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# OVERVIEW OF MEDICAID FINANCING AND THE IMPACT OF H.R. 1 ON STATE FUNDING

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# PART I: BASICS OF MEDICAID FINANCING

# Overview of Current Medicaid Financing

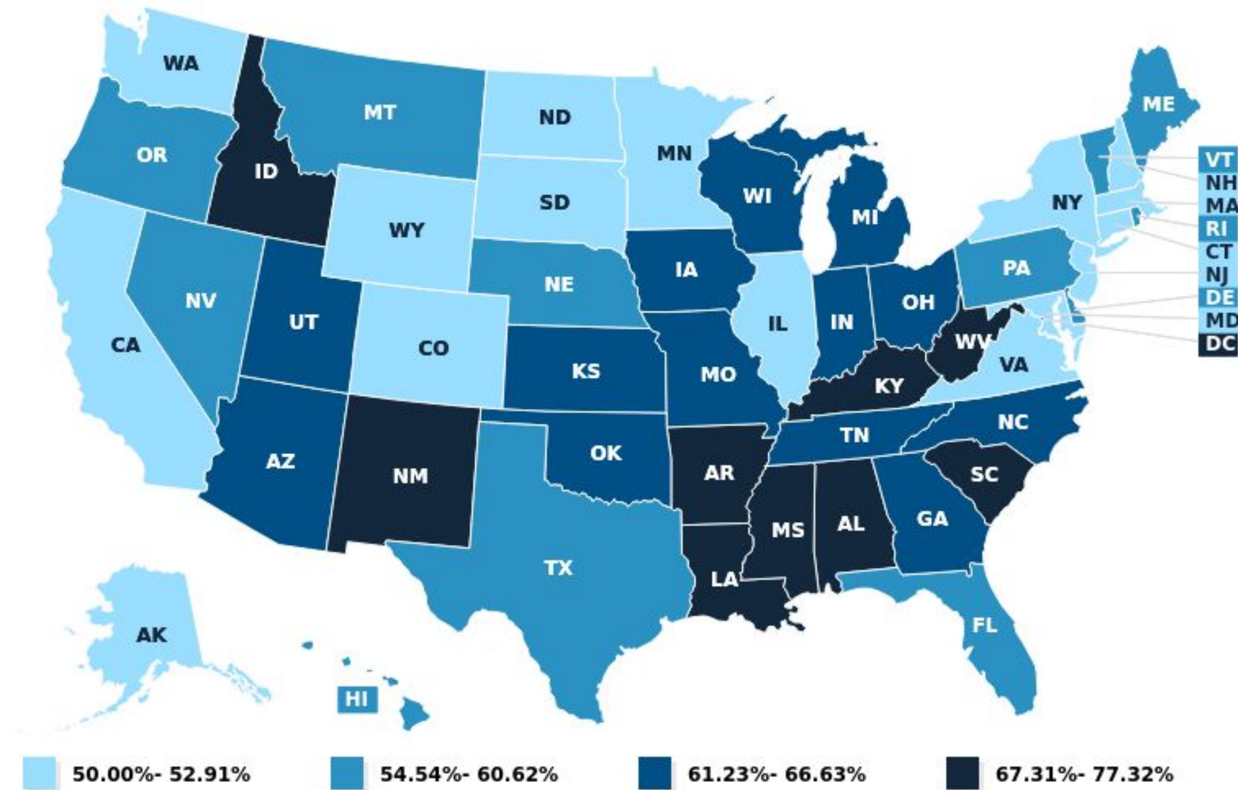
- Mandatory federal funding not subject to annual Congressional discretionary appropriations
- Federal government picks up fixed percentage of state Medicaid costs
- Open-ended financing with eligible individuals entitled to benefits and states entitled to federal funding
- Federal-state partnership requires state matching contributions

# WHAT DOES FMAP STAND FOR?

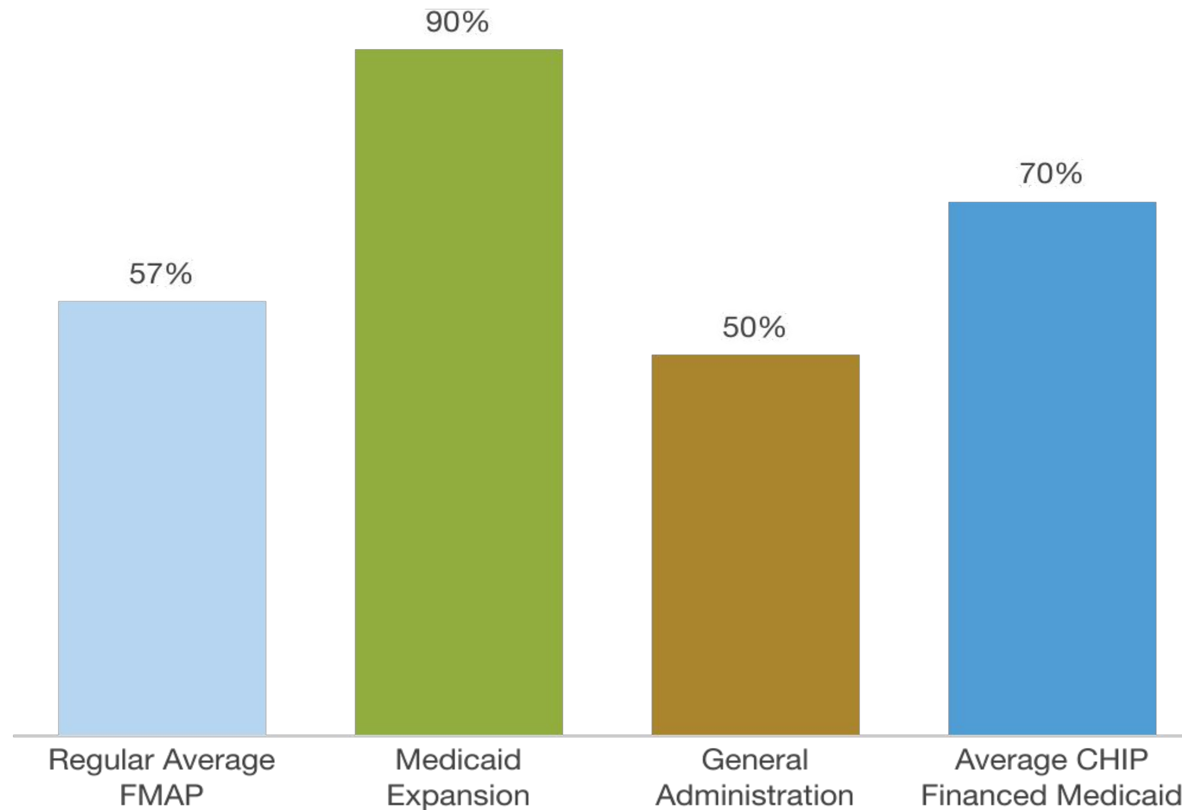
# Federal Medical Assistance Percentage (FMAP)

- FMAP = 1 – ((state per capita)$^2$/(U.S. per capita)$^2$*0.45))
- Minimum of 50% and maximum of 83%, states with average income receive FMAP of 55%
- Uses 3-year rolling average of per capita income but substantial data lag (~ 3 years) on per capita income
- Exceptions to formula for regular FMAP:
  - District of Columbia: 70%
  - Territories: 76% for Puerto Rico and 83% for other territories

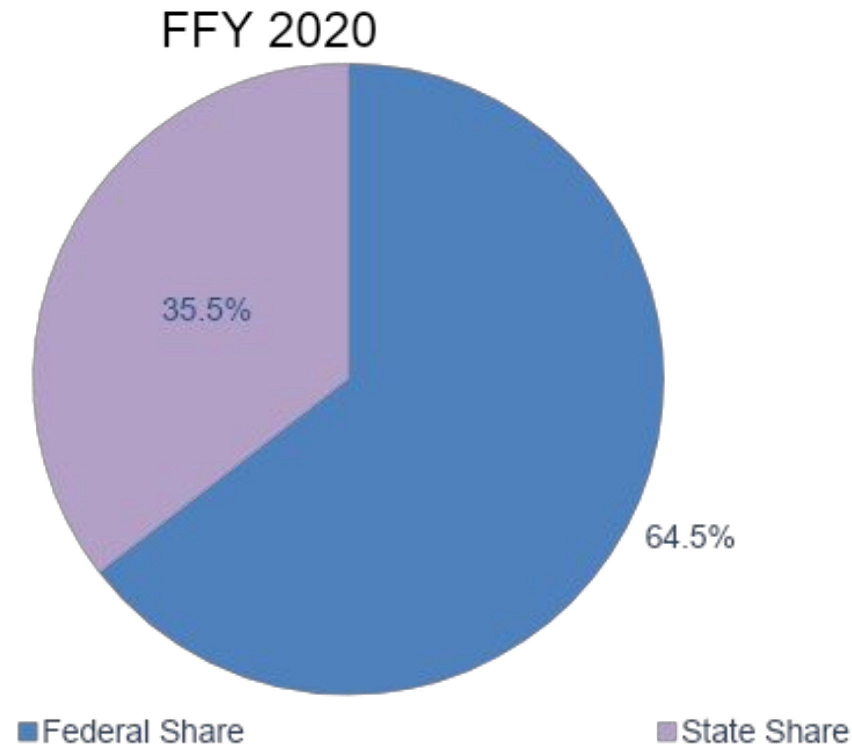
# Regular FMAPs by State (FY 2027)



# Examples of Medicaid Spending Subject to Special Matching Rates

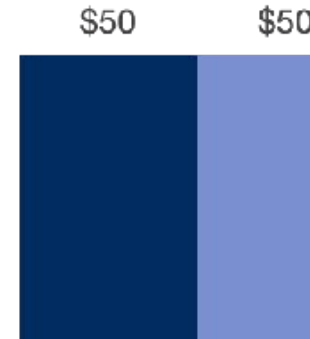


# Federal Funding as Share of Total Medicaid Expenditures (FY 2024)




Source: CCF analysis of CMS expenditure data

# Illustrating How Federal Government and States Share in Higher Medicaid Costs (50% FMAP State)



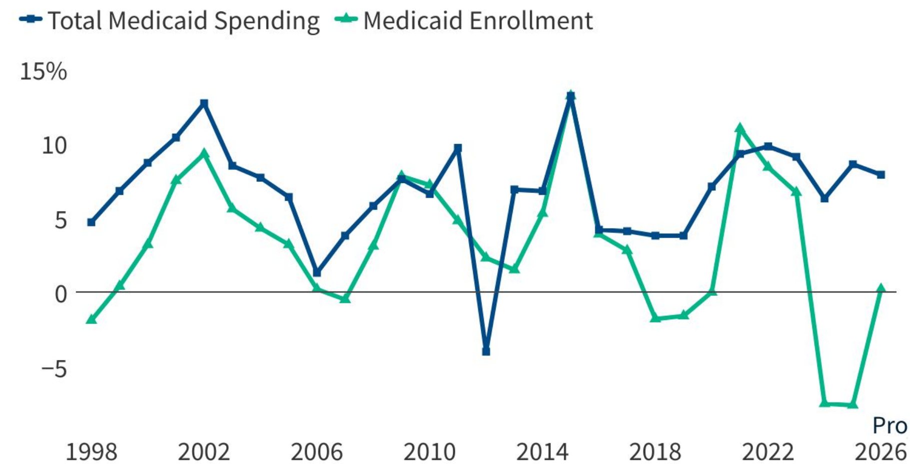
# WHAT HAPPENS TO FEDERAL MEDICAID FUNDING WHEN LIFE HAPPENS?

# Example: Recessions

Figure 2

**Percent Change in Medicaid Spending and Enrollment, 1998-2026**

Annual percentage changes, FY 1998 - FY 2026




Note: Growth percentages refer to state fiscal year (FY). FY 2026 projections based on enacted budgets.

Source: FY 2025-2026 spending data and FY 2026 enrollment data are derived from the annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025. 48 states submitted survey responses by Oct. 2025; state response rates varied across questions. Historic data reflects growth across all 50 states and DC and comes from various sources. See Methods of Medicaid Enrollment & Spending Growth: FY 2025 & 2026 for more information.

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# Example: New Drug Therapies (Hepatitis C)

# HOW WOULD BLOCK GRANTS AND PER CAPITA CAPS CHANGE FEDERAL MEDICAID FUNDING?

# Medicaid Block Grant

- Converts current financing structure to aggregate cap on federal funding for each state's Medicaid program.
- States responsible for 100% of all costs above cap
- Some block grant proposals include multiple block grants for certain eligibility groups or types of spending
- Produces large and growing federal Medicaid funding cuts as block grant amounts fail to keep pace with growth in enrollment and health care costs

# Medicaid Per Capita Cap

- Converts current financing structure to cap on federal funding per beneficiary
- States similarly responsible for 100% of costs above per-beneficiary cap
- Some per capita cap proposals include multiple caps for certain eligibility groups
- Similarly results in large and growing federal Medicaid funding cuts as cap amounts fail to keep pace with rising health care costs
- Different from block grant because per capita caps adjust for enrollment (i.e. change in number of beneficiaries)

# Illustrating How Block Grants and Per Capita Caps Leave States Responsible for All Costs Above Cap

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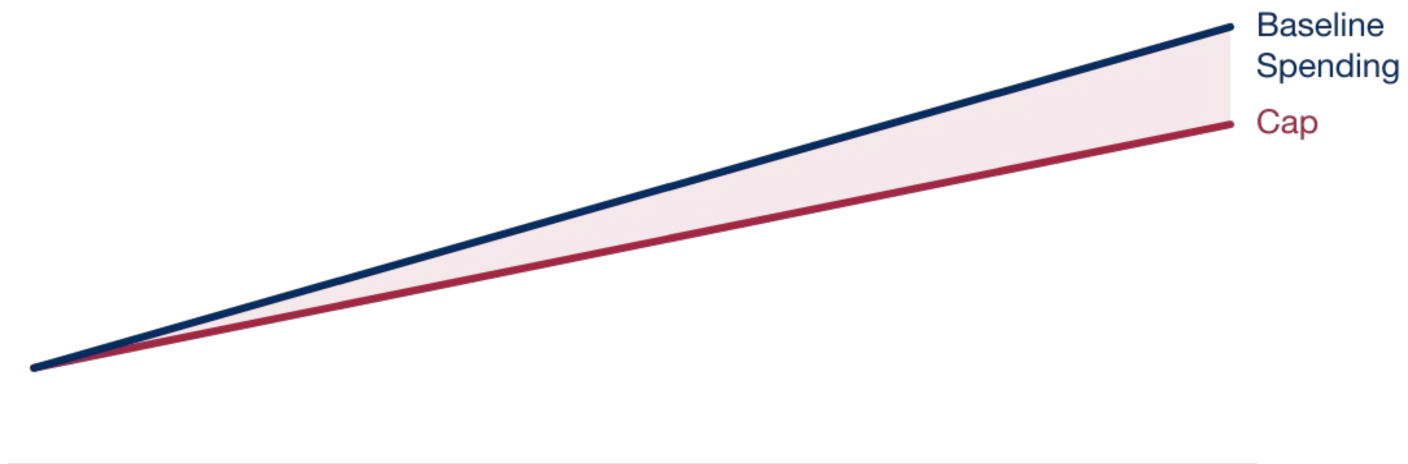
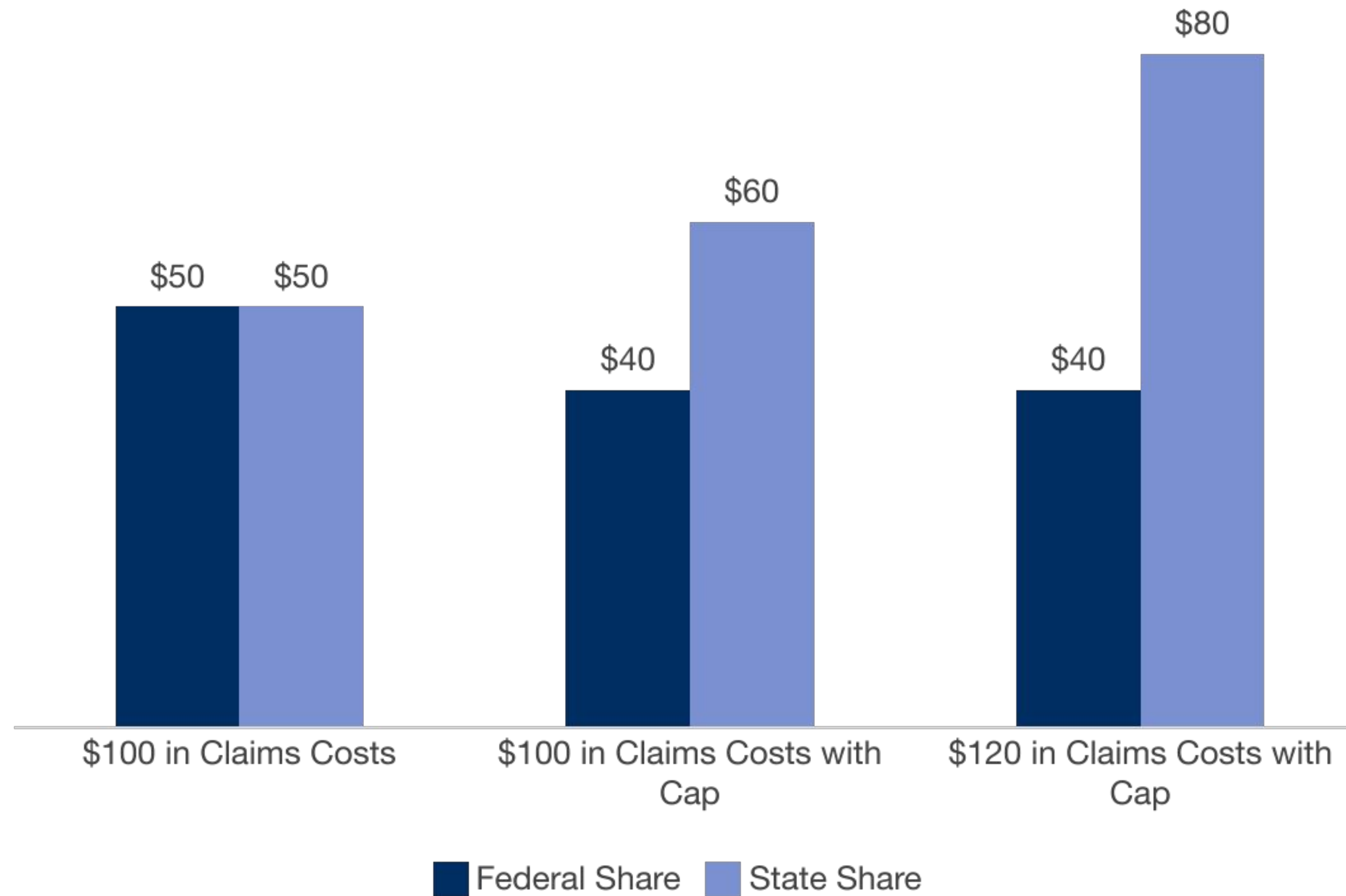
# Why Caps Produce Federal Funding Cuts



# How Block Grants and Per Capita Caps Also Leave States Responsible for Unanticipated Costs



# Impact of State Variation

- How individual states would fare under block grants and caps are affected by state-specific trends including:
  - Variation in current levels of spending
  - Variation in annual growth in enrollment and per-beneficiary costs
  - Differences across populations within states
  - Differences over time
  - States with higher-than-average growth overall or in certain populations would be worse off than other states
  - States with current lower-than-average spending or growth are locked into those spending levels or growth rates because initial caps are based on current or recent spending trends

# Likelihood of Additional Funding Cuts Over Time

- History of other federal programs converted to block grants/caps show at best neglect and at worst additional severe cuts
- Growing deficit/debt pressures to cut spending
- Ease of making additional Medicaid cuts by simply lowering annual adjustment rate to block grant or per capita cap formula

# Federal Funding for Territories Through Block Grants

- Unlike states and the District of Columbia, Puerto Rico, American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands do not receive open-ended federal financing for their Medicaid programs
- Federal funding is provided through a block grant not tied to their actual spending needs, with territories responsible for all costs above cap
- Currently territories are receiving both base block grant funding and supplemental funding amounts. Puerto Rico's latest supplemental funding extension expires after fiscal year 2027

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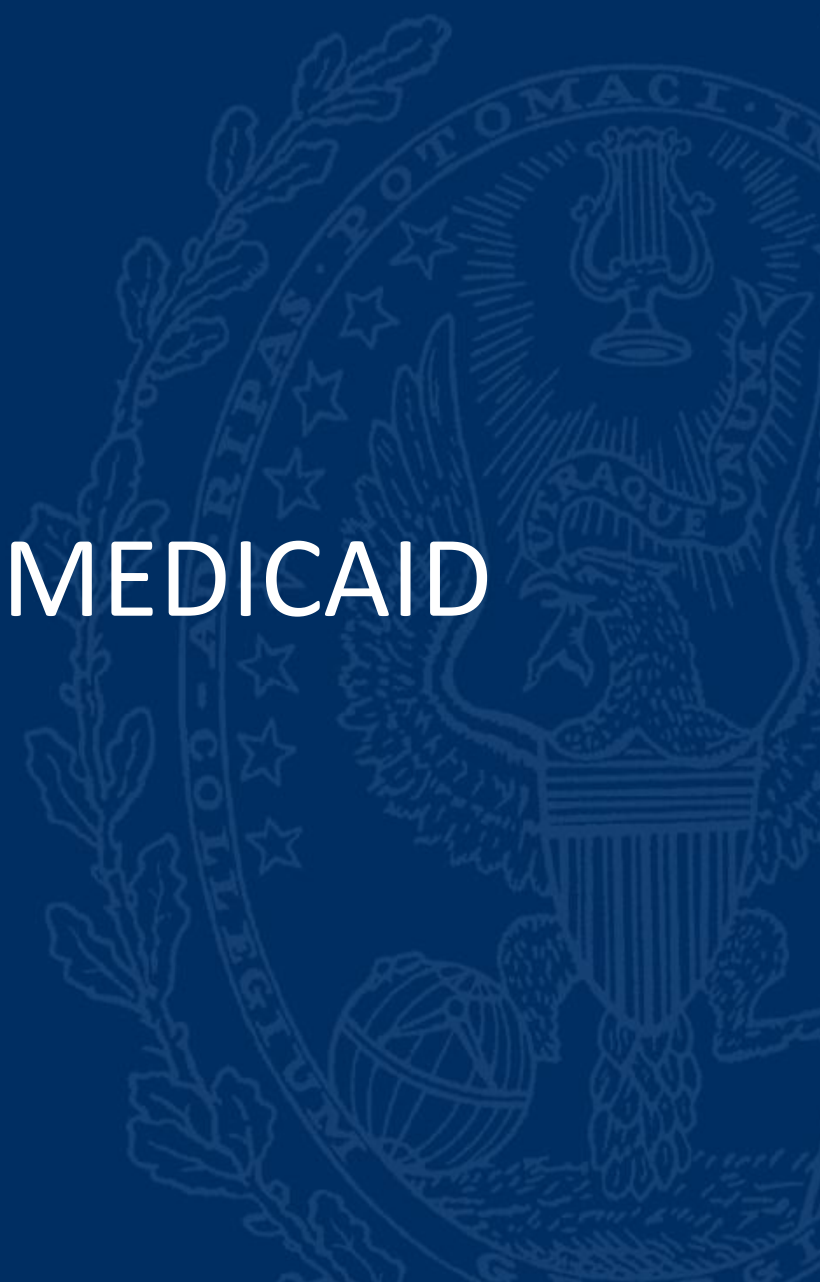
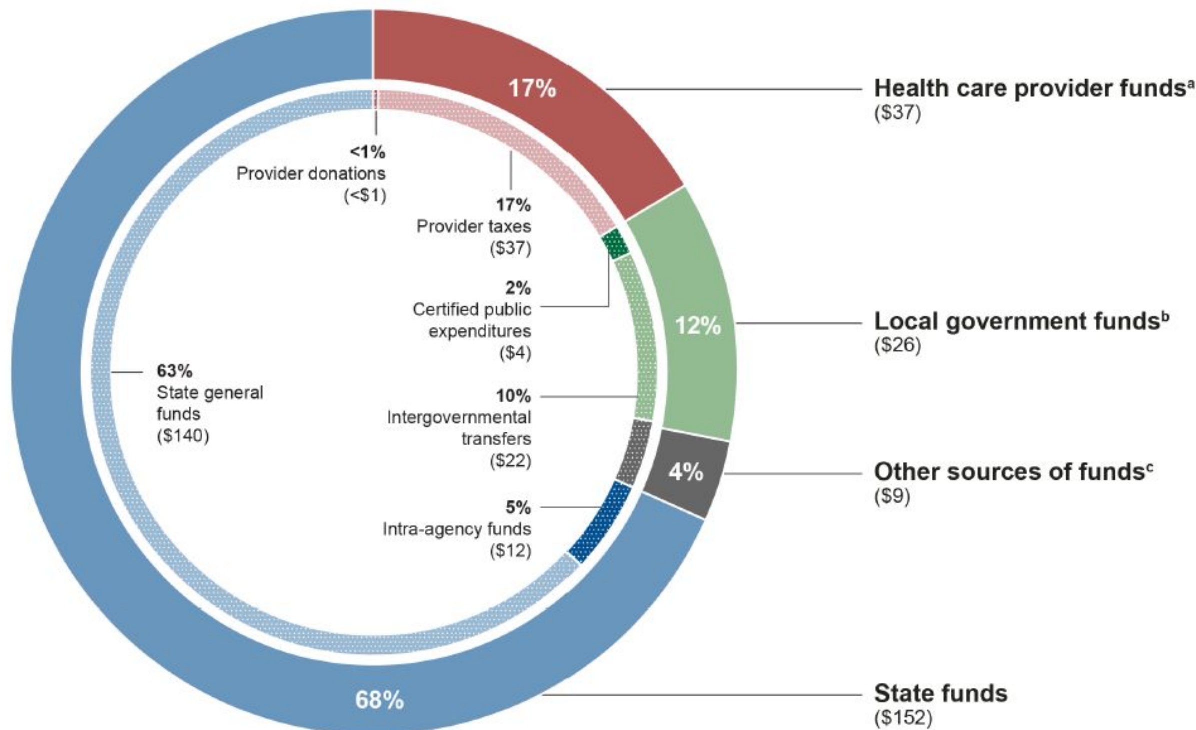


# PART II: STATE FINANCING OF MEDICAID

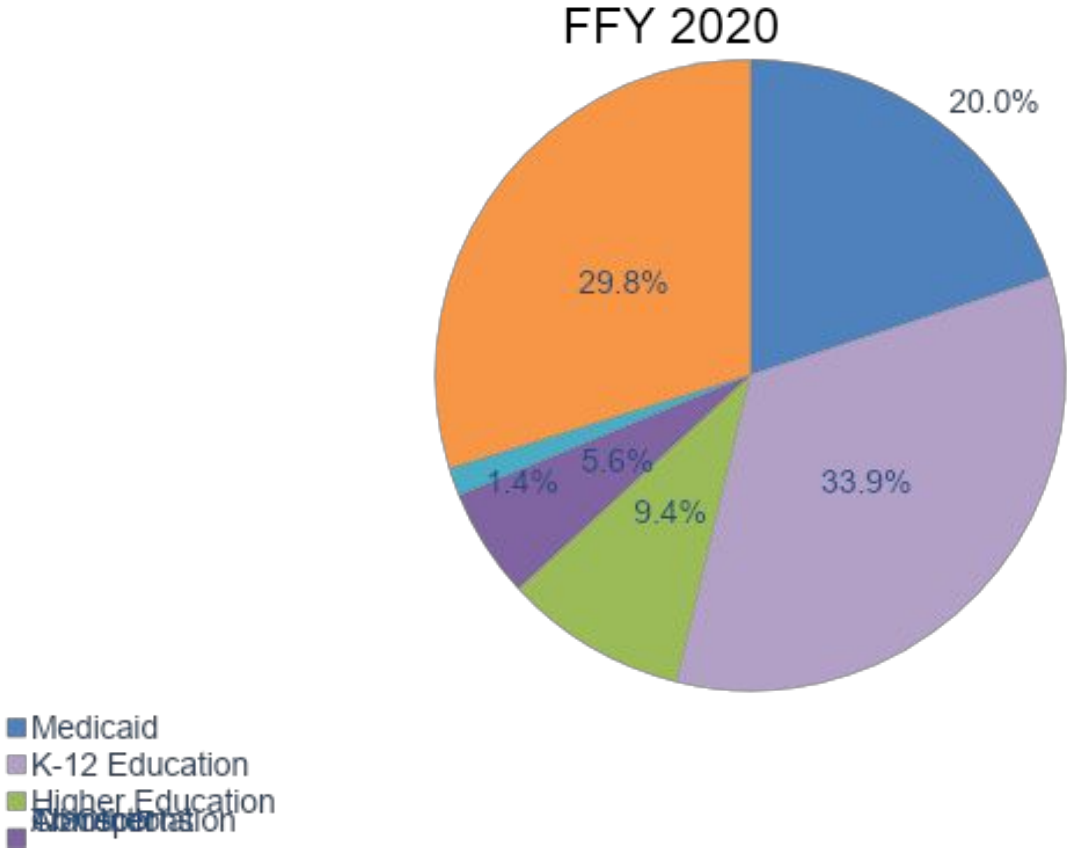
# How States Finance Their Share of Medicaid Costs

- General revenues
- Provider taxes
  - Taxes on hospitals, nursing homes, managed care plans and other health care providers
- Other dedicated state revenues
  - Tobacco taxes
- Other government contributions, subject to 40% state minimum
  - Local government matching funds (e.g. from counties)
  - Intergovernmental transfers (IGTs) and certified public expenditures (CPEs)

# Financing Sources for State Share (2018)



# Medicaid Much Smaller Share of States' General Fund Budgets than Education

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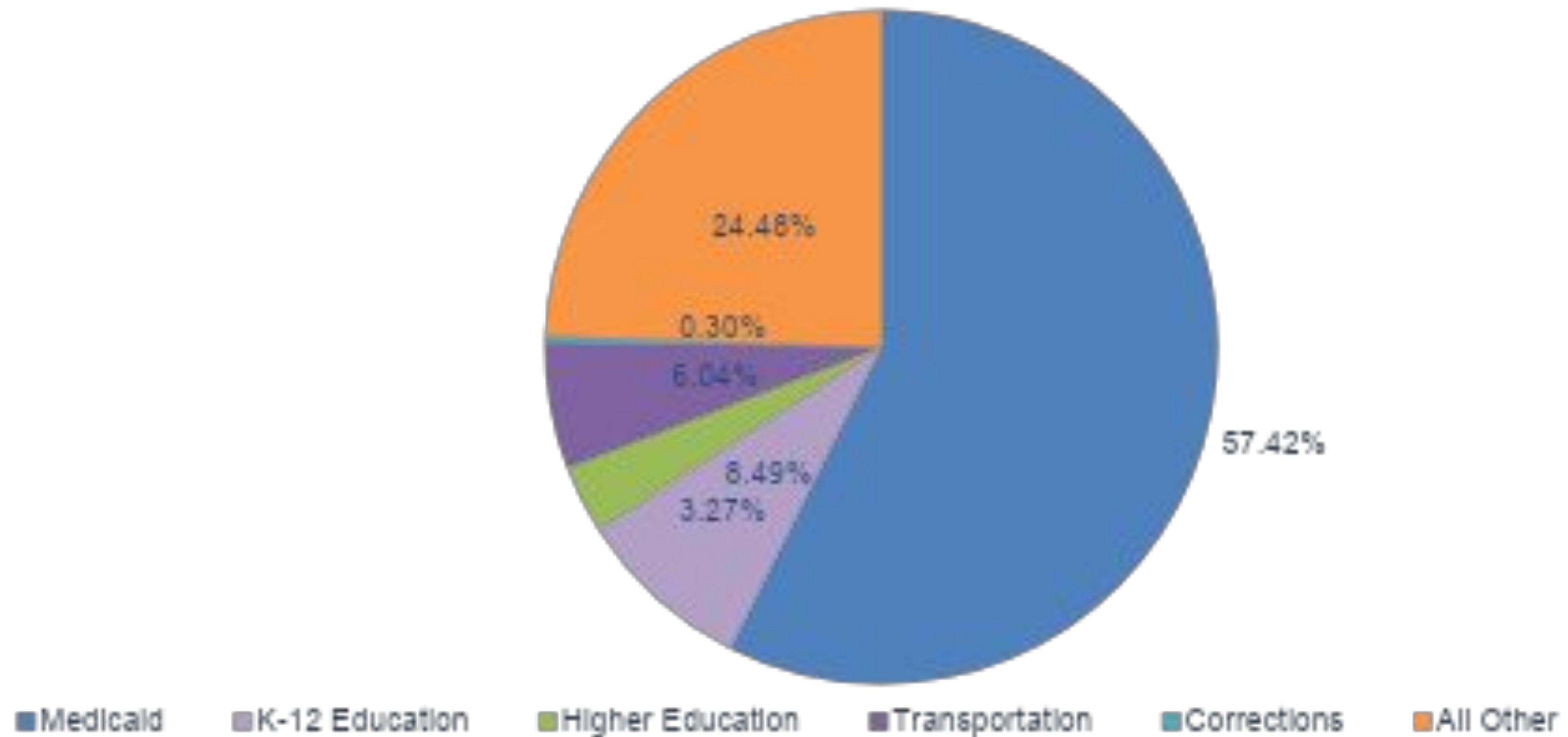
Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2025 (estimated).

# Medicaid Is Largest Source of Federal Funds for States

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Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2025 (estimated).

# WHAT HAPPENS TO STATE BUDGETS WHEN FEDERAL FUNDING IS CUT?

# Multiplier Effect: Impact of State Budget Cuts on Federal Funding

- For every $1.00 in state general fund cut, loss of federal Medicaid matching funds
- Makes total Medicaid budget cut significantly larger
- Magnitude of multiplier effect will depend on applicable FMAP

| Applicable FMAP | State GF Cut | Federal Funding Cut | Total Budget Cut |
|---|---|---|---|
| 50% | -$1.00 | -$1.00 | -$2.00 |
| 57% | -$1.00 | -$1.33 | -$2.33 |
| 70% | -$1.00 | -$2.33 | -$3.33 |
| 77.32% | -$1.00 | -$3.40 | -$4.40 |
| 90% | -$1.00 | -$9.00 | -$10.00 |

# No Automatic FMAP Increases in Response to Recessions

- During recessions, reduced economic activity leads to falling state revenues and greater demand on public programs including Medicaid
- Federal Medicaid funding will automatically increase as enrollment and spending rise
- Provides countercyclical response that helps offsets reduction in economic activity
- But nearly all states must balance budgets as revenues decline so states will be unable to generate needed state match. But every $1 in state cuts means reduction in federal funding too
- Pro-cyclical impact of such budget cuts can deepen & prolong recessions
- Congress has averted Medicaid budget cuts (2003, 2009, 2020) to preserve health coverage and to provide relief/stimulus by temporarily increasing the regular FMAP but there is no automatic FMAP increase mechanism

# LET’S TALK PROVIDER TAX RESTRICTIONS — WHAT WILL THESE MEAN?

# H.R. 1's Provider Tax Restrictions

- All states but Alaska rely on provider taxes to help finance the state share of Medicaid costs
- This could include taxes and assessments on hospitals, nursing homes, intermediate care facilities for people with intellectual disabilities (ICF-IDs), managed care plans, and others
- Three provider tax restrictions in budget reconciliation law
- $225 billion/10 years in federal spending cuts and 1.2 million more uninsured by 2034 according to Congressional Budget Office

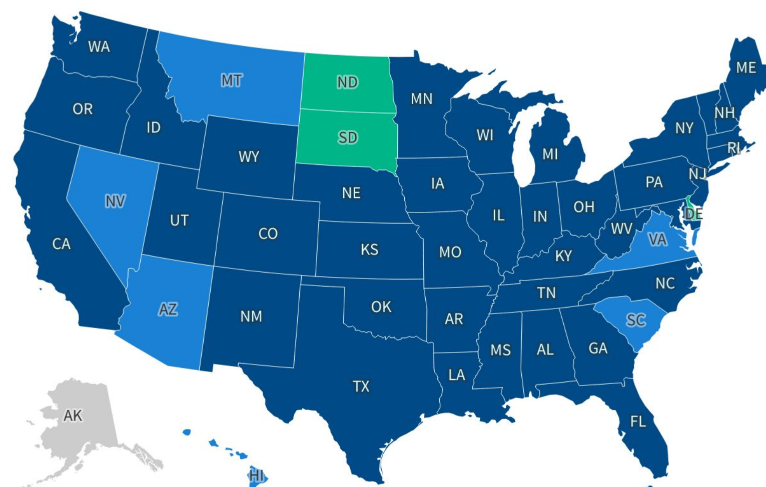
# Which States Have Provider Taxes?

Figure 1

**All States but Alaska Use Provider Taxes To Help Finance the State Share of Medicaid Spending**

Number of provider taxes or fees in place in FY 2025

- 3+ Provider Taxes/Fees (41 states including DC)
- 2 Provider Taxes/Fees (6 states)
- 1 Provider Tax/Fee (3 states)
- No Provider Taxes/Fees (1 state)




Note: FY = state fiscal year. Includes Medicaid provider taxes as reported by states. FL, KS, and MS did not respond to the 2025 survey; publicly available data used to verify taxes in place (reported in previous surveys) but not the size of these taxes.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025

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# Overview of Provider Tax Rules

- Statutory and regulatory rule framework governing provider taxes in place since 1991
- Taxes must be uniform and broad-based and must not hold providers harmless
  - Waivers for uniform and broad-based requirements if state can show mathematically that tax is proportionately assessed on Medicaid/non-Medicaid revenues
  - Hold harmless safe harbor if tax does not exceed 6% of net patient revenues

# H.R. 1: No New or Increased Provider Taxes

- Upon enactment, permanent prohibition on any new provider taxes or increases in existing provider taxes
- Whether there is an increase in an existing tax depends on size of existing tax (as measured as a % of net patient revenues)
- Existing taxes are grandfathered if they were both enacted and imposed before July 4, 2025 according to recent CMS guidance
- This means states cannot add any new provider taxes or increase current taxes to help close current or future budget shortfalls or finance improvements to Medicaid programs like HCBS expansions and increased payments to hospitals and other providers

# H.R. 1: Provider Tax Restrictions Affecting "Uniformity Waiver" States

- States have always been able to satisfy the uniformity requirement by demonstrating compliance with a mathematical test and obtaining a uniformity waiver from CMS
- Upon enactment, H.R. 1 prohibits certain existing provider taxes operating under uniformity waivers that use differential tax rates between Medicaid and non-Medicaid providers
- Affects at least 7 expansion states (CA, IL, MA, MI, NY, OH and WV) with 9 taxes (primarily managed care organization taxes) but *additional* states and taxes still could be implicated
- Final regulations implementing provision includes transition periods for affected states. Varies based on type of provider and by timing of most recent approval

# H.R. 1: Provider Tax Restrictions Targeting Expansion States Only

- Reduces permissible size of most existing provider taxes but *only in Medicaid expansion states*
- Current "safe harbor" limit of 6% of net patient revenues phased down starting October 1, 2027
- Affects all taxes except for taxes on nursing homes and ICF-IDs
- Phase down in limit by 0.5 percentage points each year
  - FFY 2028: 5.5%
  - FFY 2029: 5%
  - FFY 2030: 4.5%
  - FFY 2031: 4%
  - FFY 2032 and thereafter: 3.5%

# Many Expansion States Will Be Affected

- According to KFF, as many as 31 expansion states will have to lower some of their provider taxes
- 12 expansion states have hospital taxes above 5.5% and will have to reduce their taxes starting October 2027
- 28 expansion states have hospital taxes above 3.5%
- Some states have explicitly used hospital provider tax increases to finance their share of the cost of Medicaid expansion

**The Effective Prohibition on New or Increased Provider Taxes Could Impact All States, With Expected Cuts to Existing Taxes in 31 States**

ACA expansion states with a provider tax on hospitals, MCOs, ambulances, or other affected providers above 3.5% of net patient revenues as of July 1, 2025

- Hospital, MCO, ambulance, and/or other taxes > 3.5% net patient revenues, expansion state (31 states)
- No affected taxes, expansion state (10 states including DC)
- Not an expansion state (10 states)

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# Forthcoming Provider Tax Regulations

- CMS will soon issue proposed regulations implementing the H.R. 1 provisions restricting new provider taxes and phasing down existing provider taxes in expansion states
- The proposed regulations may go beyond H.R. 1 in further limiting provider taxes as CMS has done with other implementing regulations related to state-directed payments and work reporting requirements and guidance implementing budget neutrality in waivers
- They also may restrict funding from IGTs and CPEs even though H.R. 1 did not affect those state financing tools

# Adverse Impact on State Budgets

- States must generally balance their budgets unlike the federal government
- Provider tax restrictions (and possible IGT restrictions) mean much *less* existing revenues to support Medicaid over time and fewer revenue options moving forward
- H.R. 1's provider tax restrictions produce federal savings because states will likely be unable to fully replace lost revenues and be forced to cut their Medicaid programs, thereby cutting federal spending
- States have only three tools to cut Medicaid: eligibility, benefits and provider payment rates
- Provider rates and optional benefits including HCBS services are typically first to face budget cuts

# WHAT ELSE IS HAPPENING TO STATE BUDGETS?

# Other Cost-Shifts Facing States

- Other cost shifts from the federal government to states in H.R. 1:
  - SNAP cuts: states must share in benefit costs for first time, pick up greater share of administrative costs
  - Tax conformity: federal tax cuts led to automatic state-level tax cuts and lower state tax revenues due to linkages between tax codes unless states take steps to delink

# Resulting Need for Additional State Revenues

- If states want to mitigate Medicaid cuts to provider rates and optional benefits, as well as eligibility cuts and more red tape, they will need to raise additional revenues at the state level (such as through income taxes, corporate taxes, or other taxes) and/or *Congress will have to repeal the Medicaid cuts*
- Additional revenues to backfill cost-shifts will also help mitigate risk of other budget cuts affecting children like slashing SNAP and other vital parts of the budget like K-12 education

# H.R. 1 Resources Available from Georgetown CCF

- Say Ahhh!  - A Health Policy Blog
  https://ccf.georgetown.edu/format/blog-posts/

- H.R. 1 Resource Hub
  https://ccf.georgetown.edu/topic/hr1-resource-hub/

- State H.R. 1 Implementation Readiness Tracker
  https://ccf.georgetown.edu/2025/08/28/tracking-state-readiness-to-implement-hr-1/

- Rural Hospitals and Communities Feeling Impact of H.R. 1 Medicaid Cuts, Rural Health Fund Falls Short
  https://ccf.georgetown.edu/topic/rural-health/

- The New Medicaid Work Reporting Requirements Are Here—Don't Let the Nebraska "Soft Start" Fool You
  https://ccf.georgetown.edu/2026/05/11/the-new-medicaid-work-reporting-requirements-are-here-dont-let-the-nebraska-soft-start-fool-you/

The New Medicaid Work Reporting Requirements Are Here—Don't Let the Nebraska "Soft Start" Fool You

# H.R. 1 Resources Available from Georgetown CCF

- H.R. 1 resource hub including individual state implementation tracker
  - https://ccf.georgetown.edu/topic/hr1-resource-hub/

- Joint Georgetown University CCF and CHIR comprehensive explainer of each health provision in H.R. 1
  - 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/

- Medicaid and CHIP enrollment tracker
  - https://ccf.georgetown.edu/feature/state-by-state-medicaid-enrollment-data/

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# QUESTIONS?