 expansion adults. The provider tax freeze hits hard, compounded by modest fiscal reserves. Legacy eligibility systems built in the 1990s require modernization that budget constraints may prevent. Michigan may implement work requirements with inadequate infrastructure not from policy choice but from fiscal inability to build anything better.

West Virginia faces unique challenges despite moderate expansion population (approximately 175,000). The state has the highest chronic disease burden nationally, meaning high exemption qualification rates but also high documentation complexity. Significant rural population faces verification barriers. Limited state agency capacity constrains infrastructure development. Heavy

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provider tax reliance for Medicaid financing creates exposure to OB3 restrictions. West Virginia's implementation outcomes may reflect fiscal constraints more than policy preferences.

The District of Columbia faces existential fiscal threat beyond work requirements. Congressional proposals would reduce DC's special 70% FMAP to the standard 50% floor, separate from expansion match changes. The Urban Institute estimates maintaining current programs would require increasing local Medicaid spending by 63-83%, which DC officials describe as financially impossible. Work requirements become secondary to program survival if FMAP reduction occurs. DC's small expansion population (118,000) concentrated in Wards 7 and 8 would face requirements implemented against a backdrop of fundamental program uncertainty.

Alternative Financing Mechanisms

States facing provider tax constraints have explored alternatives, though none fully replaces lost capacity. ***General fund appropriations*** require legislative action in tight budget environments. States with divided government or resistant legislatures may find appropriations politically impossible regardless of implementation need.

Reallocation from other Medicaid spending triggers provider opposition. Cutting hospital rates to fund navigation infrastructure creates political backlash from provider associations. Reducing optional benefits creates coverage gaps that may harm members work requirements claim to help. The trade-offs are explicit and politically costly.

MCO capitation increases can shift navigation costs from state administrative budgets to managed care contracts. MCO expenditures flow through capitation rates that include federal match. However, states requesting significant capitation increases face federal scrutiny about actuarial soundness. CMS must approve rate certifications, and rates must reflect legitimate cost increases rather than financing mechanisms. The flexibility exists but is constrained.

Community benefit obligations for nonprofit hospitals create potential partnerships. Tax-exempt hospitals must demonstrate community benefit to maintain 501(c)(3) status. Navigation assistance helping community members maintain health coverage qualifies as community benefit activity. Hospitals could fund navigation programs serving both community benefit requirements and hospital revenue protection through maintained patient coverage. This approach requires hospitals to use operating revenue rather than receiving state payments financed through provider taxes.

Workforce Innovation and Opportunity Act funding supports workforce development activities overlapping with work requirement qualifying activities. WIOA funds could support job training programs that simultaneously satisfy work requirements and receive federal workforce investment. The coordination requires cross-agency collaboration that not all states can execute effectively.

The Federal Accountability Gap

Federal policy created this financing crisis but provides no federal solution. Congress imposed work requirements knowing states would need infrastructure to implement them. Congress simultaneously restricted the financing mechanism states traditionally used for such infrastructure. Congress provided no alternative dedicated funding for implementation. The federal government mandates the requirement, constrains financing tools, and offers only standard administrative match.

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If states fail to build adequate navigation infrastructure and coverage losses exceed policy intent, accountability is unclear. States had insufficient resources. Federal law prevented them from accessing their traditional financing mechanism. No alternative funding appeared. Responsibility cannot rest entirely with states when federal policy deliberately constrained their options.

CMS guidance emphasizes state responsibility for adequate implementation. Federal oversight will evaluate whether states have verification systems, exemption processes, and member support. States failing to demonstrate adequate systems may face compliance concerns. But states may fail not from unwillingness but from inability to fund what federal policy requires.

The provider tax restriction guarantees suboptimal implementation across many states. The question is not whether infrastructure will be adequate but how inadequate it will be and where coverage losses concentrate. States with strong fiscal positions, political will, and administrative capacity will build reasonable systems. States lacking any of these elements will struggle. The federal mandate is uniform; federal support is uneven; implementation outcomes will diverge accordingly.

Long-Term Fiscal Trajectory

The fiscal architecture creates a trajectory toward increasing state burden regardless of short-term implementation success. Enhanced expansion matches phase to standard FMAP by 2032 or shortly thereafter. States that expanded expecting permanent 90% federal participation face permanently higher state costs. The 10% state share that made expansion financially attractive becomes 20% to 50% depending on state FMAP.

States may respond by restricting expansion eligibility below 138% FPL, reducing covered populations while maintaining some coverage. States may invest heavily in pushing members toward employer coverage or marketplace enrollment. States may simply accept higher state costs as the price of prior expansion decisions. Each response carries distinct consequences for coverage, access, and health outcomes.

FMAP modifications require congressional action. Future Congresses could restore enhanced expansion matches, modify the base formula, or create new special cases. States cannot control these federal decisions but will lobby vigorously based on their interests. Long-term planning must account for political uncertainty. The current configuration reflects 2025 political alignment. Different alignment could produce different outcomes. Nothing about the fiscal architecture is permanent except the pattern of federal promises made and subsequently modified.

Conclusion

The architecture of Medicaid financing determines who pays for coverage, administration, and implementation infrastructure. Work requirements impose costs that must be distributed across federal and state governments, MCOs, providers, and the populations served. OB3 simultaneously mandates new activities while constraining traditional financing mechanisms. The design creates maximum fiscal stress precisely when states need maximum flexibility.

States understanding this architecture can pursue strategies maximizing federal participation within constraints. Enhanced HIT match for technology investments, MCO capitation-funded navigation services, community benefit partnerships with nonprofit hospitals, and WIOA coordination offer partial solutions. No combination fully replaces capacity lost through provider tax restrictions and DSH reductions. The $50 billion Rural Health Transformation Program provides

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infrastructure investment but cannot fund state matching costs or arrive in time for December 2026 implementation.

The fiscal foundation shapes everything built upon it. Work requirement success or failure will depend partly on verification system design, exemption policies, and navigation infrastructure, but fundamentally on whether states have resources to build and operate these systems at scale. Fee-for-service states face particular vulnerability because they cannot delegate implementation costs to MCOs. High-provider-tax states face disruption of their traditional financing mechanisms. Floor-FMAP states face the highest state share requirements. Rural states face infrastructure costs distributed across sparse populations.

The federal government will save $326 billion over ten years through work requirements. States will bear implementation costs without dedicated federal support. The fiscal math does not balance. Someone will pay the difference, whether through inadequate infrastructure, coverage losses, provider payment cuts, or state budget reallocation from other priorities. The architecture ensures the payment will occur. It does not specify who bears the burden.

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