



Here We Stand
For People. For Care.
For Medicaid.

FAQ

MEDICAID

1. What is Medicaid and who does it serve?

Medicaid is the largest source of health coverage in the country, serving more than 80 million people in the U.S. It supports a wide range of people in our communities, but especially children, older adults, people with disabilities, and families facing financial challenges. In our work, this often looks like a child accessing mental health care, a senior able to age safely at home, or a family member continuing to work while supporting a loved one.

[[Share State-Specific Data as Needed: Modern Medicaid Alliance](#)]

Behind every Medicaid statistic is a real person relying on consistent, quality care to stay healthy and finally stable.

2. Why should people who don't use Medicaid care about it?

Medicaid supports preventative care that allows people to access services early and consistently, helping children stay in school and older adults remain safely at home. It also plays a key role in stabilizing the healthcare force by ensuring care is available when and where it's needed. The result is less strain on emergency rooms and hospitals, lower costs, and healthier communities.

In short, Medicaid is one of the quiet foundations of community stability, and its benefits extend beyond those who are enrolled. You may not use it, but chances are someone in your neighborhood, your workforce, or your family does.

Everyone has a stake in protecting Medicaid.

POLICY IMPACTS

3. With states facing tight budgets, why should Medicaid take priority over other needs?

Medicaid is one of the most effective tools states have to manage both residents' health outcomes and long-term costs. Smart investments in preventative care and services like home- and community-based services help avoid more expensive emergency care down the line. When Medicaid is weakened, costs don't disappear. Instead, they shift to individuals, families, and hospitals in less efficient ways.

4. Would you agree with supporters who say work requirements promote accountability?

We all want strong accountability in Medicaid, with every dollar going to eligible individuals receiving covered, medically necessary services. Well-designed work requirements that include flexibility, reasonable exemptions, and clear communication can support this goal.

The fact is that most adults enrolled in Medicaid are already working, in school, or managing health conditions that make them exempt under current requirements. Many hold jobs with variable hours, unpredictable schedules, or limited transportation options. These realities can make consistent reporting difficult, even for those doing everything right.

When policies are overly rigid, they can introduce administrative hurdles that lead to coverage losses unrelated to employment. In these cases, people are more likely to lose coverage due to paperwork issues, missed deadlines, or job instability than a lack of willingness to work. These disruptions in coverage can make it harder to stay healthy and maintain employment over time. Rather than strengthening accountability, they can create gaps in care that add pressure on emergency rooms and hospitals.

A more effective approach is one that reflects how people actually live and work, supporting both a stable healthcare workforce and consistent access to care.

5. Critics warned of major coverage losses with the implementation of H.R. 1, the One Big Beautiful Bill Act, but those haven't fully materialized. Were those concerns overstated?

The full impact of recent policy changes has yet to be seen. For example, the [RAND Corporation](#) estimates there could be 7.6 million fewer Medicaid enrollees by 2034, largely driven by key provisions in the law, including updated work requirements, provider tax restrictions, and more frequent eligibility determinations-- many of which states are still in the process of implementing or operationalizing.

What we know from our work is that even incremental coverage disruptions can have serious consequences for real people. Coverage losses don't always show up all at once. They often happen gradually through "churn" or administrative complexity that causes gaps in access. The focus should remain on ensuring that eligible people can consistently stay connected to care.

People's lives depend on it.

6. Haven't most Medicaid coverage losses been tied to the post-pandemic unwinding rather than recent policy changes?

The unwinding period has been a significant driver of recent coverage losses, largely due to the scale and complexity of eligibility reviews following several years of continuous enrollment. But it also revealed something important: coverage is highly sensitive to administrative processes, and many eligible people can lose coverage simply because of paperwork complexity, not because they no longer qualify.

That lesson is especially relevant now. The changes under H.R. 1 introduce additional administrative requirements, including more frequent eligibility checks and new reporting expectations. We've already seen how increased complexity can disrupt coverage even for those who remain eligible. It results in gaps in care, delayed treatment, care delivery in higher-cost settings, and added strain on providers.

The need to keep systems straightforward, accessible, and focused on continuity of care has been a critical takeaway from the unwinding. When administrative burden increases, people fall through the cracks, and higher costs shift to families.

7. Are provider taxes essentially a financing workaround to increase federal Medicaid funding?

Provider taxes are among the tools states use, in collaboration with the federal government, to ensure access to care through Medicaid. This partnership is especially important for sustaining access in rural and underserved areas where provider capacity may already be limited.

We urge state leaders to pursue longer implementation timeframes that minimize the number of uninsured people while supporting stronger compliance. We also encourage common-sense strategies to address provider tax limitations-- approaches that promote long-term budget stability and help ensure that eligible individuals retain access to high-quality care.

WASTE, FRAUD AND ABUSE

8. What safeguards are currently in place to prevent fraud in home- and community-based services?

There are multiple layers of oversight at both the state and federal levels, including audits, provider screening, and ongoing monitoring. Agencies like the Centers for Medicare & Medicaid Services (CMS), along with inspectors general and other watchdogs, play a continuous role in identifying and addressing issues.

Lutheran Services in America members have long led the way as trusted providers in their communities with strong compliance processes and standards. Today, we continue to support strong Medicaid integrity and believe accountability and access must go hand in hand to ensure that every Medicaid dollar goes to eligible people receiving covered, medically necessary services.

9. How does the current focus on fraud compare to what you see as the biggest challenges in serving patients?

The biggest day-to-day challenges we see are ensuring people can access care consistently while meeting growing and more complex needs, particularly for older adults, people with disabilities, and families, including those seeking behavioral health support.

At the same time, workforce shortages remain a central pressure point, affecting access to services and continuity of care. Addressing fraud, waste, and abuse is also a core responsibility of Medicaid and an important part of maintaining trust. Strong



program integrity efforts help ensure that resources are used appropriately and that eligible individuals can rely on consistent, high-quality care.

For Lutheran Services in America members, the commitment to strong Medicaid integrity is reflected in the trust we have built within our communities over time -- trust grounded in reliable care, strong standards, and a shared focus on serving people with dignity.

10. We're hearing more about fraud in certain areas, specifically in hospice care and durable medical equipment. Does that reflect what you're seeing, or is something else driving the conversation?

There have been targeted issues in certain areas that deserve attention and action, but our experience is that those cases are not representative of the broader system or the vast majority of providers delivering quality care every day.

It's important to address specific problems directly without undermining access to essential services for people who need them most.

11. Critics have claimed that expanding coverage previously came at the expense of oversight. Has that been something you've seen?

Federal law has always required program integrity and accountability alongside coverage expansion. The real issue isn't whether to address fraud because that has always been a core part of Medicaid health and service delivery, but rather how to continue to weed out a small number of bad actors that jeopardize the long-standing commitment to the integrity of the vast majority of providers.

12. Why does Medicaid allow family members to be paid as caregivers?

Workforce shortages across the healthcare system have made it increasingly difficult for individuals to access consistent, quality, long-term care. As a result, families are often called on to step in quickly, especially following an emergency health event involving an older adult or child with complex needs.

Medicaid plays a critical role in addressing support gaps by allowing trusted individuals to be compensated for providing care when traditional providers are unavailable. This approach helps ensure continuity of care, supports independent living, and helps prevent more costly health outcomes.



By stabilizing care in the home and supporting the broader care workforce, Medicaid helps maintain access to essential services while managing costs across the local healthcare system.

HERE WE STAND

13. What is the Here We Stand Campaign and what is it trying to achieve?

Here We Stand is an effort to highlight the real-life impact of Medicaid for people and in communities across the country. It focuses on sharing stories, reinforcing what works, and supporting fact-based conversations about how to strengthen access to care. At its core, the campaign is about ensuring lawmakers understand the human impact behind policy decisions.

14. What role do nonprofit and faith-based providers play in the Medicaid system?

As nonprofit, faith-based providers, Lutheran Services in America members are mission-driven and reinvest every dollar back into care, not profits. We often serve people who have nowhere else to turn, in both urban and rural areas, and we do this work while maximizing resources. Our members often combine Medicaid funding with charitable contributions, philanthropic support, and local partnerships.

Medicaid enables us to deliver care that is tailored to each person's needs, [grounded in evidence-informed practices, and responsive to what communities are experiencing](#). This approach is shaped by data, real-world experience, and strong local relationships, ensuring care remains both effective and accountable to stakeholders.

15. How do you respond to those who say Medicaid advocacy is too political?

Lutheran Services in America represents nearly 300 nonprofit and faith-based providers across the country. Our members are deeply embedded in their communities, having emerged in response to local needs and built trust over generations by delivering care to residents who often have no other options. That gives us a unique voice in this conversation.

Our focus is on people, not politics. We are sharing what we see every day: how access to care affects families, communities, and health outcomes.



We're here to protect what works and speaking up reflects our responsibility to those we serve.

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