WHAT'S AT STAKE

WHAT MEDICAID FINANCING MEANS FOR OLDER ADULTS AND PEOPLE WITH DISABILITIES

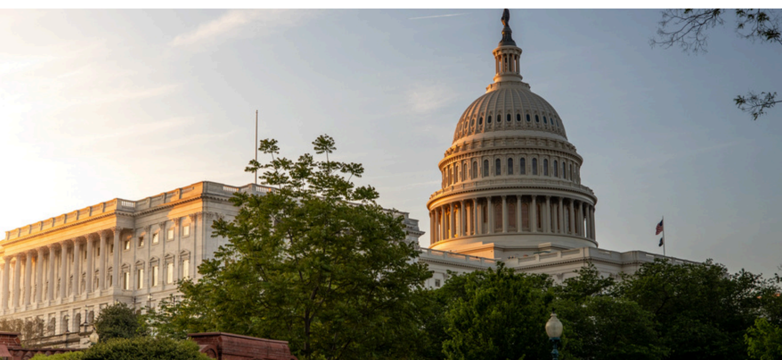
This fact sheet explains what Medicaid financing means for older adults, people with disabilities, and the health care system.

Medicaid is financed and administered through a federal-state partnership. Under current law, the federal government matches state Medicaid spending based on a statutory formula, without a pre-set limit.[1] If state spending increases, for example due to increased enrollment or unexpectedly high program costs, then federal spending increases as well. The countercyclical nature of Medicaid, where economic downturns increase spending, makes the flexibility of the open-ended financing structure vital; it allows federal funds to flow to states based on actual costs and needs as economic and other circumstances change. For example, a pandemic like COVID-19 can increase Medicaid costs by boosting enrollment, per capita spending, or both.[2]

State-directed payments allow states to draw down additional federal matching funds—with federal permission—to help bolster payment rates for Medicaid providers.[3] In addition, most states bolster their match, and often pay the state portion of state-directed payments, through provider taxes.[4]

HR 1's Changes Dramatically Cut Medicaid Funding

The 2025 reconciliation bill, HR 1, changed how states can use state-directed payments and provider taxes to fund their Medicaid programs.[5] Together, these changes will shift massive costs to states and cause underfunding of state Medicaid programs.



- **State-Directed Payments:** In many states, provider reimbursement under Medicaid is lower than through other forms of coverage. This can make providers unwilling to accept Medicaid. As one workaround, states providing coverage through Medicaid managed care can get additional federal funding and require the plans to increase provider payments under certain circumstances.[6] HR 1 limits the amount of state-directed payments states can use, cutting $149 billion from Medicaid over 10 years.[7]

- **Provider Taxes:** Most states also use provider taxes to increase Medicaid funding. As the name implies, provider taxes are taxes on providers that states collect to help pay for state Medicaid expenditures. Because these taxes are on providers who are then paid with Medicaid dollars, many policymakers consider these taxes abusive, as states are able to draw down federal matching funds without putting up new state dollars.[8]

Radical Restructuring Proposals

HR 1’s cuts will go into effect over the next several years. But some policymakers have historically supported a more fundamental restructuring of Medicare’s financing infrastructure.[10] These proposals often recommend transforming the program from a guaranteed benefit to a fixed payment system, coupled with new limitations on costs or care.

While block grants and per capita caps function slightly differently, both are designed to produce federal savings over time regardless of need or state liabilities. Both would also ultimately leave states unable to afford coverage and important services. This would limit access to needed care and place millions of low-income people at risk of becoming un- or underinsured.

- **Block Grants:** Under a block grant, states would receive a fixed amount of federal funding each year to operate their Medicaid programs. States would be responsible for all costs that exceed the federal amount. Since block grants are designed to achieve federal savings, the grants would undercut current spending, though the effects might take several years to become obvious.[11] Depending on how it is designed, the base grant might

automatically to keep pace with inflation, but the share borne by the federal government would likely not adjust in times of need, making economic downturns a double hazard for state coffers.

The dangers of block grants are illustrated by Puerto Rico's Medicaid financing. The territory receives its Medicaid funding as a block grant, so once the funds are exhausted, it must cover remaining costs itself. This lack of countercyclical assistance has been deadly: Before Hurricane Maria, the territory's funding limitations were already not keeping pace with need. Maria spiked costs, escalating the territory's debt, exacerbating a strained health care system, and devastating families.[12]

- **Per-Capita Caps:** A per-capita cap sets a limit on the amount of federal funding the state receives per Medicaid enrollee. These caps could be determined for all enrollees or separate caps could be calculated based on broad Medicaid coverage groups.[13] In either case, to generate federal savings, spending on each enrollee would either be set lower than current spending or indexed to grow more slowly than is expected under current law. While this approach would tie federal funding to population changes, it would still not address changes in health costs, like those associated with a pandemic, natural disaster, or expensive new therapy.[14]

Specific Risks for Older Adults and People With Disabilities

> ***HR 1's actual Medicaid cuts and the hypothetical cuts from proposed structural changes would have the same effect. If federal spending is curtailed, devastating impacts on older adults and people with disabilities are likely to follow.***

- **Highest Cost Beneficiaries:** As Medicaid funding shortfalls—whether through HR 1's cuts or through proposed restructuring—grow larger over time, states would have little choice but to cut the most expensive parts of the program to curtail costs. Older adults and people with disabilities would likely bear the brunt of major cuts, as their health care costs comprise over half of all Medicaid spending while accounting for only 23% of the Medicaid population.[15]

- **Home- and Community-Based Services:** HCBS services are generally for Medicaid beneficiaries who would otherwise be institutionalized in a nursing facility.[16] HCBS can be less expensive than nursing facility care —some of the savings are a result of underpayment of direct care workers, or a reliance on family caregivers[17]—but it is still costly. Importantly, most HCBS programs and services are optional for states.[18] This means that at least some states would likely seek to

cut HCBS or institute draconian waiting lists or caps if they began to experience massive shortfalls in funding, as has happened before.[19] This in turn would force more beneficiaries to leave their homes and communities for nursing facilities and, paradoxically, drain more from state budgets.

- **Increased "Flexibility":** Most proposals to institute major structural financing changes would promise states more flexibility to administer their Medicaid programs, such as by removing or loosening federal requirements on what benefits and eligibility categories states must maintain.[20] If federal requirements are removed, states would be free to cut services, impose cost sharing, roll back eligibility categories, or restrict enrollment through waiting lists or caps.

- **Nursing Facility Residents:** Medicaid was the primary payer for 63% of nursing facility residents as of July 2024.[21] Coverage of nursing facility care is required by the Medicaid statute, but this requirement could potentially be eliminated or waived by a new financing statute. Depending on the statute, states could also gain the ability to put waiting lists or caps into place, which could leave millions of residents at risk of losing both care and facility housing.

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