The Disability and Aging Collaborative

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CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

Answers to FAQ on Medicaid and Budget Reconciliation Proposals

Thank you for meeting with coalition members of the Disability and Aging Collaborative (DAC) and the Consortium for Constituents with Disabilities (CCD). Below are some answers to frequently asked questions about Medicaid, Medicaid's funding structure, and the proposed changes included in the proposals for budget reconciliation.

Medicaid is a cornerstone of the health and well-being of every community in America.

Medicaid is a lifeline for people with disabilities and older adults.

Medicaid, along with CHIP, provides health insurance and essential care to nearly 80 million people across the country – including more than 9 million people with disabilities who qualified through the SSI pathway, 17 million older adults ages 50+, and millions of pregnant people,

children, families, caregivers, and people with very low incomes trying to make ends meet. Nationally, 1 in 5 people with Medicaid have disabilities.

Of the nearly 80 million people enrolled in Medicaid and CHIP, 20 million people – all people with very low incomes – are adults who receive their health care through Medicaid expansion. People enrolled in Medicaid through expansion include single adults, family caregivers, direct care workers, shift workers, people working in grocery stores and on construction sites, and aides in public schools. They all have very low incomes – no more than $22,000 for a single adult or $45,000 for a family of four. Although many people with disabilities can get Medicaid by qualifying for SSI, more than 2/3rds of Medicaid enrollees with disabilities entered through a non-SSI pathway. Millions of people who get health care through Medicaid expansion are people with disabilities. This includes:

- People recently diagnosed with cancer who need treatment before they are sick enough to qualify for SSI.
- People who have serious mental health needs or substance use disorders and have trouble filling out all the paperwork and complying with all the red tape necessary to get SSI.
- People with disabilities who are working and earn a little too much to qualify through the SSI pathway, but aren't offered employer-sponsored health coverage.
- New veterans with disabilities whose TRICARE coverage has expired but who make too much money to qualify for SSI.
- People who are waiting the average 232 days to get a disability determination from SSI, who need health care in the meantime.

Medicaid expansion has helped fill these massive gaps.

How does Medicaid support people with disabilities and older adults to live at home rather than in institutions?

Medicaid, not Medicare, is the primary funder of long-term care. 1.5 million people in nursing facilities are covered by Medicaid, more than 2/3rd of nursing home residents. 7.8 million people with disabilities and older adults rely on Medicaid for essential at-home care - known as home and community-based services (HCBS). Medicaid pays for the direct care workers that people with disabilities and older adults rely on for their care, and Medicaid supports both unpaid family caregivers and paid care workers with coverage for their own health care.

As part of their agreements to administer Medicaid, states must cover certain populations and provide specific mandatory benefits. For example, nursing facility care is a mandatory service under federal law. In contrast, HCBS, which aligns with most constituents' preferences to age in their homes and communities, are optional benefits. **Therefore, states are not required to provide the long-term care that supports people with disabilities and older adults to live and age with dignity in their own homes and communities.** Currently, more than 700,000 people are on waiting lists for HCBS - underscoring the system's fragility and that there is already greater need than there is access to services.

Why would people with disabilities and older adults be at risk of losing home and community-based services (HCBS) if there are cuts or changes in the federal share of funding to Medicaid?

When the federal share of Medicaid funding is reduced, states are forced to cut services, including reducing hours of services, limiting eligibility, reducing provider rates, or making up the difference by taking funding from other critical areas. States must continue offering mandatory services, meaning they will look to cut optional services in the face of a budget shortfall. The vast majority of spending on optional services (86%) are services that support people with disabilities and older adults. In particular, HCBS are optional services and comprise over half of all optional state Medicaid spending. Between 2010 and 2012, in response to a reduction in federal Medicaid funding, every state and DC cut spending to one or more HCBS programs (see each state's cuts here). Service reductions and the reduced number of people enrolled greatly increased the waiting lists for the HCBS programs. Already, states are considering what to do with their optional services in the event of federal Medicaid funding cuts. For example, Idaho passed legislation in March 2025 that requires their Department of Health and Welfare to "take any action necessary to offset the increase in state funding, including but not limited to reductions in provider payment rates or **elimination of optional benefits**."

Without Medicaid, people with disabilities and older adults who need care to remain in their homes and communities have nowhere else to turn. Without access to critical benefits like HCBS, individuals are more likely to end up in costly institutional settings, experience preventable hospitalizations, and face a decline in overall health and well-being.

How do cuts to Medicaid hurt people with Medicare?

A cut to Medicaid is also a cut to Medicare. More than 12 million seniors and people with disabilities across the country are covered by both Medicaid and Medicare, known as dual eligibles. People who are dually eligible qualify for Medicaid based on their age or disability, and because they have low incomes. Medicaid covers many of the gaps in Medicare. In addition to long-term care, Medicaid covers services Medicare does not, including transportation to medical appointments, dental, vision, and hearing. Medicaid helps make Medicare affordable for enrollees by paying for premiums and cost sharing. Cuts to Medicaid risk driving Medicare enrollees deeper into poverty and hindering access to their Medicare benefits. Additionally, 30% of Medicaid dollars support Medicare enrollees.

Every proposal under consideration to cut or make changes to Medicaid funding or eligibility will harm people with disabilities and older adults, because every proposal shifts costs to states.

Whether by reducing federal funding directly or by imposing new administrative costs on states, every Medicaid proposal under consideration will shift costs to states. States in turn will be forced to cut benefits, cut enrollment, cut provider payments, or some combination. HCBS and

other optional services that people with disabilities and older adults rely on daily to live in the community will be at particular risk.

Lowering the FMAP Floor or Other FMAP Reductions:

If Congress reduces the FMAP floor or changes the formula for the millions of people who receive Medicaid through expansion because of their very low incomes, states will not be able to afford the reduction in federal funding. Lowering the FMAP floor or removing it entirely would significantly shift costs for providing Medicaid coverage and services onto states. If the FMAP floor were removed entirely, states would have to pay an additional $530 billion to maintain the level of coverage and services currently provided. No state can afford to fill that gap without cutting benefits, limiting eligibility, reducing provider rates, or raising taxes.

Similar to per capita caps and block grants, reducing federal funding to states by lowering the FMAP will shift more costs to states, leaving them with massive budget shortfalls. Since states cannot run deficits, they will have to cut optional services, like HCBS, cut eligibility, or reduce already low provider rates. This once again puts people with disabilities and older adults at risk of losing their health care and losing access to HCBS, pushing people into emergency rooms or to go without care entirely and family caregivers leaving the workforce to provide care. In DC, where more than 17,000 people with disabilities and older adults rely on Medicaid for their home and community-based services, reductions in DC's FMAP will put them at particular risk.

Reducing the FMAP for the Medicaid Expansion Population:

Much like lowering the overall FMAP floor or removing it entirely, reducing the 90% FMAP for the expansion population would result in massive budget holes for states, leading states to cut services, reduce eligibility, lower provider rates, or increase state revenues. Reducing the FMAP for the expansion population will put health care at risk for 20 million people with low incomes across the country, and do particular harm in the 9 states with "trigger" laws. In all other states with Medicaid expansion, states would either need to fill the gap in their funding or reduce services, eligibility, or provider rates, once again putting optional services on the chopping block, risking access to home and community-based services for people with disabilities and older adults. Lowering the FMAP or funding in any state would drive up health care costs by forcing people into emergency rooms and delaying preventative care, weighing on the whole health care system.

In addition to the risk to optional services, decreasing the FMAP for the expansion population will hurt the millions of people with disabilities who receive Medicaid through the expansion, as outlined above. Additionally, 11% of Medicaid enrollees under age 65 who receive long-term supports and services through Medicaid are enrolled through the Medicaid expansion. They qualify due to their low incomes, not through a disability pathway. Many family caregivers and direct care workers are in the Medicaid expansion, providing critical care that enables people with disabilities and older adults to live in their homes. Direct care workers are so vastly underpaid that 30% of direct care workers use Medicaid for their own health insurance. Medicaid expansion fills massive gaps.

Work Requirements:

Work requirements do not increase the number of working adults. Experience shows they do terminate health care. This includes workers who meet the requirements but lose coverage due to increased red tape. This includes people with disabilities who don't meet exemption requirements or encounter barriers getting an exemption. When Arkansas piloted work requirements in 2018, 18,000 people who were in fact still eligible under the program's rules lost coverage in just 7 months, forcing people to pay their health care costs out of pocket and doubling the number of people who had serious problems paying their medical bills. Employment did not increase. Nearly 2/3rds of people who get their health care through Medicaid and are not enrolled in SSI or SSDI or are not also eligible for Medicare are already working, and those who aren't working are overwhelmingly people with disabilities, family caregivers, retired, or students. Medicaid helps keep people in the workforce by providing the upfront care and services necessary for people to work, including providing job supports for many people with disabilities, like job coaching or assistance with getting ready and getting to work each day.

People with disabilities cannot be effectively carved out of work requirements. More than 2/3rds of people with disabilities enrolled in Medicaid are enrolled through non-SSI pathway, and many of these individuals are enrolled through the expansion pathway. Additionally, family caregivers and direct care workers who provide critical care are at risk of losing their health coverage under work requirements, and may be pushed into situations that make it more difficult to provide care.

Increasing the administrative load on the states by implementing work requirements slows the processing of applications for Medicaid and other services, including SNAP. In Georgia, the percent of people applying for Medicaid who reported waiting more than a month and a half for the applications to be processed nearly tripled following the implementation of Pathways to Coverage. For one senior couple in Georgia, the wait time for approval of their Medicaid took more than 120 days. Additionally, work requirements leading to coverage losses will decrease payments to hospitals, especially rural hospitals, forcing closures in places all people rely on for care.

Medicaid enrollees who are seasonal workers, shift workers, work multiple part-time jobs, or work in rural America, are at particular risk of losing coverage from work requirements. Schedules can be changed through no fault of their own. For people in rural America, there is already a lack of availability of jobs, especially jobs that offer employer-sponsored health insurance, and lack of broadband access that all severely limit the ability to comply with work requirements.

When people are erroneously disenrolled from Medicaid, states experience cost shifts as well that will strain their budgets. First, they lose federal funding for the coverage itself but end up paying for uncompensated care in more expensive settings like emergency rooms. These ineffective policies are also incredibly expensive for states to administer. States are saddled with the costs of implementation. In Georgia, over 80% of the more than $40 million in taxpayer

funds went to overhead and administration of the work requirements, including going to out-of-state consultants. The extra costs on states will once again put hospitals at risk of closure and HCBS at risk of cuts.

Reducing or Limiting Provider Taxes:

Provider taxes make up 17% of the state share of the cost of Medicaid on average. Every state except Alaska utilizes at least one provider tax – and these provider taxes make it possible for states to cover the state share of the cost of Medicaid. Every state has different needs and complexities in financing its budget, and provider taxes allow states the flexibility to finance their Medicaid programs as they see fit within the boundaries of the law. Limiting provider taxes would reduce the funding available to states to administer their Medicaid programs, forcing states to either fill the gaps in their budgets from other funding sources, or again turn to cutting optional services.

Disincentivizing States from Using State Medicaid Dollars to Cover Undocumented Immigrants:

As outlined by the CBO, states already cannot use federal Medicaid dollars to provide health coverage to immigrants who are undocumented. The Emergency Medicaid spending that reimburses hospitals who provide emergency care to undocumented immigrants and lawfully present immigrants who are ineligible for Medicaid or CHIP accounts for less than 1% of total Medicaid expenditures, but provides necessary funding for hospitals already operating at the tightest margins. If Congress reduces the federal Medicaid funding to states that cover undocumented immigrants, optional services like HCBS will again be at risk. Additionally, at least 1 in 4 direct care workers are immigrants, including one in three home care workers. Immigrants tend to work longer in long-term care jobs than non-immigrants, playing a critical role in a sector already facing drastic shortages in every state, with many older adults, people with disabilities, and family caregivers unable to access the care they need due to the need for additional workers.

Repealing the Medicaid Eligibility and Enrollment Rules:

The Eligibility and Enrollment Rule is designed to promote efficiency and improve the enrollment process for people who are already eligible for Medicaid. The rule reduced red tape, making it easier for people who are eligible for Medicaid to get and receive their services. This rule helps people with disabilities and older adults with low incomes by reducing the risk of being denied or losing coverage for procedural reasons rather than actual ineligibility. It also improves access to preferred and more economical HCBS by allowing people who are eligible for Medicaid HCBS to predict their share of costs, as people covered by Medicaid in nursing facilities can already do.

Because this rule helps people with disabilities and older adults remain in their homes and communities by improving access to Medicaid services for those already eligible, repealing the rule will mean more people will not receive the services they are eligible for.

Per Capita Caps and Block Grants:

Per capita caps and block grants would change the funding structure of Medicaid, from the current system that has no set limit or cap, to providing states with a set amount of funding, either set overall in a block grant or set per enrollee, in a per capita cap. Neither block grants nor per capita caps would keep up with the growing cost of health care due to inflation. Per capita caps and block grants would also not account for an increased need for Medicaid with emerging health threats, natural disasters, or new treatments. Under per capita caps, maintaining the current benefit levels and enrollment would require states to pay approximately $2000 more **per enrollee,** which no state can afford. States will be forced to cut benefits, reduce eligibility, or decrease payment rates, pushing more providers out and leaving people without access to their doctors or their direct care workers.

For people with disabilities and older adults, who make up only 20% of enrollees but more than half of Medicaid spending, capping or block granting funding would be devastating. Blowing holes in state budgets will make it impossible for states to balance the budget without kicking people off their health care and removing access to home and community-based services. As laid out above, any reductions in federal funding at this scale will push states to reduce their optional Medicaid services, because they are required to continue to meet the needs of mandatory services. 86% of all optional spending is spent on services for people with disabilities and older adults, underscoring that there is no real way to reduce funding without hurting our communities. People with disabilities, older adults, and family caregivers are already struggling with the high cost of care, and cannot afford to fill in the gaps left if Medicaid is cut.