

RESEARCH MEMO

Medicaid Growth, Financing, Relationship to Commercial Costs and Prices, and Other Demographic and Economic Effects

To: Colorado Commission on Medicaid
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Thank you for reaching out to NCSL with the following questions about the state's Medicaid program:

1. What share of growth in this program is Colorado policy and what share is health care inflation?
2. What is happening to commercial health care costs in Colorado, and how does that interact with what Medicaid pays?
3. What do demographics and labor supply imply for this program over the next five to ten years?
4. Which federal financing tools are other states using that Colorado is not?

Responsive information and resources for each question are provided below. Where available, Colorado-specific information and resources have been included. In the absence of Colorado-specific information, available research, analytical frameworks and national information is included instead.

Please do not hesitate to contact us with any further questions on this or any topic. As your professional membership organization, we are honored to support the work of state legislatures.

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EXECUTIVE SUMMARY

Generally, for each question asked, NCSL has provided an:

- Overview
- Nuances
- Colorado-specific analyses (where available)
- Additional resources

Question 1: Teasing out contribution of policy and health care inflation to Medicaid spending growth

The factors that contribute to Medicaid spending growth are multi-faceted and have complex interactions. Both policy changes and health care inflation have been identified across states as contributing to Medicaid spending growth. One recent analysis of national health care spending in Medicaid (as of 2024 spending data) noted:

- Per enrollee Medicaid costs grew at a higher rate, which could be attributed to:
 - Higher acuity and utilization
 - Rising provider payments, specifically directed payments.
 - Higher administrative costs.

NCSL was unable to identify evidence that analyzes the proportion of Medicaid spending growth in Colorado that can be directly attributed to either health care inflation or policy changes. One state-specific analysis compares Colorado Medicaid spending growth to medical inflation, enrollment and obesity growth, but this comparison does not reflect an analysis of how these factors contributed to underlying Medicaid spending growth directly.

In the absence of state-specific analysis, data directly from the Medicaid agency or Colorado's all-payer claims database trended over time is most likely to provide insight into the benefits, provider types, etc. driving spending, even if the underlying cause (policy change or health care inflation) is unclear.

Question 2: Commercial Health Care Costs and Interaction with Medicaid Payment Rates

There are several longstanding assumptions related to Medicaid payment rates and commercial health costs, specifically:

- Medicaid payment rates fall below Medicare and commercial payment rates.
- Low Medicaid payment rates cause providers to "cost shift" to commercial insurers (e.g. charge higher rates to commercial insurers).
 - Under this theory, the inverse should also be true: increasing Medicaid payment rates would result in lower commercial payment rates.

However, a growing body of evidence contradicts these assumptions, specifically:

- While Medicaid **base** payment rates for physicians and hospitals fall below Medicare rates, when supplemental and directed payments are taken into account, hospital rates may exceed Medicare and even extend up to the average commercial rates.
 - MACPAC analysis using data from 2010 indicates that Colorado hospital rates were 80% of Medicare, even accounting for supplemental payments, although such data may no longer be current given its age.
- Limited evidence supports the "cost-shifting" theory and instead finds that reducing public hospital prices may reduce private prices.
 - Colorado-specific analysis in 2020 found that increases in Medicaid payment rates did not result in lower commercial health rates.
- Emerging evidence and economic modeling suggests that Medicaid provider taxes and directed payments may increase commercial payment rates.
- Evaluations of state experiments with hospital global budgets – where hospital rates are set consistent across private and public payers – have resulted in reduced spending for both Medicare and commercial payers.

Question 3: Effect of demographic shifts and labor supply on Medicaid for the next five to ten years

An aging population, aging workforce, and workforce shortages in long-term services and supports and behavioral health could pressure state Medicaid programs. In addition to broader state fiscal implications of demographic shifts, an aging population increases demand for Medicaid long-term services and supports, specifically institutional care and caregiver supports.

While services provided in homes and communities are less expensive to cover per enrollee, they can pose spending challenges on states if not offset by decreased institutional care. And while workforce shortages often prompt Medicaid payment increases, there is limited evidence on their effect. A growing body of evidence evaluating the effect of Medicaid provider payment increases on provider participation in Medicaid and access suggest potential alternative approaches.

Question 4: Federal financing tools available to states

Nationally, 68-70% of funding for the non-federal share of Medicaid spending comes from the state general fund. However, approximately 6-12% of Medicaid funding (for the non-federal share) comes from local funding sources, and approximately 4-6% comes from other revenue, like tobacco settlement funds.

Medicaid financing and revenue sources are complex and idiosyncratic to the state, meaning that there is no publicly available breakdown for exactly how each state finances the non-federal share of Medicaid spending. The Department of Health Care Policy and Financing is the best source of information on the state's use of various financing mechanisms.

Colorado does leverage Medicaid coverage for state-funded services in schools and in correctional settings through the state's school health services program and a reentry demonstration waiver.

NCSL also provided state examples of how other states use alternative Medicaid revenue sources, including:

- Intergovernmental transfers
- Certified public expenditures
- Medicaid covered state services in education, corrections and state employee health plan spending
- Other alternative revenue sources

QUESTION 1: TEASING OUT CONTRIBUTION OF POLICY AND HEALTH CARE INFLATION TO MEDICAID SPENDING GROWTH

Overview

Generally, state Medicaid spending is driven by Medicaid-specific factors and broader health market and economic factors.

Medicaid-specific factors that contribute to Medicaid spending are:

- The total number of people enrolled.
- The types and volume of services used.
- Payments made to providers and managed care organizations.
- The administration of the program.

Health market and economic factors that contribute to Medicaid spending – and the state’s contribution to overall Medicaid spending – include:

- Average state per capita income, which influences the [federal match rate](#).
- Provider prices.
- Labor market costs.
- Inflation.
- Administrative waste.
- Disease and condition prevalence.
- Technological advances in treatment.
- Demographic trends.
- State economic conditions – [Medicaid is countercyclical](#).

Federal and state Medicaid policy can influence the Medicaid-specific factors that contribute to Medicaid spending. For example, in recent years, states have consistently [increased provider payment rates](#), [enhanced benefits](#) and extended eligibility more frequently than states have restricted payment, benefits or eligibility.

According to the annual KFF budget survey, [factors that are contributing to Medicaid spending growth in 2025 and 2026 include](#):

- Higher health needs among enrollees
- Rate increases
- Increasing costs of long-term care, pharmacy and behavioral health, driven by new advances, increased utilization and increased demand.

According to a blog from the [National Association of Medicaid Directors](#), in 2025 five Medicaid budget pressures facing states were:

- Federal policy changes
- Prescription drugs
- Long-term care
- Health care labor costs
- Program administration

While each of the preceding sources list factors that are contributing to Medicaid budget pressures, none explicitly break down how much each factor directly contributes to Medicaid spending.

Nuances

While there is national and state level analysis on how various factors contribute to [commercial health costs](#) (including spending, price, use, service mix and cost burden) NCSL did not identify an equivalently detailed breakdown for Medicaid in research for this question. It's unclear exactly the extent to which each factor independently contributes to Medicaid spending growth, as each state's policy and economic environment is unique. Additionally, Medicaid spending data lags due to the time it takes to pay claims and reconcile federal and state expenditures.

There is some analysis of national Medicaid spending and the factors primarily contributing to Medicaid spending growth. According to a [2026 Health Affairs research article](#) analyzing the factors contributing to national health care spending across payers in 2024, including Medicaid:

- Total Medicaid spending increased by 6.6 percent in 2024, a slower growth rate than in previous years.
- Medicaid enrollment declined by 8.6 percent (or 7.9 million) in 2024 as states resumed eligibility redeterminations after the end of pandemic-era coverage provisions.
- Per enrollee Medicaid spending surged by 16.6 percent in 2024, which was a dramatic increase compared with the 6.5 percent rise in 2023 due to two primary factors:
 - Higher proportion of enrollees with complex medical conditions, greater health needs, and higher utilization rates, due to changes in enrollment composition due to unwinding.
 - Rising provider payment rates, along with growth in state-directed payments to providers through managed care organizations.
 - Medicaid government administration costs increased by 19.8 percent in 2024 compared with 9.2 percent in 2023, likely due to unwinding.
- All Medicaid services except home health care and nursing and residential care facilities experienced slower growth than in 2023.
 - Hospital care (34 percent share), spending increased 8.5 percent after 9.2 percent growth in 2023.
 - Other health, residential, and personal care (21 percent share), spending increased 8.9 percent after 9.7 percent growth in 2023.
 - Services used for long-term care – including other health, residential, and personal care services; home health care; and nursing and continuing care retirement communities—grew 8.9 percent in 2023 and 9.5 percent in 2024.
 - The population that uses long-term care was more likely to remain enrolled in Medicaid following the unwinding.
- Federal spending decreased and state spending increased in 2024 due to the phasing out of enhanced federal funding during the COVID-19 public health emergency.
 - Federal Medicaid spending increased by only 0.7 percent in 2024, down from 3.6 percent in 2023.
 - State and local Medicaid spending increased to 19.2 percent in 2024 up slightly from 18.2 percent in 2023.

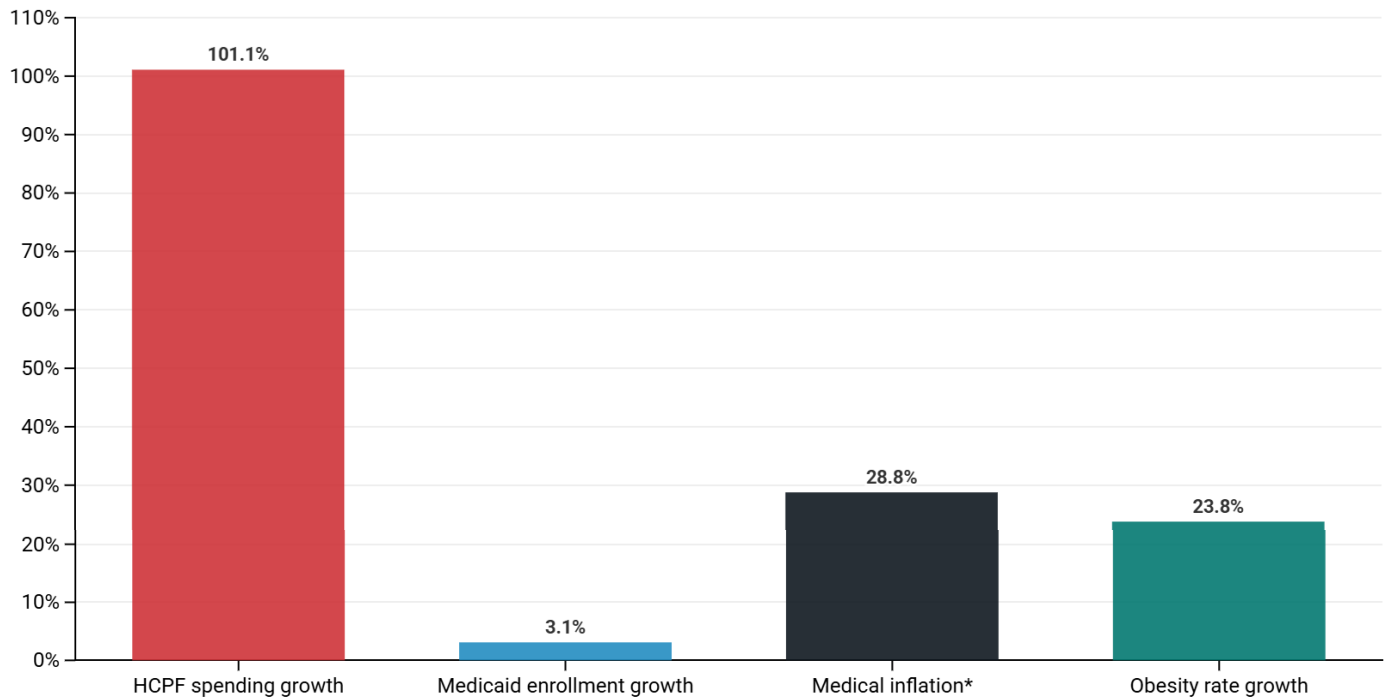
While policy changes may impact Medicaid spending, directly attributing spending to policy changes is challenging. Coverage does not automatically lead to access and utilization. Policies increasing provider payments rates, extending eligibility, or covering new benefits may not contribute to spending growth unless individuals access the services, providers are available to provide the service, and providers bill for the services.

Colorado-Specific Analyses

- [Challenges Facing Medicaid and Department of Health Care Policy and Financing in Colorado: A Guide for Policymakers](#) | Colorado Common Sense Institute (2026)
 - According to this report, “CSI’s analysis suggests that much of HCPF’s last decade of spending increases could have been avoided in the absence of expansive policy and other nonessential spending. The agency’s total spending growth over that period, 101%, is higher than the combined growth rates of Medicaid enrollment, medical inflation, and obesity (a proxy for public ill-health).”

- It is important to note that comparing different spending growth rates is ***not a causal analysis*** and does not estimate the extent to which medical inflation, obesity or specific policy changes actually contributed to Medicaid spending growth.

HCPF Spending Growth in Context (FY2015–2025)



Source: Colorado Common Sense Institute (2026)

- [Colorado Medicaid's Sustainability Framework](#) | HCPF (2025)
 - According to Colorado's Medicaid agency, Medicaid cost trends are running at unsustainable levels in recent years due to:
 - Increases in medical inflation
 - Increases in benefits
 - Expansion of coverage programs
 - Outlier trends in certain areas
 - Outlier increases to provider reimbursement rates over the last several years

QUESTION 2: COMMERCIAL HEALTH CARE COSTS AND INTERACTION WITH MEDICAID PAYMENT RATES

Overview

While there are long-standing assumptions about the relationship between commercial health care costs and Medicaid payment rates, evidence supporting those assumptions is limited and mixed. This section outlines underlying assumptions while the **Nuances** section below provides more context on the available evidence.

A standing assumption is that neither Medicare nor Medicaid payment rates cover the actual costs of care with Medicaid paying the least of all payers and commercial insurers paying the highest. Low Medicaid payment rates are often assumed to shift costs to private insurance and consumers. Under this assumption, providers negotiate higher commercial insurance rates to make up for low Medicare and Medicaid payment rates, **known as cost-shifting**. Under this assumption:

- When Medicaid payment rates are reduced, providers negotiate higher commercial payment rates to make up for the difference, leading to higher commercial premiums for consumers and driving health prices up.
- Conversely, if Medicaid payment rates increase, provider cost shifts to commercial insurance should fall, lowering commercial insurance costs.

*Note that some literature and **Colorado-specific analysis** contradicts this assumption (see below).*

Private health insurance also has independent spending growth patterns and cost drivers from Medicaid. While health spending has increased across all payer types – including Medicaid, Medicare and private insurance – per enrollee spending in the commercial health care market has **grown more rapidly** than Medicare and Medicaid spending per enrollee since 2008.

- From 2008 to 2024, **per enrollee spending** by private insurers increased by 96.5%, compared with 59.5% for Medicare and 51.6% for Medicaid.
- Higher spending can translate to higher out-of-pocket costs for many consumers covered by private insurance. **Nearly half of insured adults** report difficulty affording their healthcare costs.

A **range of factors** contribute to commercial health care spending.

- Utilization, prevalence of chronic disease, an aging population, innovations in technology and research, expansions in health coverage and unit prices for services all contribute to health spending.
- **Many experts** attribute the rise in private insurance spending to increases in prices for services and fees.
 - For example, according to the **Healthcare Costs Institute**, between 2018 and 2022, total healthcare utilization increased by 4%, while prices rose by 14% during the same period.
- Recent **data** suggests that **growth has also been driven by** increases in the volume and intensity of care, as well as shifts in coding practices.

Nuances

Below is an overview of some of the research evaluating the underlying assumptions about the relationship between Medicaid payment rates and commercial health costs, specifically whether Medicaid is the lowest payer and the effect of cost shifting.

Medicaid **base** payment rates compared to other payers

Researchers have evaluated whether Medicaid payment rates fall below Medicare rates for physicians and for hospitals. Other Medicaid provider types for services that are not traditionally covered by Medicare – like behavioral health and home- and community-based services providers – are not directly comparable to Medicare rates.

According to researchers:

- Medicaid payment rates *for physicians* have historically and consistently fallen below Medicare payment rates averaging 75% of the Medicare fee schedule between 2019 and 2024.
- Medicaid **hospital payments** are more variable, particularly when supplemental payments are taken into account (more on that below), but Medicaid **base** hospital payment rates were 78% of Medicare payments on average based on data from 2010.

The role of Medicaid supplemental payments and financing choices on **total** provider payment rates

While Medicaid base rates are often lower than Medicare payment rates, additional lump sum payments specific to Medicaid can increase total provider payments above Medicare for some providers. There are two primary types of supplemental payments:

- **Supplemental payments** made directly through the state agency that are capped at either an upper payment limit of 100% of Medicare, the Medicaid shortfall, or to address uncompensated care costs
- **Directed payments** made through Medicaid managed care organizations (MCOs) were capped at an upper payment limit of the average commercial rate for one of three purposes:
 - Uniform rate increase for an identified class of providers.
 - Minimum fee schedule for an identified class of providers.
 - Value-based payments, including those with pay for reporting or pay for performance incentives.

Supplemental and directed payments are often funded through Medicaid-specific financing mechanisms, like provider taxes and intergovernmental transfers (see **Question 4** for more information on this below).

Under the **One Big Beautiful Bill Act**, codified as **Public Law 119-21** (OBBBA), directed payments for hospitals and physician services at academic medical centers are now subject to a lower upper payment limit of 100% or 110% of Medicare (depending on state expansion status).

- According to a **2016 MACPAC analysis**, Medicaid hospital payments can range from 49% - 169% of Medicare when supplemental payments are taken into account (based on 2010 data). According to this report:
 - Medicaid net payments – inclusive of supplemental payment and provider contributions – were 6% higher than Medicare overall.
 - Supplemental payments made up 44% of total hospital payments in 2014.
- Subsequent MACPAC analysis of Medicaid hospital payment rates has also found that **state financing choices for supplemental payments – such as provider taxes or intergovernmental transfers that are paid by the provider to fund the supplemental payment – can lower the net payment for hospitals**. Additionally, gross payments may not cover hospital costs for both Medicaid & uninsured patients (based on 2011 data).

Relationship between Medicaid payments and commercial costs and “cost-shifting”

Limited evidence supports the “cost-shifting” theory and instead finds that reducing public hospital prices may reduce private prices. Some economic models and emerging evidence also indicate that Medicaid-specific financing and payment mechanisms – specifically provider taxes and directed payments – may increase commercial health costs. And state experiments with hospital global budgets – where hospital rates are set consistent across private and public payers – have resulted in reduced spending for both Medicare and commercial payers.

- An [evidence review on cost shifting conducted by the California Health Care Foundation from 2025](#) found that:
 - There is little evidence for cost shifting by hospitals. The most recently published studies tend to find that reductions in prices by public payers (Medicaid and Medicare) are associated with reductions in private prices.
 - It is not clear that hospitals have unused ability to negotiate higher prices from private insurers, which would tend to leave them without the ability to cost shift in response to changes in payment rates by public payers.
 - In response to public price reductions, hospitals are more likely to reduce costs, which may decrease quality or access to care for patients.
- Recent analysis published by the federal Office of the Assistant Secretary for Planning and Evaluation (ASPE), estimates that the [recently enacted limits on provider taxes and directed payments in OBBBA](#) will reduce non-Medicaid prices (for commercial insurance and Medicare) by 3.5%.
 - Specifically, the authors estimate that non-Medicaid payers benefit \$0.98 for each dollar that provider-tax and directed payment restrictions reduce total Medicaid spending (including both federal and state dollars) and that non-Medicaid consumers will pay a lower price of \$0.57 less for each dollar of reduced Medicaid spending attributed to provider tax and directed payment limits.
- According to [economic modeling from the Paragon Health Institute](#), 45-80% of Medicaid provider taxes may be passed on to commercial patients and a 6% hospital provider tax could increase commercial prices by 3-5% for hospital services.
 - In applying its model using a differences-in-differences approach, Paragon estimated that a 2010 hospital tax in California was associated with an increase in commercial hospital prices of roughly 3-4% relative to prices in neighboring states (Arizona, Oregon, and Nevada).
- Bidirectional effect from commercial health prices to what Medicaid pays for services in the market as well.
 - What drives commercial costs → hospital prices, consolidation.

Evaluations of hospital global budget pilots have demonstrated that budgeting the same hospital rates across multiple payers may reduce or flatten spending for all payers. The multi-year [Maryland Total Cost of Care model](#) – a CMS Innovation Center model – set hospital payments at the same rate across Medicare, Medicaid and commercial payers. Evaluations of the model demonstrated [savings for the Medicare program](#) and indicators of improved outcomes:

- 2.1% reduction in total Medicare spending
- 6.1% reduction in hospital spending
- 16.2% reduction in hospital admissions
- 16.8% reduction in preventable admissions) and commercial payers and flat spending for Medicaid.

During the evaluation period, public data suggested that [Maryland Medicaid spending growth \(8.7%\) was below the national average during the same time period of the model \(14.3%\)](#), but the evaluators interpret these findings with caution, due to potential changes in beneficiary characteristics and the effects of the public health emergency during the evaluation period.

Colorado-specific analyses

Below are Colorado-specific resources and analysis of commercial costs, Medicaid cost shifting and use of Medicaid directed payments.

Commercial Costs Resources

- The Center for Improving Value in Health Care (CIVHC), Colorado's All-Payer Claims Database, publishes analyses of commercial cost trends and comparisons of commercial costs to Medicare payments:
 - [Colorado All Payer Claims Database](#)
 - [Annual Reports](#)
 - [New Data Shows Increases in Health Care Costs Not Tied to Service Use](#), CIVHC (2024)
 - [Colorado Hospital Prices Compared to Medicare Payments – New Interactive Report and Resources Now Available](#), CIVHC (2022)

Consumer Costs in the Commercial Market

- Pursuant to Colorado Revised Statutes § 10-16-111, the Division of Insurance within the Colorado Department of Regulatory Agencies is required to report information on the financial status of commercial health insurance carriers, commercial health insurance premiums and factors that drive premiums in both the individual and group markets. [The most recent report available contains data from 2024](#) and was published on March 2, 2026. Per the report:
 - [Colorado Health Insurance Cost Report](#), Colorado Department of Regulatory Agencies (2024)
 - In 2024, the total direct written premium for health insurance increased by 12% or \$687 million for the top 95% of health insurance carriers from 2023.
 - Administrative expenses increased by \$358 million from 2023, from 16.7% of written premium to 20.5%. The largest increases came from charitable contributions, legal expenses, and federal taxes.
- [Data from the most recent 2026 open enrollment period](#) for Colorado's marketplace plans estimated that customers now pay, on average, \$19 million more per month in premiums than they did in 2025. Slide 17 lists county-level costs data for both customers receiving marketplace financial assistance as well as those not receiving assistance.
- [2026 data from KFF](#) reported average marketplace plan premiums for the 2026 open enrollment period and found an average premium of \$673 per month in Colorado, compared to the national average of \$741 per month.
- [Per a July 2026 press release](#) by the Colorado Division of Insurance, premiums for individuals enrolled in the individual health insurance market in Colorado are expected to see an average increase of 11% in 2027, less than the national median increase of roughly 14%. Please note that this figure represents only rate increases insurers have requested, not those the Division has approved.

Medicaid Analysis of Cost Shifts

- [Colorado Cost Shift Analysis](#) | HCPF (2020) – In 2020 HCPF conducted an analysis on hospital cost shifts, evaluating whether Medicaid supplemental payments to hospitals resulted in hospitals charging lower prices to commercial insurers. This analysis found that Medicaid supplemental payments did not prevent cost shifts and further found:
 - Hospital profits have increased by more than 280% between 2009 and 2018.
 - Colorado hospitals' prices grew 71.3% between 2009 and 2018 while adjusted discharges only grew 16.6%.
 - Uncompensated care levels in Colorado were at historic lows in 2020.
 - Cost shifts to commercial insurers are “driven by strategic hospital decisions, not by shortfalls from public insurance,” and that “increased funding generated by public, taxpayer funded programs, which

are intended to reduce private insurance premiums and out-of-pocket costs, are not being passed along to health care consumers and employers.”

- According to the Colorado Health Institute, the cost shift analysis resulted in a conversion of the state’s hospital provider tax into [Colorado’s Hospital Transformation Program](#) to better tie hospital reimbursement to quality-based initiatives.
- According to a [2016 MACPAC analysis](#), Medicaid hospital payments in Colorado were approximately 80% of Medicare payment rates when MACPAC evaluated data from 2010.

Medicaid Directed Payments in Colorado

- While analysis from the Colorado-based [Common Sense Institute](#) identifies Colorado’s more recent use of directed payments, the Institute does not evaluate the extent to which these payments did or could contribute to Medicaid spending growth or effect
- Colorado has had [limited use of Medicaid managed care since 2012](#) and has [historically not used directed payments until 2024 and 2025](#).
- Below is a list of all of Colorado’s approved directed payments since 2024 based on a list of publicly available CMS-approved directed payment preprints, the rating period in which it was in effect and authorized total and state funded amount.
 - **Uniform increase for inpatient and outpatient hospital services and behavioral health inpatient and outpatient services** for rating periods from July 1, 2025 – June 30, 2026.
 - Approved April 24, 2026.
 - New rate increase retroactively effective from July 1, 2025.
 - Separate payment term amount up to \$725,112,312 (federal and state).
 - \$268,291,555 identified as the state’s share.
 - **Minimum fee schedule for behavioral health outpatient services** for rating period July 1, 2025 – June 30, 2026.
 - Approved March 11, 2026
 - Renewal of an existing minimum fee schedule in effect since July 1, 2024.
 - Risk-based rate adjustment up to \$522,726,178 (federal and state)
 - \$182,764,438 identified as the state’s share
 - **Uniform increase for professional medical services at an academic medical center** for rating period July 1, 2025 – June 30, 2026.
 - Approved January 30, 2026
 - New rate increase retroactively effective from July 1, 2025.
 - Separate payment term amount of up to \$11,331,455 (federal and state)
 - \$3,527,482 identified as the state’s share.
 - **Minimum fee schedule for Community Mental Health Centers and Comprehensive Behavioral Health Providers** for rating period July 1, 2024 through June 30, 2025.
 - Approved June 3, 2025
 - New fee schedule retroactively effective from July 1, 2024.
 - Identified as a value-based payment type, incorporated into capitation rates through a risk-based rate adjustment.
 - Total dollar amount of the payment up to \$458,371,233 (federal and state)
 - \$162,910,567 identified as the state’s share.

Resources:

- [Challenges Facing Medicaid and Department of Health Care Policy and Financing in Colorado: A Guide for Policymakers](#) | Common Sense Institute Colorado (2026)
- [The Hidden Cost of Medicaid Provider Taxes: Higher Prices in the Commercial Market](#) | Paragon Health Institute (2026)
- [An Overview of State-Directed Payments and Medicaid Provider Taxes: History and Potential Effects of the Working Families and Tax Cut Legislation on Health Care Costs](#) | Assistant Secretary for Planning and Evaluation (Aug 2026)
 - Specifically, see the section titled: **The Supply-Demand Relationship Between Provider Taxes, SDPs, and Non-Medicaid Prices in the Inpatient Health Care Market.**
 - *NCSL Note: Please note that federal documents refer to the One Big Beautiful Bill Act, codified as Public Law 119-21 as the Working Families and Tax Cut legislation.*
- [Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019](#) | Health Affairs (2021)
- [Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees](#) | Health Affairs (2025)
- [Does Shift Happen? Key Concepts and Evidence in the Hospital Cost-Shifting Debate](#) | California Health Care Foundation (2025)

QUESTION 3: EFFECT OF DEMOGRAPHIC SHIFTS AND LABOR SUPPLY ON MEDICAID FOR THE NEXT FIVE TO TEN YEARS

Overview

State Medicaid programs are likely to face growing budget and operational pressures over the next decade as demographic trends increase demand for services while workforce shortages affect access and pressure states to increase provider payment rates to compensate. The National Association of Medicaid Directors (NAMd) identifies both [long-term care demands and health care workforce shortages](#) as among the most significant budget pressures facing Medicaid programs. These pressures are expected to intensify as the population ages and demand for long-term services and supports (LTSS), behavioral health services and caregiver supports continues to grow.

In addition to Medicaid budget pressures, shifting demographics may have broader effects on state fiscal stability and labor supply. According to Pew, [an aging population](#) can have [complex fiscal effects](#) on state budgets and revenue based on state tax revenue sources, tax exemptions for older adults and more. And according to the CDC, the [workforce is aging as well](#), with workers aged 65 or older growing 117% and employment of individuals 75 years or older growing by 117% over the last 20 years.

For Medicaid, the most significant implications involve LTSS, including home- and community-based services, nursing facility care and other supports for older adults and people with disabilities, who account for higher per enrollee costs and a disproportionate share of spending compared to enrollment.

Resources

- [Aging Workforce Data and Statistics](#) | CDC (2026)
- [Understanding the Aging Workforce: Defining a Research Agenda](#) | National Academies (2022)
- [Can Healthcare Labor Supply Keep Up With Aging-Driven Demand?](#) | Federal Reserve Bank of Kansas City (2026)
- [The Aging Population Is Changing States' Revenue, Spending and Service Demand Outlook](#) | Pew (2026)
- [The Aging of America Tests the U.S. Healthcare System](#) | West Health (2024)

Caregivers

Unpaid caregivers are an essential component of the long-term care system. [According to the CDC](#), the number of caregivers increased from 43.5 million in 2015 to approximately 53 million in 2020. By 2035, approximately 78 million Americans are expected to be age 65 or older, increasing demand for both paid and unpaid caregiving supports.

Family caregivers help many older adults and people with disabilities remain in community settings, potentially delaying or preventing institutional care. As caregiving responsibilities increase, states may face growing demand for respite services, caregiver supports and other policies designed to support the unpaid caregiving workforce.

Resources

- [Caring for the Caregivers](#) | NCSL
- [Caregiving in the U.S. 2025](#) | AARP (2025)
- [America's Unseen Workforce](#) | Otsuka & Columbia
- [Dementia Caregiving as a Public Health Issue](#) | CDC (2024)

Workforce Shortages: LTSS, Behavioral Health & Select Regions for Maternal Health

Specific sectors of health workforce shortages are more likely to effect the Medicaid program, specifically LTSS, behavioral health and maternal health.

LTSS

- As more individuals require assistance with activities of daily living or instrumental activities of daily living, states may face increasing pressure to expand access to both institutional and home- and community-based services. Meeting this demand will depend heavily on the availability of direct care workers.
- [The U.S. Bureau of Labor Statistics](#) projects demand for home health and personal care aides to increase by 33.7% and demand for nursing assistants to increase by 7.6% between 2019 and 2029.
- [HRSA workforce projections](#) similarly anticipate increased demand across LTSS occupations.
- At the same time, [providers continue to report challenges recruiting and retaining workers](#). Because labor represents a substantial share of LTSS spending, workforce shortages may increase Medicaid costs even when enrollment growth remains relatively stable.
- The sustainability of the LTSS workforce may also be influenced by demographic factors within the workforce itself. [Direct care occupations rely heavily on women, older workers and immigrants](#), making broader labor force and immigration trends particularly relevant to future service capacity.

Behavioral Health

- Demand for behavioral health services has increased in recent years, [including among Medicaid beneficiaries](#). At the same time, workforce projections indicate that many behavioral health professions may face substantial shortages in coming decades.
- [HRSA projects that by 2038 workforce supply](#) may meet only:
 - 30% of projected demand for addiction counselors.
 - 55% of projected demand for mental health counselors.
 - 48% of projected demand for psychologists.
 - 50% of projected demand for adult psychiatrists.
 - 61% of projected demand for child and adolescent psychiatrists.
 - 60% of projected demand for marriage and family therapists.
 - 80% of projected demand for school counselors.
- These projections suggest workforce capacity may remain a challenge.

Maternal Health

- Workforce projections for maternal health providers suggest a more varied picture than in behavioral health. [HRSA projects that by 2038 the supply of nurse midwives](#) could reach approximately 140% of projected demand, while the supply of obstetrician-gynecologists is projected to meet approximately 86% of projected demand.
- Although these projections suggest stronger workforce adequacy than many behavioral health professions, provider distribution and geographic access remain important considerations. [Medicaid finances a substantial share of births nationwide](#), making continued access to maternal health providers an important consideration for state policymakers.

Resources:

- All
 - [Health Workforce Projections](#) | Health Resources & Services Administration (2025)
 - [Occupational projections and worker characteristics \(2025-35\)](#) | Bureau of Labor Statistics
 - [Births Financed by Medicaid by Metropolitan Status](#) | KFF (2024)
- LTSS
 - [Shoring Up the Long-Term Care Workforce](#) | NCSL (2019)
 - [Long-Term Services and Supports: 2025 Annual Report](#) | Washington Dept of Health and Human Services (2025)
 - [Direct Care Workers in the United States, Key Facts 2025](#) | PHI (2025)
 - [Top Five Medicaid Budget Pressures for Fiscal Year 2025](#) | National Association of Medicaid Directors (2025)

- Behavioral Health
 - [Shortages in the Behavioral Health Workforce](#) | NCSL Podcast (2025)
 - [Exploring the Rise in Mental Health Care Use by Demographics and Insurance Status](#) | KFF (2026)
 - [Oregon Center for Excellence for Behavioral Health and Aging](#)

Nuance

Costs of LTSS and Rebalancing

Populations that use institutional care at higher rates include [older adults and individuals who are dually eligible for both Medicare and Medicaid](#), both of which are likely to increase as the population ages.

As discussed in more detail in the NCSL report, [Building Sustainable Long-Term Care Infrastructure Across States](#), institutional care is more expensive than care provided in the home and community. Far fewer people receive institutional services than HCBS, those who do have higher per person costs, [according to CMS](#):

- Institutional services cost an average of \$54,462 per person in 2023.
- HCBS care costs an average of \$17,298 per person in 2023.

According to estimates from a [2025 report](#), if 3% of current California Medicaid HCBS users shifted to nursing facilities, the state's Medicaid LTSS spending would increase by \$57 million in the first year and \$1.17 billion over five years.

However, increased growth in HCBS can cause its own budget problems for states. For example, according to a [2024 report](#) from South Dakota's Legislative Research Council, "new community-based services create budget problems if they are not offset by decreased use of nursing facilities."

Medicaid Payment Rate Effects on Labor Supply, Workforce Shortages and Downstream Effects

Workforce shortages may pressure state Medicaid programs to increase provider payment rates to ensure access to care. However, the evidence is limited and mixed as to the effect of provider payment rate increases.

- As noted in a recent Health Affairs Forefront piece on widespread state action to increase Medicaid behavioral health payment rates: "Despite widespread adoption, the evidence base for Medicaid rate increases as a lever for improving access [remains thin](#)."
- Research from the [Medicaid and CHIP Payment and Access Commission \(MACPAC\)](#) and a roundtable discussion with stakeholders and experts indicates that:
 - Provider rate increases have inconsistent effects on provider participation and beneficiary access to services.
 - A small share of providers care for a large share of Medicaid beneficiaries, and more research is needed to understand how increased rates affect these providers.
 - Certain physician specialties also accept new Medicaid patients at a higher rate than others.
 - Some evidence concludes that administrative barriers may affect provider participation as much as payment rates in some states.
 - There is tension between policy goals of expanding the total number of providers that participate in Medicaid and expanding access to providers who already participate.
 - While research on beneficiary access to care has predominately focused on the number of providers participating in Medicaid, there is a need for measures of access to care that focus on beneficiary needs and experiences.

Resources

- [Nearly Every State Raised Medicaid Mental Health Rates. Now What?](#) | Health Affairs Forefront (2026)
- [Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services](#) | MACPAC (2025)
- [Building Sustainable Long-Term Care Infrastructure Across States](#) | NCSL (2026)

QUESTION 4: FEDERAL FINANCING TOOLS AVAILABLE TO STATES

The Medicaid program is jointly funded by both the federal government and state or territorial governments. States can choose how to fund the non-federal share, which can be made up through a mix of state and local funding sources and Medicaid-specific financing mechanisms.

At least 40% of the state's share must be financed by the state directly and [up to 60% may come from local governments](#). Each state [decides](#) how to finance its share of the Medicaid program and state legislatures play a key role in choosing which financing mechanisms to leverage.

Most state spending on the Medicaid program comes from the state general fund. However, the state's share of Medicaid program expenses can be funded through other [mechanisms](#). These mechanisms include [health care-related taxes, certified public expenditures, and intergovernmental transfers](#).

- **Health care-related taxes** (also known as provider fees or taxes), are taxes levied against all private providers within a category (like hospitals, nursing homes or EMS providers), regardless of whether the provider accepts Medicaid patients.
- **Certified public expenditures** occur when a governmental provider (like a county hospital or nursing facility operated through a municipality) pays for Medicaid-covered services eligible for the financial match. The actual costs incurred by the non-state entity can be used to support the state's share.
- **Intergovernmental transfers** occur when one governmental entity (like a county or local education agency) transfers funds to the Medicaid agency before a Medicaid payment is made to increase the state's share.

States can use these mechanisms to increase the state share—and subsequently [draw down more federal funding and increase the federal share of Medicaid spending](#)—without increasing state general fund expenditures. [Federal legislation enacted in 2025](#) prohibits states from imposing new or increased provider taxes and progressively reduces the upper taxation rate of existing taxes by 0.5% annually between 2028 and 2032.

There is no state-specific data that documents how much each state relies on each Medicaid financing mechanism for its Medicaid program. However, as of SFY 2018, the [Government Accountability Office \(GAO\)](#) [estimated that the non-federal share of Medicaid payments was made up of:](#)

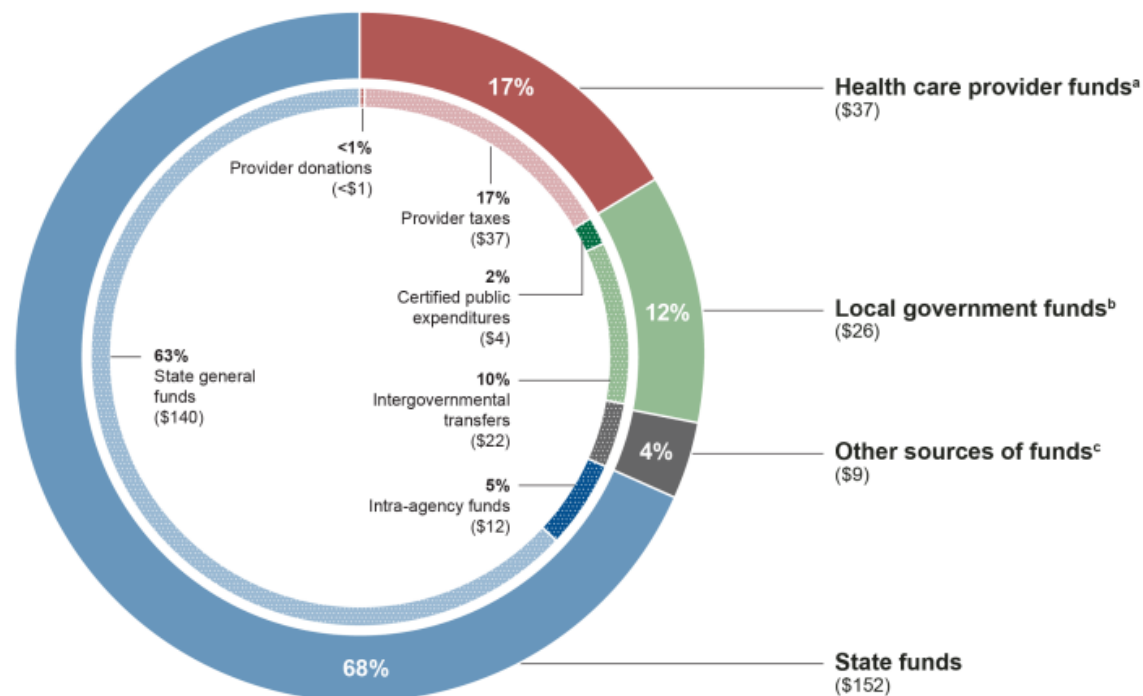
- 63% state general funds
- 17% provider taxes
- 2% certified public expenditures
- 10% intergovernmental transfers
- 5% intra-agency funds
- 4% other sources, such as tobacco settlement funds or state trust funds.

A recent survey of Medicaid agencies in 2025, [conducted as part of KFF's annual Medicaid budget survey](#), [found that the non-federal share of Medicaid payments](#) was made up of:

- 70% state general funds
- 18% provider taxes
- 6% funds from local governments (including certified public expenditures and intergovernmental transfers)
- 6% other sources.

Figure 2: Nonfederal Share of Medicaid Payments Financed with Funds from Health Care Providers, Local Governments, States, and Other Sources in State Fiscal Year 2018

Percentage (dollars in billions)



Source: GAO analysis of state questionnaire data. | GAO-21-88

Colorado-Specific Analyses

Colorado Revenue Sources for the Non-Federal Share

The Colorado Healthcare Affordability and Sustainability Fee is one of the ways that Colorado finances its Medicaid program. Given the complexity of the structure of Medicaid financing mechanisms and specific state context, the state Medicaid agency is the best source of information as to whether and the extent to which Colorado uses intergovernmental transfers or certified public expenditures to finance its Medicaid program. Note that states may not separate local government revenue by Medicaid-financing source and not all state agencies may collect this information.

According to a 2020 issue brief published by the Commonwealth Fund, Colorado has historically leveraged its [Medicaid hospital tax to fund the entirety of the state's share of Medicaid expansion](#) (10% share of spending on adults between 19-64 years old who make less than 138% of the federal poverty level).

According to a [50-state survey of state hospital, ambulance and managed care taxes published by RAND in 2026](#), Colorado has historically levied a hospital tax up to the upper tax rate of 6% of net patient revenue, but not an ambulance or managed care tax. Note that under the [One Big Beautiful Bill Act, codified as Public Law 119-21](#), all states are prohibited from enacting any new provider taxes that were not already in existence prior to July 4, 2025. Additionally, Colorado's hospital provider tax revenue will decrease by 0.5% annually between 2028 and 2032, until the new upper tax rate of 3.5% is reached.

Colorado Use of Medicaid to Cover State-Funded Services

Colorado has a [school-based services program](#) that allows [school districts to submit claims](#) for Medicaid covered health services provided in schools to Medicaid beneficiaries. Two resources from Healthy Students, Promising Futures describe the financial impact of Colorado's school-based services program:

- [Understanding the Financial Impact of Expanding Medicaid Funded School Health Services in Colorado](#) | Healthy Students Promising Futures (2021) – This describes Colorado's process for implementing school-based services over three phases from 2015 through 2019 and provides financial analysis of three scenarios of benefit rollout.
 - During initial phases of evaluation, Colorado found that school nurses were spending 18% of their time on services for Medicaid-enrolled students who were not already receiving Medicaid coverage and 6% of services delivered by school psychologists were on Medicaid-enrolled students.
 - Financial analysis modeled the effects of three different coverage scenarios, which estimated that Colorado could see new federal funds ranging from \$123,000 to \$12 million depending on the coverage model used.
- [Financial Impact of Comprehensive School Medicaid Programs](#) | Healthy Students Promising Futures (2026) – Describes the financial impact of school-based Medicaid programs in seven states, including Colorado. According to this summary:
 - "Colorado expanded its school Medicaid program in 2020 to include reimbursement for services across all plans of care, not just the IEP (view the state case study). The state received \$2.75 million in new federal funds for the 2020-2021 school fiscal year despite pandemic-related billing challenges. An additional \$5.27 million in federal funds was received for fiscal year 2021-22. After billing for school psychologists took effect in October 2022, Colorado received an additional \$6.23 million in 2022-23. Following the conclusion of the Public Health Emergency Unwind when Medicaid enrollment redeterminations resumed, \$2.77 million in additional federal funds was received for 2023-24."

Colorado has also received CMS approval for its [Medicaid Reentry and Community Health Section 1115 waiver](#) to provide limited services up to 90 days pre-release to incarcerated beneficiaries in both state-run and local correctional facilities. Reimbursement for reentry will start on January 1, 2026 for state-run correctional facilities and on January 1, 2027 for local correctional facilities.

State Actions and Options to Leverage Alternative Revenue Sources in Medicaid

States can consider options to use intergovernmental transfers, certified public expenditures, alternative revenue sources like tobacco settlement funds or leveraging Medicaid coverage in other state-funded programs. Some examples are included below.

Intergovernmental Transfers (IGTs)

States can consider options to leverage intergovernmental transfers as a source of local funding for the non-federal share.

For example:

- [Michigan](#) directs the state Department of Health to use certified public expenditures or intergovernmental transfers to offer supplemental reimbursements to eligible ground emergency medical transportation providers that provide services to medical assistance recipients.
- [North Carolina HB 696](#) (2026) Requires intergovernmental transfers from local management entities and managed care for FYs 2025 – 2027.

Certified Public Expenditures (CPEs)

States can consider options to leverage certified public expenditures as a source of local funding for the non-federal share by identifying the “contributing public agency” eligible to submit a CPE.

For example, “contributing public agencies” eligible to submit CPEs – according to state plan amendments - may include:

- **Counties and cities**
 - *State Example:* [Texas](#)
- **Local Educational Agencies**
 - *Source(s):* [Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming](#) | CMS (2023) – See Section VI.C. Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs.
 - *State Examples:* [California](#), [Missouri](#), [Texas](#)
- **Public health entities**, such as community mental health clinics, community centers, local behavioral health authorities, local health departments and public health districts
 - *State Examples:* [Texas](#), [Public Health Providers – Charity Care Program](#).
- **Government owned and operated providers**, such as hospitals, nursing homes, ambulance providers, etc.
 - *State Examples:* [Connecticut](#), [Florida](#), [Massachusetts](#), [Michigan](#), [New Hampshire](#), [Texas](#),
- **State operated facilities for veterans** operated by the state’s Department of Veterans Affairs
 - *State Example:* [Connecticut](#).

States may also establish mechanisms within the state agency to oversee and monitor use of local funds in Medicaid. For example, [Texas SB 1](#) (2021) authorized 14.0 FTEs for the “oversight, evaluation, and monitoring of the use of all funds, including local funds, in the Medicaid program.”

The state agency created the [Provider Finance Department, Local Funding](#) team, responsible for overseeing local funding sources for Medicaid, including CPEs. For purposes of monitoring sources of local funding for Medicaid, [TAC § 355.8702](#) defines a “governmental entity” as:

- a state agency
- a political subdivision of the state including a:
 - hospital authority
 - hospital district
 - health district
 - city
 - county
 - local education agency, defined as a Texas independent school district or charter school
 - other unit of local government established by Texas statute

Other Alternative Revenue Sources

States can leverage alternative revenue sources to fund the Medicaid program, such as tobacco settlement funds, premium assessments on insurers, and other sources of state revenue for Medicaid program funding.

For example:

- [Arkansas HB 1025](#) (2024) authorizes the Arkansas Department of Health to transfer funds from the state’s tobacco settlement funds to the Breast Cancer Control Fund to provide for the state’s matching share for Medicaid services provided for breast and cervical cancer screening and treatment.
- [Iowa HF 2739](#) (2026); [Fiscal Note](#) Modifies Medicaid managed care tax; requires health maintenance organizations to pay a premium tax at a rate of 0.95% of taxable funds.

- **New Jersey AB 5324** (2026) Imposed fee on certain employers that employ 50 or more Medicaid beneficiaries and their dependents; fees are assessed on a sliding scale with higher fees assessed on the employer the more Medicaid beneficiaries or their dependents employed.
- **New Mexico SB 88** (2025) / **HB 71** (2025) Created Medicaid Trust Fund; Reallocated excess mineral leasing revenue to the Fund.
- **Utah HB 599** (2026) Appropriates funds from e-cigarette and nicotine fund to be used for substance use disorder services and treatments. Permits appropriated funds to be used as Medicaid matching funds.

Medicaid Covered State Services

States can consider options to leverage Medicaid funding for Medicaid covered services, delivered to eligible Medicaid beneficiaries in settings that would otherwise be covered by the state, specifically in school-based settings, corrections, and state employee health plans.

For example:

- *Medicaid School-Based Services in K-12 and Higher Education*
 - **Illinois HB 4201** (2022) Amends the University of Illinois Act, provides for a benefits navigator, which means an individual who is designated by the University for the purpose of helping students at the university determine eligibility for benefit programs and identify campuswide and community resource support, provides that the university shall designate a benefits navigator who has a detailed understanding of eligibility requirements for benefit programs and campuswide and community resource support and provide training.
 - **Virginia SB 73** (2026) This bill directs the Virginia Department of Medical Assistance Services to train local school division staff regarding Medicaid billing navigation for reimbursable services rendered at school sites. The training shall focus on understanding federal Medicaid billing processes, identifying eligible services, ensuring compliance, and developing best practices. DMAS shall coordinate with the Department of Education and provide such training virtually not less than semi-annually.
- *State Employee Health Plans*
 - **West Virginia SB 268** (2023) permits state employees who are eligible for Medicaid to choose to participate in the state Medicaid program and authorizes the Public Employees Insurance Agency to pay the state's share of the employee's participation.
- *Corrections – Suspending Medicaid Eligibility for Inpatient Services, Leveraging Pre-Release Services Coverage*
 - Connecting incarcerated and formerly incarcerated people to Medicaid coverage may also help state and local governments [offset costs](#) previously assumed by the criminal justice system.
 - All states are required to suspend Medicaid eligibility when a beneficiary becomes incarcerated. While Medicaid will not pay for health services while an individual is incarcerated (in a jail or prison), Medicaid can pay for services when an incarcerated individual receives care in a hospital or other institutional setting for more than 24 hours.
 - States also have [new requirements and flexibilities](#) to cover health services for incarcerated youth and young adults.
 - States can provide post-disposition youth and young adults with a limited set of benefits up to 30 days pre-release and can choose to provide full Medicaid benefits to pre-disposition youth and young adults while awaiting disposition of charges.
 - **Washington & Wyoming** submitted state plan amendments to cover eligible incarcerated youth and young adults with the full scope of Medicaid benefits while they are awaiting disposition of charges.

Resources

- [Medicaid Financing 101](#) | NCSL
- [Connecting Recently Released Prisoners to Health Care: Opportunities to Leverage Medicaid](#) | NCSL (2023)

- [Primer on Medicaid Financing Arrangements](#) | GAO – See this resource for visual representations of how Medicaid financing arrangements work.
- [Local Governments Play an Important Role in Medicaid Financing](#) | Health Affairs Forefront (2026)
- [CMS Needs More Information on States’ Financing and Payment Arrangements to Improve Oversight](#) | GAO (2020)
- [Financial Impact of Comprehensive School Medicaid Programs](#) | Healthy Students Promising Futures (2026) – describes state savings attributed to Medicaid school-based services, including example from Colorado.

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