



POLICY BRIEF | JUNE 2026

RESTORE MEDICAID

Stabilize the program that
millions of direct care workers
and consumers rely on.

Restore Medicaid

Congress and the states must act to protect Medicaid from further erosion while seeking sustainable financing solutions for long-term care.

INTRODUCTION

Medicaid, a joint federal and state program, is the primary payer of long-term services and supports (LTSS) in the United States.¹ As federal policy changes and funding decisions dramatically reshape Medicaid programs around the country, the consequences for LTSS are profound. Medicaid cutbacks are threatening access to essential care and support for millions of older adults and people with disabilities, while also undermining direct care job quality and workforce stability. The ripple effects over time will increase pressure on family caregivers, drive up costs of care overall, and ultimately weaken the economy.

This brief assesses the changing Medicaid landscape and proposes critical actions to mitigate the damage and build a strong direct care workforce and stable LTSS system for the future. The brief is part of a three-part series that also addresses how federal changes to immigration and labor policy are reshaping the landscape of long-term care and directly harming direct care workers. These briefs are designed to help policymakers, advocates, and others understand these federal policy changes and their interconnected impacts—and champion a better way forward.

Spotlight on the Direct Care Workforce

5.4 million personal care aides, home health aides, nursing assistants, and direct support professionals

85% Female

64% People of Color

28% Immigrants

\$17.36 Median Hourly Wage

\$25,998 Median Annual Earnings

36% Live in or Near Poverty

49% Access Public Benefits

31% Rely on Medicaid

772,400 New Direct Care Jobs Projected Between 2024-2034

9.7 Million Total Direct Care Job Openings Projected Between 2024-2034

How many home health aides have health insurance? They don't. Yet still they have to get up every day and go care for somebody else. And if they get sick for a day, they have to worry that they're not going to get paid for that day.

– Nicola Brown, Care Partner (CNA), Stone Mountain, GA

UNPRECEDENTED CUTS TO MEDICAID

The budget reconciliation act of 2025 (HR 1) enacted a slew of Medicaid cuts that doubly impact direct care workers as providers of Medicaid-funded services and as Medicaid users themselves.

Federal Cuts Jeopardize State Budgets

Drastic reductions in federal funding for Medicaid through HR 1 come at a time when states are already grappling with slower revenue growth and rising health care and LTSS costs.² In this context, HR 1 is expected to drive significant budget shortfalls nationwide that will require states to make difficult trade-offs within and across public programs and services, including but not only Medicaid. The resulting cutbacks will affect direct care workers' wages and job stability, as well as undermining their access to other much-needed benefits such as health insurance, food assistance, childcare subsidies, and more. At the same time, heightened federal scrutiny of state Medicaid programs is leading to higher compliance burdens on states and the withholding of federal funds, in direct contravention of the federal-state partnership that has defined Medicaid since its inception.³

States Reduce Access to Medicaid LTSS

In fiscal year 2022, the federal government provided nearly 70 percent of Medicaid funding.⁴ With limited options to overcome revenue shortfalls driven by HR 1, many states are already considering or implementing cuts to Medicaid coverage, benefits, and provider payments, with home and community-based services (HCBS) especially vulnerable because they are optional.⁵ For example, Colorado has proposed a number of cuts including reduced

provider rates and new spending caps and service limits across a number of Medicaid HCBS programs⁶; and Idaho's proposed fiscal year 2027 budget includes the extension of a four percent provider rate cut plus a \$22 million decrease in Medicaid spending in the general fund, amounting to \$45 million in total cuts.⁷

To note, a few states *are* making key investments while resources allow. California recently increased HCBS reimbursement rates for in-home supportive services to reflect the higher statewide minimum wage,⁸ for example, and Georgia's fiscal year 2027 budget includes \$5.5 million to expand HCBS program enrollment.⁹ The ultimate impact of HR 1 on state Medicaid programs will emerge over the next decade, depending on the decisions states make now and going forward.

Administrative Burdens Undermine Access to Health Care

HR 1 creates new enrollment and eligibility requirements in Medicaid that could significantly disrupt coverage for direct care workers, among others.¹⁰ Most notably, individuals enrolled through Medicaid expansion will be required to prove their compliance with "community engagement" requirements (also known as work requirements) and complete eligibility redeterminations twice annually.¹¹ These new hurdles are likely to cause eligible direct care workers to lose Medicaid coverage due to procedural or administrative challenges, further destabilizing an already strained workforce. Nebraska became the first state to implement Medicaid work requirements in May 2026, ahead of the federal deadline of January 1, 2027.¹²

Did You Know? Medicaid covers home and community-based services for 8.4 million people while also covering care for 720,000 nursing home residents across the country.¹³

WHY MEDICAID MATTERS FOR THE DIRECT CARE WORKFORCE

Direct care jobs are deeply tied to Medicaid. Because Medicaid accounts for nearly half of all LTSS spending and the federal government covers the majority of Medicaid costs, federal cuts to Medicaid will directly affect the workforce that provides these services.¹⁴

As states respond to federal cutbacks with a range of cost containment strategies, direct care workers will experience greater employment precarity and lower job quality—including through wage stagnation and reduced access to training and career development opportunities and employment benefits. These harms will exacerbate turnover and vacancy rates, which will put further stress on the remaining workforce, compromise access to care, and increase pressure on family caregivers to fill the gaps, with negative implications for their own health and labor force participation.

Medicaid also matters personally to direct care workers who rely on the program for their own and their families' coverage.¹⁵ Increased administrative requirements and eligibility barriers will likely cause many workers to lose coverage, creating additional financial insecurity, compromising their health and wellbeing, and pushing them to leave the field for jobs in other sectors that offer more reliable schedules and/or employer-sponsored health insurance.¹⁶

Did You Know? The Congressional Budget Office estimates that HR 1, the budget reconciliation act signed into law by President Trump in July 2025, will cut \$1 trillion from Medicaid over the course of the next 10 years.¹⁷



CALL TO ACTION

Today's policy choices will determine whether the direct care workforce—and the long-term care system this workforce sustains—can meet growing care needs into the future. The following recommendations describe what policymakers must do to mitigate recent assaults on Medicaid and build more stable, equitable care infrastructure across our country.

Restore and Strengthen Medicaid Funding for LTSS

Federal and state leaders should prevent any further erosion of Medicaid while proactively seeking out sustainable funding solutions for our nation's long-term care infrastructure, as demand for care continues to rise. One immediate step should be for federal leaders to curtail current efforts to destabilize and defund state Medicaid programs in the name of program integrity—and instead work with states to identify if and where additional data collection or oversight might be needed to protect the effective and efficient delivery of services.

To mitigate growing financial pressure on state Medicaid programs, federal and state leaders should also explore alternative financing models for LTSS. Washington State's WA Cares Fund, the first universal long-term care insurance program in the nation, provides a strong example to learn from and potentially replicate.¹⁸

Congress should also consider new federal approaches to financing long-term care beyond Medicaid, including the public-private partnership model put forward through the bipartisan WISH Act¹⁹ and the different financing models that have been implemented in other countries.²⁰

Minimize Burdensome Medicaid Requirements

State and Congressional leaders should work collaboratively to minimize loss of Medicaid coverage among eligible individuals, including many direct care workers, when implementing the work requirements and other changes mandated by HR 1. Although states will need to verify compliance with the work requirements mandate by January 2027, they still retain significant flexibility in how to implement them.²¹

For example, as of March 2026, 18 states had identified new data sources to facilitate automatic verification of exclusion or compliance and 14 states had plans to increase their staff capacity to verify exclusions or eligibility, reflecting those states' commitment to reducing individual administrative burdens and the risk of procedural disenrollments.²²

Congressional leaders should take further steps to mitigate harmful coverage losses by: supporting federal funds to states for modernizing their verification systems; directing the Centers for Medicare and Medicaid Services (CMS) to encourage streamlined verification processes; strengthening oversight and correction of procedural terminations; and expanding outreach and enrollment assistance funding to help direct care workers and other eligible individuals maintain coverage.

Invest in a National Direct Care Workforce Strategy

To meet our country's growing LTSS needs, state and Congressional leaders must prioritize sustained investment in the direct care workforce. A national direct care workforce strategy should include establishing universal entry-level competencies, stackable and

portable credentials, and integrated career pathways, underpinned by financing structures that support wage progression and retention.²³ Investing in the direct care workforce—our nation’s largest workforce—will pay dividends for individuals, families and communities, our health and long-term care systems, and our economy overall.

For more than three decades, PHI has provided evidence-based, non-partisan research, analysis, technical assistance, and advocacy to policymakers, advocates, employers, and other partners in the long-term care field. Known as the nation’s leading authority on the direct care workforce, we stand as a trusted resource ready to provide expert assistance in navigating complex policy and practice challenges and designing solutions that work effectively for direct care workers and those they support.

Please reach out to [Amy Robins, Senior Director of Policy](#), for more information and opportunities to collaborate.

NOTES

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ABOUT PHI

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

Drawing on more than 30 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver highquality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care.

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