Fact Sheet: Changes in State Financing Mechanisms for Medicaid Programs

Overview

States have historically been afforded flexibilities in how they structure, operate, and finance their Medicaid programs to meet each state's specific needs. On July 4, 2025, the budget reconciliation bill, "One Big Beautiful Bill Act" (OBBBA), was signed into law, making cuts of almost $1T to Medicaid funding. The OBBBA also makes changes to two important state funding mechanisms: provider taxes and state-directed payments. These restrictions in financing mechanisms will create funding shortfalls that threaten community-based services for people with intellectual and developmental disabilities (I/DD).

Provider Taxes

States are currently permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general revenue, local government funds, and health care related taxes (i.e. provider taxes). Provider taxes are permissible under federal statute and regulation and serve as a crucial source of Medicaid funding for states since the tax revenue collected from providers is put back into Medicaid services, thereby allowing states to draw down additional federal matching funds.

States use this additional federal funding in several ways to support their Medicaid programs. Provider taxes help to support provider rate increases and to improve access to services. States also have used funds collected from provider taxes to support the Medicaid program more broadly. During economic downturns, when state tax revenues fall while demand for public services like Medicaid increases, states are more likely to impose or increase provider taxes to help fund the state share of Medicaid.[1]

While states may vary in the type or amount of provider taxes they impose, states were formerly permitted to impose provider taxes up to 6% or less of net patient revenues. In 2018, the most recent year for which data is available, provider taxes accounted for an average of 17% of the state share of the cost to operate their Medicaid programs.[2] However, on July 4, 2025, OBBBA made the following changes to provider taxes:

- Freezes provider taxes at their current levels as of the date of enactment; and

[1] KFF Fact Sheet: *States and Medicaid Provider Taxes or Fees*; June 2017.
[2] Alice Burns, Elizabeth Hinton, Elizabeth Williams, and Robin Rudowitz; *5 Key Facts About Medicaid and Provider Taxes*; March 2025.

- Reduces the maximum provider tax rate by .5% each year, as follows, until it reaches 3.5% in states that expanded Medicaid through the Affordable Care Act expansion:[3]
    - For FY 28: 5.5%
    - For FY 29: 5%
    - For FY 30: 4.5%
    - For FY 31: 4%
    - For FY 32 (and subsequent years): 3.5%

State-Directed Payments

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 home and community-based services (HCBS) for people with I/DD. 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.

OBBBA requires the Secretary of HHS to revise federal regulations to limit SDP rates. Medicaid expansion states and non-expansion states will be treated differently under the new federal law as follows:

- For non-expansion states, the total payment rate is capped at 110% of the specified total published Medicare payment rate.
- For expansion states, the total payment rate is capped at 100% of the specified total published Medicare payment rate.

SDPs approved prior to the legislation's enactment are grandfathered in but must be reduced by ten percentage points each year (starting January 1, 2028) until they reach the allowable Medicare-related payment limits.

Medicaid Cuts Put Community Disability Services at Risk

Historically, many individuals with I/DD lived in and received government-funded services in large, expensive state-operated institutions. However, with the advent of Medicaid-funded community-based support, came a new era of person-centered services and support for people with I/DD in America. As a result, states across the country were able to significantly reduce their expense and reliance on large and restrictive public facilities in favor of supporting individuals with I/DD in their

[3] Provider taxes imposed on nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) remain frozen and are exempt from the annual reductions in expansion states.

homes and communities. Unfortunately, those community-based services that people with I/DD rely on to remain in their homes and communities are optional Medicaid benefits.

Across the country, community providers assist people with intellectual and developmental disabilities (I/DD) to live, work, and thrive in their homes and communities. Even if not targeted specifically at cuts to community-based services, reductions in Medicaid funding authorized through OBBA may have a devastating impact on access to services for people with disabilities. Because community-based services are not federally mandated, they are especially vulnerable to Medicaid funding reductions.

Historically, when states face Medicaid funding shortfalls, non-mandatory services like HCBS are among the first to be scaled back, restricting access to essential supports for people with disabilities. In fact, data shows that between 2010 and 2012, in response to a reduction in federal funding in the wake of the great recession, every single state and the District of Columbia cut spending to one or more of its HCBS programs, either by reducing inflation-adjusted, per-beneficiary spending, or by reducing the number of beneficiaries.[4]

Access to community-based services for people with I/DD is already in a fragile state and cannot withstand further cuts. Long-term underinvestment in community-based services, together with stagnant and insufficient reimbursement rates, has led to an exodus of qualified workers from the field. ANCOR's State of America's Direct Support Workforce Crisis 2024 survey reveals that 90% of community providers experienced moderate or severe staffing challenges in the past year, resulting in 69% of community providers turning away new referrals.[5].

As states consider the budgetary impacts from the OBBBA, we must ensure community-based services for people with I/DD remain available for those that need it. State actions to reduce, restrict, or eliminate community-based supports in order to achieve short-term savings only serve to further exacerbate budgetary pressures as people with I/DD seek more expensive mandatory services, such as hospitals and emergency rooms, to receive needed services. States may also encounter costly and time-consuming litigation from those unable to access support outside of institutional settings. Sufficient funding for community-based services is crucial for people with I/DD, our economies, and our communities.

Contact Us

For more information on state financing mechanisms for Medicaid programs, please contact Tom Rice, Director of Policy and Regulatory Affairs, at trice@ancor.org.

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[4] Jessica Schubel et al., Health Affairs: *History Repeats? Faced With Medicaid Cuts, States Reduced Support for Older Adults and Disabled People* (Apr. 16, 2025).

[5] The State of America's Direct Support Workforce Crisis 2024 (Alexandria, VA: ANCOR, 2024).