

The Disability and Aging Collaborative

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Answers to FAQ on Medicaid and the Proposed Senate Version of the “One Big Beautiful Bill Act.”

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Below are some answers to frequently asked questions about Medicaid, Medicaid’s funding structure, and the proposed changes included in the [Senate’s proposal](#) for budget reconciliation.

Medicaid is a cornerstone of the health and well-being of every community in America.	1
Medicaid is a lifeline for people with disabilities and older adults.	2
How does Medicaid support people with disabilities and older adults to live at home rather than in institutions?	2
Why would people with disabilities and older adults be at risk of losing home and community-based services (HCBS) if there are cuts to federal funding, including reducing or limiting provider taxes?	3
How do cuts to Medicaid in the Senate’s proposed bill hurt people with Medicare?	4
How do specific provisions in the Senate’s proposed bill hurt people with disabilities and older adults?	4
Severely Limiting the Use of Provider Taxes Through Reductions or Moratoriums:	4
Limiting State Directed Payments:	5
Work Requirements:	5
Prohibiting Implementation of the Medicaid Eligibility and Enrollment Rules:	7
Reducing the FMAP for the Medicaid Expansion Population in States that Use State Dollars to Cover Certain Immigrants And Taking Coverage Away From Many Immigrants:	7
Reducing Home Equity Limits:	8

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 whose income is 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 231 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 to federal funding, including reducing or limiting provider taxes?

When Medicaid funding is limited or reduced, or states face additional costs for administering new programs or other new costs, they will be forced to cut spending. Since Medicaid is already a large part of states' budgets, states will likely be forced to cut services, including reducing hours of services, limiting eligibility, or reducing provider rates. 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 Medicaid 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 in the Senate's proposed bill 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](#).

How do specific provisions in the Senate's proposed bill hurt people with disabilities and older adults?

Whether by reducing federal funding directly or by imposing new administrative costs on states, every Medicaid proposal under consideration that cuts funding or curtails states' abilities to finance their Medicaid programs will shift additional 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. Other policies in this bill in addition to the provisions discussed below would make it harder for older adults and people with disabilities to enroll in, maintain, and use their coverage, including more frequent eligibility checks, mandatory cost-sharing, and decreased retroactive eligibility.

Severely Limiting the Use of Provider Taxes Through Reductions or Moratoriums:

[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.

Imposing a moratorium on new or increased provider taxes would be challenging enough for states, but the Senate version of the budget reconciliation bill proposes even harsher restrictions on how states finance their Medicaid programs, which will lead to even deeper cuts in federal funding. For example, the Senate proposes reducing the limit on provider taxes from 6% to 3.5% for the 41 states that have adopted Medicaid expansion. Although new congressional budget office estimates are not yet available, previous estimates from the Congressional Budget Office state that reducing provider taxes from 6% to 2.5% would amount to [a \\$241 billion cut in federal funding](#).

Limiting State Directed Payments:

Similarly, state directed payments (SDPs) allow states to provide additional funding to Managed Care Organizations (MCOs) above and beyond their capitation rates that allow for uniform rate increases for specific services, including HCBS. These SDPs have allowed MCOs to pay their network providers for services rendered to Medicaid beneficiaries at the same level as their commercial clients. In doing so, SDPs improve access to care by

eliminating the financial disincentives that providers encounter when serving Medicaid beneficiaries.

This legislation would revise the payment limit for SDPs, requiring states to cap the total payment rate at 100 percent of the Medicare payment rates for expansion states and 110 percent of the Medicare payment rates for non-expansion states, instead of the Average Commercial Rate (ACR). The Senate language also goes further than the House bill, preventing states from continuing to utilize current SDP rates. While hospitals are the most common target for SDPs, SDPs are also often [used to increase the availability of mental health and substance use disorder providers, and other HCBS](#). Capping the SDP as proposed will likely decrease access to care for Medicaid beneficiaries, since some providers will be unable to serve those individuals under the lower reimbursement rates.

Work Requirements:

The mandatory work requirements in the bill [will terminate Medicaid coverage for about 5.2 million Americans](#). And the most recent CBO analysis explicitly estimates that the majority of the people who lose Medicaid because of these penalties, even if they are working, [will not become insured through another provider](#), especially with the bill's lockout from the ACA marketplace.

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. Even if policies are targeted toward the Medicaid expansion population, they will endanger services for people with disabilities and older adults. [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, [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. In fact, [personal care aide is the second most common occupation among Medicaid expansion enrollees without children](#). Their work schedules typically vary from week to week, putting these direct care workers at great risk of having their Medicaid coverage taken away.

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.

Prohibiting Implementation of the Medicaid Eligibility and Enrollment Rules:

The Eligibility and Enrollment Rules are designed to promote efficiency and improve the enrollment process for people with disabilities, older adults, and kids who are already eligible for Medicaid. The rules reduce red tape, making it easier for people who are eligible for Medicaid to get and receive their services. The rules specifically help 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, stopping the policies from taking effect will mean more people will not receive the services they are eligible for. CBO estimates that stopping implementation of the Medicaid eligibility and enrollment rule will mean that 1.3 million fewer low-income seniors and people with disabilities will get help with Medicare cost-sharing through the Medicare Savings Programs. People with Medicare in every state will lose this coverage. In Georgia, Florida, and Texas alone, 250,000 fewer low-income Medicare enrollees are estimated to receive Medicaid coverage for their Medicare premiums and cost-sharing through the Qualified Medicare Beneficiary program (QMB).

Reducing the FMAP for the Medicaid Expansion Population in States that Use State Dollars to Cover Certain Immigrants And Taking Coverage Away From Many Immigrants:

Reducing the 90% FMAP to 80% for the expansion population in states that use non-federal dollars to cover healthcare for undocumented immigrants will result in massive budget holes for states, leading states to cut services, reduce eligibility, lower provider rates, or increase state revenues. States will 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 or driving up the uninsured rate by incentivizing states to kick people off of coverage would drive up health care costs for everyone by forcing people into emergency rooms and delaying preventative care, weighing on the whole health care system. This [will affect at least 14 states and DC](#), as they have expanded coverage to undocumented immigrants with their own funds. The Senate version of the bill goes further than the House version, also eliminating Medicaid eligibility for many types of lawfully present immigrants, including refugees, asylees, and certain abused spouses and children and victims of trafficking— many of whom have experienced significant trauma, but will now be barred from accessing appropriate Medicaid funded mental health support.

Immigrants also make up a [significant portion](#) of the direct care workforce. Narrowing what lawfully present immigrants have access to Medicaid and limiting state's options to cover immigrants with their own Medicaid dollars will inevitably harm the direct care workforce, which is already facing a [catastrophic staffing shortage in every state](#). Direct care workers who provide the critical, life-saving care that people with disabilities and older adults rely on [are not typically provided employer-sponsored health insurance](#) and cannot afford to lose their care.

Reducing Home Equity Limits:

Medicaid eligibility rules generally exempt the applicant's home as a countable asset. However, for LTSS eligibility, states are required to consider the value of the home above a designated threshold, which is indexed to inflation. H.R. 1 both reduces and freezes this home equity limit. Over time, the cap on home equity will continue to tighten, as the proposed legislation no longer links home equity to inflation. This would effectively force individuals to choose between forfeiting essential health care or borrowing against their home's value and thus jeopardize their homeownership. For older adults and people with disabilities, losing a home likely means losing access to Medicaid HCBS. This often leaves costlier institutional care as their only option. Individuals already in nursing facilities may never return to the home where they've spent decades of their lives.

Lowering the equity threshold would disproportionately impact low-income individuals, many of whom purchased their homes decades ago when property values were far lower. This issue is particularly acute for older Medicaid enrollees, who, despite being "cash poor" and reliant on fixed incomes, have accumulated equity in their homes over a lifetime. In regions where real estate values have surged, these homes may constitute their sole asset—yet an arbitrary limitation could render them ineligible for vital health care services. Stripping them of Medicaid access due to home equity constraints would not only create undue financial hardship but also erode their security, stability, and ability to remain in their communities.