How Medicaid Helps Fund K–12 Education

Using State Data to Observe the Targeted Role Medicaid Funding Plays in Supporting Health Services in Public Schools

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Medicaid is a joint federal and state program that provides health insurance for almost 70 million low-income individuals, older adults, and people with disabilities and their families. In 2025, children made up 48 percent of enrollees.[1]

In addition to serving as a critical source of health insurance for enrolled individuals, Medicaid provides critical health care in public school districts when Medicaid-enrolled students receive certain health services through their public school, including services required in students' Individualized Education Plans (IEPs) and vision screenings (Herring et al. 2023).

Medicaid programs are facing unprecedented cuts as a result of H.R. 1 (also known as the One Big Beautiful Bill Act), the budget reconciliation law passed in July 2025 that is anticipated to decrease Medicaid enrollment and reduce federal Medicaid spending by close to $1 trillion. Understanding the financial contribution of Medicaid to district revenues before H.R. 1 can help education leaders more effectively anticipate the law's impact. This essay describes the role Medicaid played in providing health care funding to schools before H.R. 1. Using data from 2014 to 2024, we provide estimates of school-based federal Medicaid reimbursement to schools, relative to total K–12 revenue, by state. We document our methodology in a technical appendix.

Our estimates are not projections of how federal cuts will affect schools. But by demonstrating how much Medicaid has historically supplemented resources for K–12 education, we hope to equip state education and Medicaid officials, state policymakers, school districts, school-based health care providers, and advocates and funders with the information they need to respond to impending federal Medicaid changes and the downstream (e.g., state) shifts they may prompt.

This essay proceeds with brief background on how Medicaid operates in schools and a summary of federal changes to Medicaid and what they could mean for schools and states. We then present and discuss four figures that describe the role Medicaid has played in school funding recently. We close with strategic considerations for state and local education leaders. Data and methods explanations can be found in the appendix.

How Medicaid Operates in Public Schools

Medicaid shows up in schools directly by reimbursing schools for health services provided to Medicaid-enrolled students. This includes the provision of eligible direct services; early and periodic screening, diagnostic, and treatment benefits; and administrative services. The specifics of what services are covered, who can provide them, and reimbursement rates vary state to state above a federal floor, but in all states, schools can bill Medicaid for eligible services mandated in Medicaid-enrolled students' IEPs. Some states have expanded school Medicaid to allow reimbursement for eligible services provided to Medicaid-enrolled students who do not have an IEP, following 2014 federal guidance (the Free Care Rule reversal).

Schools can receive Medicaid reimbursement either from the state Medicaid agency or through arrangements with managed care organizations. Schools (or their districts) provide and document services delivered; states administer the Medicaid program by setting policies, enrolling providers, and processing or overseeing payments; and the federal government provides matching funds and regulatory guidance. Districts then get reimbursed for the federal government's share of the costs while many states require school districts to cover the state's portion of the costs.

Health care services provided by schools and funded by Medicaid enable students to be more successful in school and life.

Medicaid also affects schools more indirectly. Forty-four states use Medicaid participation to directly certify students for free meals in schools in addition to using Supplemental Nutrition Assistance Program (SNAP) data, a process called direct certification.[2] Many state education funding formulas rely on direct certification counts or on free and reduced-price meal counts derived in part from direct certification to allocate additional funding for low-income students.

What Federal Changes to Medicaid Could Mean for States and Schools

Among several changes that will affect state budgets (e.g., SNAP modifications), H.R. 1 enacted several Medicaid policy changes, including establishing work requirements and requiring more frequent eligibility determinations for adults enrolled in the Affordable Care Act's expansion, eliminating eligibility for certain immigrant groups, and restricting Medicaid financing options for states (e.g., prohibiting new provider taxes). Most of H.R. 1's Medicaid provisions will be implemented by January 2027, but some will not take effect until 2029.[3]

The Congressional Budget Office projects H.R. 1 will reduce Medicaid enrollment by 7.5 million people over the next 10 years and reduce federal Medicaid spending by more than $900 billion[4] across that period.[5] Though children's eligibility is largely unaffected by H.R. 1, some coverage losses could occur among children.[6] For example, we might see a spillover or reverse "welcome mat" effect, whereby children who are still eligible for Medicaid do not remain enrolled because of provisions that impede their parents' eligibility and enrollment (Hudson and Moriya 2017). Additionally, new work requirements for some parents of children ages 14 and older are projected to reduce Medicaid enrollment among parents of children in this age group (Buettgens et al. 2026), which could translate to disproportionately higher risk of coverage loss among high school students (ages 14 to 18). In addition, eligibility for a very small number of children may be directly affected under the law's restriction of eligibility for Medicaid coverage for some lawfully present immigrants.[7]

When faced with a Medicaid funding gap, states could adjust eligibility, benefits, or reimbursement to reduce Medicaid spending. States have considerable latitude over their Medicaid programs, in terms of optional eligibility, benefits, provider reimbursement, and funding mechanisms. For example, states could allocate more of their state budgets to Medicaid to cover the funding gap, reduce payment rates to health care providers, limit certain optional benefits, enforce harsher eligibility and certification or verification requirements, or do some or all of the above.[8] Alternatively, states could raise revenues, such as through increased taxation, or reduce spending outside of Medicaid on other state expenses.

Thus, we can anticipate a few ways H.R. 1 could affect state K–12 revenues:

1. Schools may see fewer revenues from Medicaid. If student enrollment in Medicaid declines or if the Medicaid program cuts back on eligible services or reimbursement rates to address budget shortfalls, schools will see fewer Medicaid dollars while still (under current disability law) being required to provide services that are mandated under a student's IEP.

2. If student Medicaid enrollment declines, fewer students may be counted as low income for other purposes. For the 44 states that use Medicaid and SNAP participation to certify students for free meals, Medicaid enrollment declines among children could mean reduced counts of students in need, which in turn means public schools serving those students would qualify for less support.
3. Medicaid may crowd out education spending as states try to close federal gaps. Medicaid is the second-largest share of state spending from their own funds. K–12 education is the largest. Federal Medicaid funding is the largest source of federal funds to states (NASBO 2025). Federal cuts are anticipated to affect every state, though to differing degrees. Cuts may lead states to try to bridge funding holes by decreasing other large spend areas, with K–12 education being a potentially appealing option because of its size.

Four Figures Demonstrating the Substantial, Yet Targeted, Role Medicaid Plays in School Funding

FIGURE 1

School-Based Medicaid Spending in Fiscal Year 2024

In fiscal year 2024, school-based Medicaid spending accounted for at least $8.1 billion in total service and administration expenses

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Sources: Medicaid Budget and Expenditure System, Financial Management Report for fiscal year 2024 (available from "Expenditure Reports from MBES/CBES," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes), Financial Management Report Net Expenditures file (from the same source), ADM-National Totals (total computable, federal share, and state share of school-based administration expenditures), and MAP-National Totals (total computable, federal share, and state share of school-based services expenditures). See also Akash Pillai, Elizabeth Williams, and Robin Rudowitz, "Medicaid and Upcoming State Budget Debates," KFF, January 23, 2026, https://www.kff.org/medicaid/medicaid-and-upcoming-state-budget-debates/.

Notes: ADM = Administration; MAP = Medical Assistance Program. Single-year totals computed from publicly available Centers for Medicare & Medicaid Services data should be interpreted with caution because of differences in state reimbursement timing. We include this one-year estimate in a departure from the five-year averages we use otherwise for comparison with other single-year estimates. See Healthy Schools, Promising Futures (HSPF), "Medicaid Provides More Than $8 Billion Annually to Support School-Based Health Services" (HSPF, 2026).

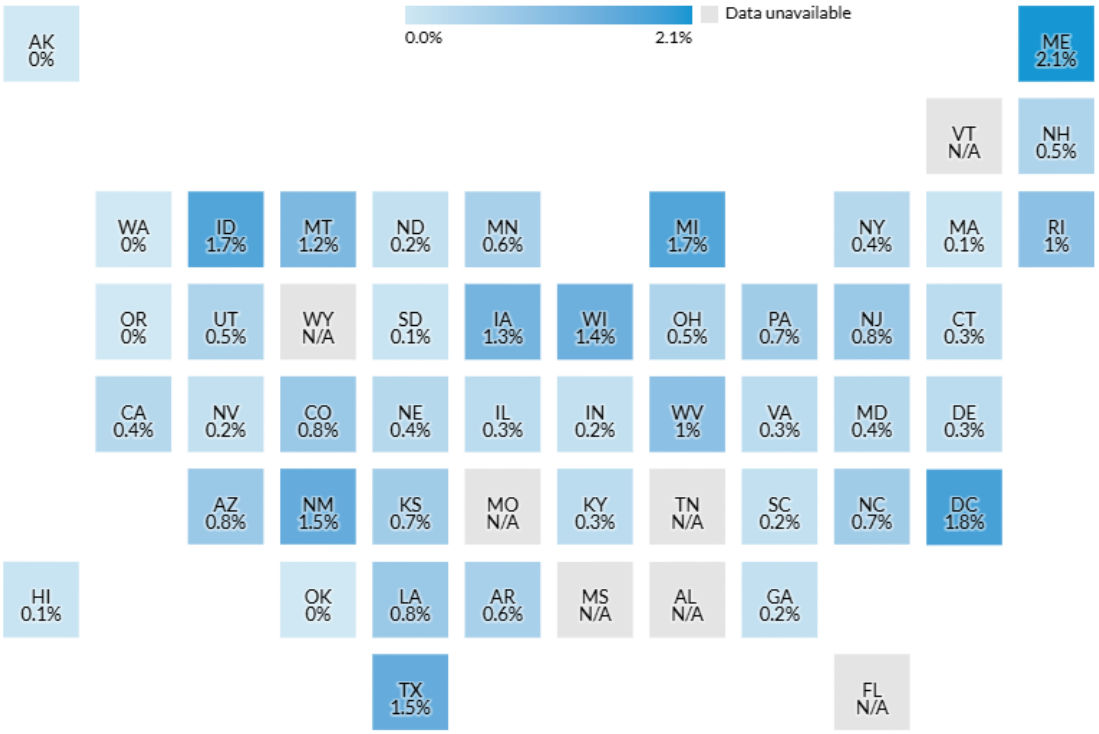
Medicaid accounted for at least $8.10 billion in school revenue in 2024.[9] This includes $4.43 billion from the federal government and $3.60 billion from states, though most states require schools to cover some or all of the nonfederal share of costs using such mechanisms as intergovernmental transfers and certified public expenditures (MACPAC 2025). The funds Medicaid brings into schools are used to pay for health-related staff and personnel, such as nurses and psychologists, mental and behavioral health services, and assistive technology and specialized equipment (Mandle et al. 2025). Given inconsistencies in Medicaid administration and expenditure reporting

processes (see appendix A), this $8.1 billion is a floor. For example, expenditures on services provided to students without individualized education plans (IEPs) are undercounted.

FIGURE 2

Federal School-Based Medicaid Spending as a Percentage of Total K–12 Revenue, Average 2020–24

Federal school-based Medicaid spending makes up 0.1 to 2.0 percent of total public K–12 revenue by state



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Source: Medicaid Budget and Expenditure System, Financial Management Reports for fiscal year 2020 through fiscal year 2024 (available from "Expenditure Reports from MBES/CBES," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes). Total K–12 education revenue is state-level data from National Center for Education Statistics' Common Core of Data.

Notes: N/A = not available. *N* = 44 states with full data from 2020 to 2024. Amount is for federal Medicaid share for school-based service and administration expenses only (not including supplemental support from the American Recovery and Reinvestment Act or from pandemic-related support). Because expenditure reimbursement data may represent different years of administration by state, data are not adjusted for inflation. Visit our webpage for an interactive version of this map that presents several of the policy context considerations (e.g., school Medicaid expansion and Affordable Care Act Medicaid expansion) discussed below alongside school-based Medicaid spending estimates.

We see substantial cross-state variation in federal school Medicaid revenue as a share of total K–12 funding, ranging from well under 0.5 percent in some states to 2.0 percent or more in others (figure 2). States including Maine, the District of Columbia, and Michigan are at the high end, while states such as Alaska, Oregon, Oklahoma, and Washington appear at the low end. Most states cluster in the middle, between 0.8 percent and 1.5 percent. Even in the highest-ranking states, however, federal Medicaid reimbursement represents a relatively small share of overall K–12 revenue, suggesting it plays a targeted rather than foundational role in school finance.

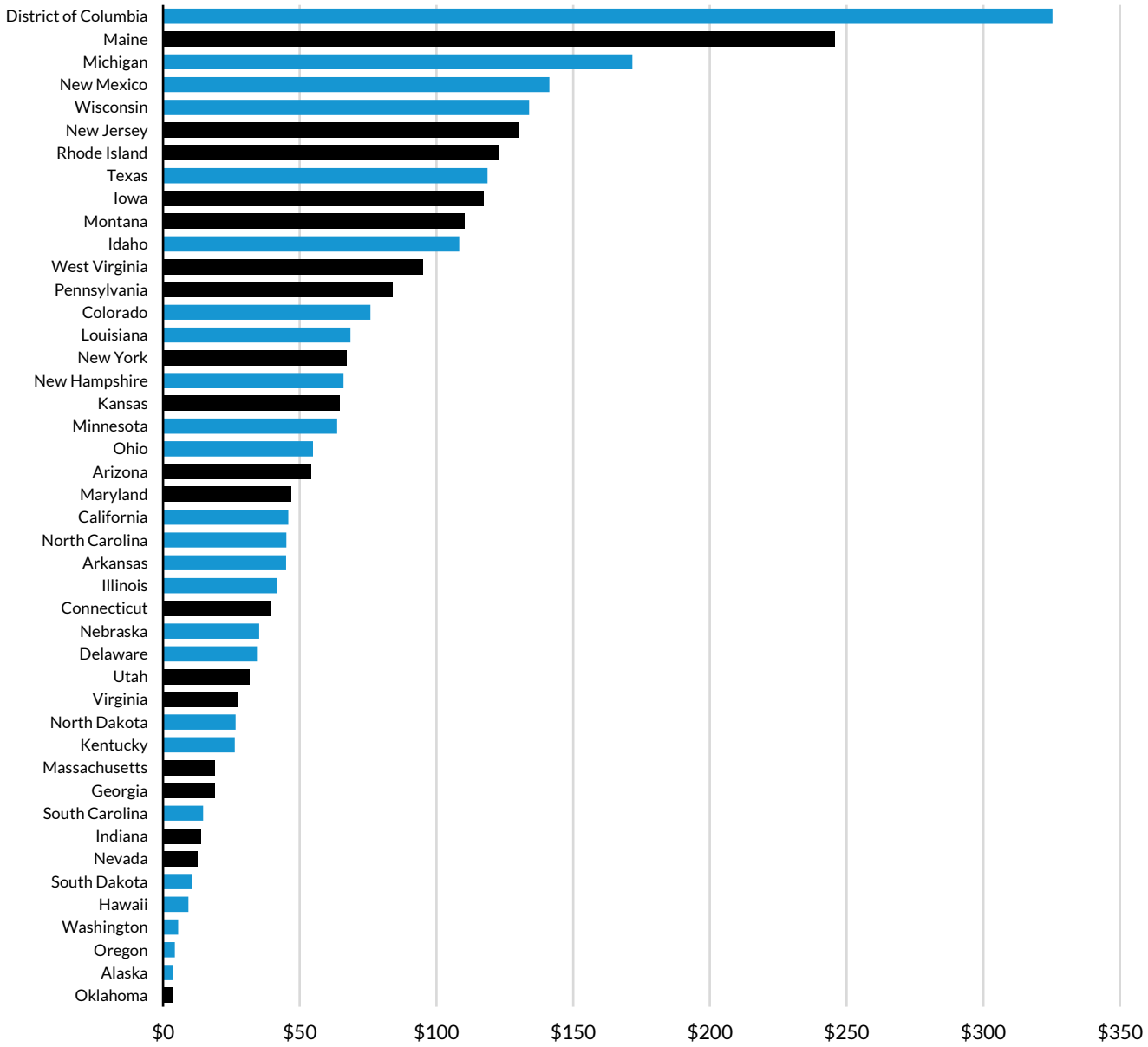
Several factors may help explain these patterns. States that have expanded school-based Medicaid billing to allow reimbursement for services provided to all Medicaid-enrolled students, not just those with IEPs, tend to draw down more Medicaid revenue, though the data undercount expenditures on students without IEPs (HSPF 2022).

Michigan and Colorado, for example, have expanded their school Medicaid program. In states that have not expanded, that have expanded only recently, or that have faced greater administrative upheaval or slower school district uptake in their implementation of school-based Medicaid expansion (e.g., Oregon), revenue share is generally lower. Medicaid expansion through the Affordable Care Act may also increase the number of enrolled students (Haley et al. 2021), perhaps because of the welcome mat effect, whereby children eligible for Medicaid are more likely to become enrolled because their parents are eligible and enrolled. Differences in state-level child poverty rates likely shape student Medicaid eligibility and therefore school Medicaid revenues. For example, states such as New Mexico and Louisiana, which often rank among the highest-poverty states, have relatively higher Medicaid revenue shares.[10] Differences in the strength of state and district administrative infrastructure for claiming federal funds likely affect how fully states convert eligibility into actual school funding. See appendix B for state-level policy context.

FIGURE 3

Average School-Based Medicaid Spending per Pupil, 2020–24

Federal school-based Medicaid spending accounts for a few dollars up to about $325 in per pupil revenue by state



School Medicaid spending per pupil, average 2015–19

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Sources: Medicaid Budget and Expenditure System, Financial Management Reports for fiscal year 2020 through fiscal year 2024 (available from "Expenditure Reports from MBES/CBES," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes). Total K–12 education revenue is state-level data from National Center for Education Statistics' Common Core of Data. School Medicaid Expansion data come from "School Medicaid Expansion Map," Healthy Students, Promising Futures, accessed April 27, 2026, https://healthystudentspromisingfutures.org/map-school-medicaid-programs/.

Notes: *N* = 44 states with full data from 2020 to 2024. The blue bars indicate states that have expanded school Medicaid; the black bars indicate states that have not expanded school Medicaid as of March 2026. Amount is for federal Medicaid share for school-based service and

administration expenses only (not including supplemental support from the American Recovery and Reinvestment Act or from pandemic-related support). Because expenditure reimbursement data may represent different years of administration by state, data are not adjusted for inflation.

We see substantial cross-state variation in school Medicaid spending per pupil (total K–12 enrollment). The District of Columbia spends the most—well above $300 per pupil—followed by Maine and Michigan, which are also notably higher than most states. A second tier—including states such as New Mexico, Wisconsin, and New Jersey—falls in a middle band that spends $100 to $150 per pupil. At the low end, states such as Alaska, Oklahoma, and Oregon spend only a few Medicaid dollars per pupil. In practice, Medicaid dollars are spent on Medicaid-enrolled students, not on all students as estimated above, but a per pupil estimate allows education leaders to easily see the scale of revenue for their state. Evaluating Medicaid revenues compared with overall K–12 enrollment therefore reduces the scale of Medicaid's impact for the students who receive it.

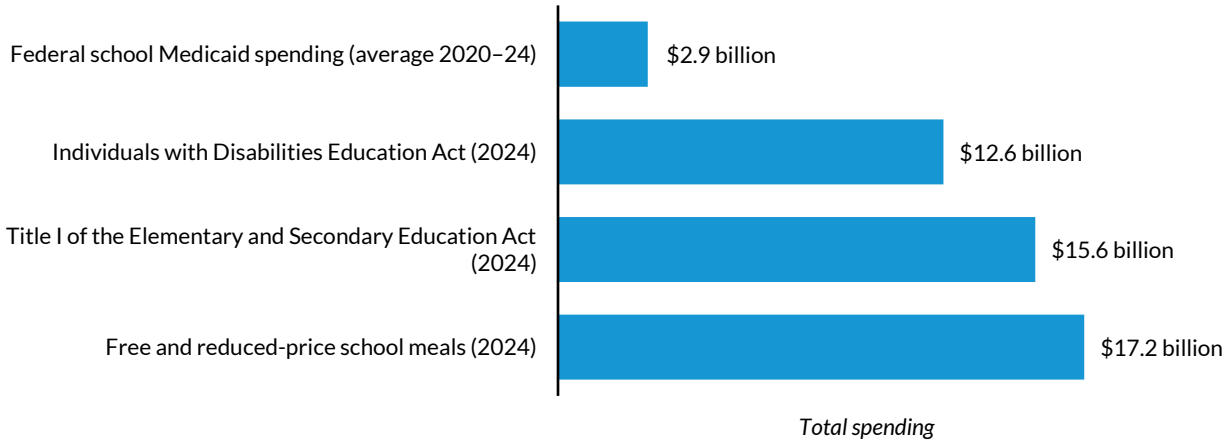
The gap between the highest and lowest states is more than tenfold, indicating that federal Medicaid rules alone do not determine how much funding schools receive. Some of the policy and contextual factors described in the previous figure apply here as well (appendix B) and can be accessed on the interactive online version of figure 2. States that have expanded school-based Medicaid billing to cover services for all Medicaid-enrolled students—not just those with IEPs—such as Michigan, tend to capture more reimbursement. Higher child poverty and Medicaid enrollment rates, as in New Mexico, also increase the pool of billable services, though poverty alone does not guarantee higher spending. Administrative capacity, state guidance, and student enrollment size—particularly in smaller systems such as DC—likely further amplify these differences.

To view an interactive map–based version of this figure, visit our web page.

FIGURE 4

Spending on Federal Programs for K–12 Education

Federal dollars for school-based Medicaid spending are small compared with spending on other federal K–12 programs



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Sources: Federal school Medicaid five-year average comes from Medicaid Budget and Expenditure System, Financial Management Report for fiscal year 2024 (available from "Expenditure Reports from MBES/CBES," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes), Financial Management Report Net Expenditures file (from the same source), ADM-National Totals (federal share of school-based administration expenditures) and MAP-National Totals (federal share). IDEA data come from "IDEA Section 618 Data Products," US Department of Education, last updated December 19, 2024, https://data.ed.gov/dataset/idea-section-618-data-products, and from "State Nonfiscal Public Elementary/Secondary Education Survey Data," US Department of Education, Institute of Education Sciences, National Center for Education Statistics (NCES), accessed April 9, 2026, https://nces.ed.gov/ccd/stnfis.asp. (This table was prepared in December 2023.) Title I data come from the NCES Digest of Education Statistics, table 204.04. (This table was prepared June 2023.) Free and reduced-price meal data come from "Child Nutrition Programs—National School Lunch Program," US Department of Agriculture, Economic Research Service, last updated August 5, 2025, https://www.ers.usda.gov/topics/food-nutrition-assistance/child-nutrition-programs/national-school-lunch-program.
Note: ADM = Administration; IDEA = Individuals with Disabilities Education Act; MAP = Medical Assistance Program.

Comparing federal funding for school Medicaid with other federal sources of K–12 funding reinforces the small role the federal government plays in supporting schools via Medicaid (figure 4). Federal funding for school Medicaid averages about $2.9 billion annually (2020–24), far below K–12 funding via the Individuals with Disabilities Education Act ($12.6 billion in 2024), Title I of the Elementary and Secondary Education Act ($15.6 billion in 2024), and the National School Lunch Program's free and reduced-price meals component ($17.2 billion in 2024). Although school Medicaid is an important focal funding source—particularly for health-related services and for low-income children—it represents a small fraction of overall federal K–12 spending compared with these larger, formula-driven education and nutrition programs. Still, it accounts for 6 percent of funding, and given how tight state budgets are, any reduction would present a challenge.

Strategies for School and State Leaders

The analyses above suggest that Medicaid plays a substantial but targeted role in funding school-based health services. The amount of revenue schools receive directly from Medicaid is limited (though, as noted, our estimates represent a floor): 2 percent of K–12 spending in the state with the highest share but much less than that in most states.

These shares are likely higher in some districts that serve higher concentrations of low-income, Medicaid-enrolled students, especially those with formally acknowledged disabilities (i.e., an IEP). And when looking at state-level aggregates, we should not forget the specific students who rely on Medicaid-covered services in school—such as physical, occupational, and speech therapy; nursing; and behavioral health—to thrive in the classroom and beyond. Substantial evidence finds that Medicaid-supported school-based health services help students access health care and improve well-being (Heinrich et al. 2025; Meinhofer et al. 2025). For the specific students who lose access to these services because of any of the mechanisms we discuss here—or others—the impacts will be meaningful, even if the overall revenue effects for schools are marginal.

Still, H.R. 1's major changes generally do not directly target students or children. Although states may make changes to the Medicaid programs that affect covered services and reimbursement rates, early indicators suggest that the loss of direct revenue is likely to be limited. We will know more as state responses become clearer and as more of the H.R. 1 Medicaid changes are implemented over the next five years (Serafi et al. 2025).[11]

Instead, the more important dynamics for K–12 spending are likely to be increased competition for state funds (affecting overall education funding levels) and changes in the distribution of funds attributable to the implications for measuring economic disadvantage (Gutierrez 2026).

State and local leaders who are concerned about long-run changes in K–12 education revenue attributable to Medicaid and downstream changes can take some mitigating steps now. To preserve Medicaid spending in schools, education leaders can help keep students (and families) enrolled by leaning on schools' ability to receive reimbursement for administrative costs. State leaders may consider expanding their school Medicaid program to enable states and school leaders to maximize their Medicaid reimbursements (Healthy Schools Campaign 2025).

States that are concerned about a broader impact on identification of students who are directly certified as low income through Medicaid could consider rebasing their ISP calculation, which is typically conducted every four years, to capture current student participation if they anticipate a decline in Medicaid enrollment among students. In the longer term, states could consider using alternate sources of data on student socioeconomic status, such as state income tax data.

Further study could zoom in to understand how district-level patterns play out within the state-level patterns we describe here. As state-specific enrollment projections for children become available and states continue to respond in the current legislative session and beyond, more forward-looking analysis can aim to produce percentage revenue effects for schools.

Appendix A. Data and Methods

For this analysis, we use state-level data from the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) maintained by the Centers for Medicare & Medicaid Services (CMS).[12] These data report the federal and state shares of Medicaid-allowable and claimable school-based service and administrative expenditures. We use the most recent information available, which is from fiscal year 2024, combined with previous years of data (2020–23) to assess school-based Medicaid reimbursements overall and by state. For most analyses, we focus on the federal share of school Medicaid reimbursement to isolate the portion that is most directly affected by H.R. 1 and given that most states pass the state share of school Medicaid costs on to school districts. The exception to this is figure 1, which presents the overall picture of total school-based Medicaid spending by source (state, federal, and other).

Limitations

Medicaid data are subject to various limitations that reflect the systemic challenges of implementing a program at the intersection of local, state, and federal policy contexts and community needs. We acknowledge several relevant policy considerations and related limitations with respect to school-based Medicaid data and how we contend with them.

CMS's Free Care Rule Reversal

The Free Care Rule reversal issued by CMS in 2014 enables states to expand the school Medicaid program to provide eligible services to all Medicaid-enrolled students as opposed to those with an IEP (MACPAC 2024), thereby extending Medicaid's reach. As of 2025, 27 states have opted into the free care reversal, allowing for Medicaid-enrolled students to receive Medicaid coverage regardless of IEP status.[13] Approaches to expanding look different from one state to the next, such as in terms of the breadth of services covered (HSPF 2023). This variety and expansion of reporting complexities make it more difficult to compare across years and geographies (Lim et al. 2024). MBES data do not reflect school Medicaid expansion; they best capture expenditures for students with an IEP and seem uneven in how well they capture expenditures for non-IEP students. The guidance to states for this reporting might also be interpreted by some as voluntary in terms of MBES reporting for non-IEP services.

The COVID-19 Public Health Emergency

The COVID-19 public health emergency disrupted school-based Medicaid services and likely contributed to decreasing data quality.[14] School closures led to steep declines in in-person services during 2020 and 2021, while subsequent telehealth flexibilities issued by CMS were adopted unevenly across states (NCES 2022; Randi and Girmash 2021).[15] Administrative strain and remote operations delayed documentation and claims submission, increasing lag times and incomplete reporting. At the same time, continuous Medicaid enrollment policies expanded coverage and increased the number of children enrolled during and in the years following the pandemic.

Data Lags Resulting from Administrative Burdens

School-based Medicaid costs are billed through a process that reconciles provider reimbursements at the end of the year against the interim rate they are paid during the year. The multistep process of settling costs (Herring et al. 2023) contributes to the one-to-two-year lag in Medicaid expenditure data. In addition, the total CMS remittance data combine adjusted data from different fiscal periods (e.g., year-round fee-for-service claims and final annual reconciled provider payments). So the numbers reported for a given year may not have actually been observed in that year. Administrative burden is disproportionately felt by high-need districts (AASA 2019).

Managed Care Blind Spots

Among the 42 states that administer Medicaid through managed care organizations,[16] encounter data are often less complete, slower to be finalized, and more inconsistently incorporated into public reporting than traditional fee-for-service claims (OIG 2021; Crossette-Thambiah et al. 2024). Carve-outs for services such as behavioral health can further fragment reporting, making it difficult to capture the full scope of school-based care.[17] Publicly available data may understate service volume or misrepresent year-to-year patterns of utilization in managed care environments. We make note of these states in the appendix table B.1. Certain managed care payment structures (e.g., capitation as opposed to fee-for-service) that do not distinguish by service setting may also make it difficult to isolate school-based services, especially for students without IEPs.

Lack of Granularity

Publicly available data on school-based Medicaid spending are largely released only in aggregated, state-level summaries—often through CMS—rather than at the district, school, or student level. These datasets typically report total expenditures or broad service categories without detail on service intensity, provider type, student disability

category, or demographic characteristics (Arbogast et al. 2022). Thus, our analyses do not disaggregate in any of these ways.

Five-Year Averages and Other Constructed Measures

Because of the inconsistencies, lags, and disruptions in MBES data generally and especially in the recent past, we present five-year averages. To be included in most of the analyses, a state had to have MBES data for each year in the five-year window we examined (n = 44)[18] for 2020 to 2024. The exception to this is figure 1, which presents the most recent totals (2024) alone to aid comparison with other published figures (HSPF 2026).[19] Although not shared here, we also ran the relevant following analyses for 2015 to 2019, and they are available upon request.

By combining MBES/CBES data with state-level total enrollment counts, state-level total K–12 revenues, and total federal K–12 revenues by program, we constructed the measures we highlight in figures 2 through 4. This includes federal school-based Medicaid revenues as a percentage of total K–12 revenues (five-year average federal school-based health Medicaid expenditures divided by total K–12 revenues by state) and federal per pupil Medicaid reimbursement by state (five-year average federal school-based health Medicaid expenditures divided by total K–12 enrollment by state). Figure 4 compares the five-year average total federal school Medicaid spending with spending on other large federal K–12 education revenue sources, including Title I, the Individuals with Disabilities Education Act, and free and reduced-price school meals.

Additional methodological explanation and technical documentation can be found beneath each figure.

Appendix B. Federal School Medicaid Spending

TABLE B.1

Federal School Medicaid Spending, by State, Alongside Relevant Policy Context

State	Average school-based Medicaid spending per pupil, 2020–24	Average federal school-based Medicaid spending as a share of total K–12 revenue, 2020–24	School-based Medicaid expansion status[a]	ACA Medicaid expansion status[b]	Medicaid expansion trigger law status[b]	State uses Medicaid managed care model[c]	Medicaid enrollment among children, Dec. 2024[d]	Number of children in poverty, 2024 (poverty rate)[e]
AK	$3.73	0.0%	Not adopted	Adopted	No trigger law	No	82,744	22,000 (13%)
AL	N/A	N/A	Not adopted	Not adopted	No trigger law	No	493,403	226,000 (20%)
AR	$45.04	0.6%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	338,784	138,000 (20%)
AZ	$54.21	0.8%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	693,992	228,000 (15%)
CA	$45.83	0.4%	Adopted	Adopted	No trigger law	Yes	3,752,849	1,208,000 (15%)
CO	$75.81	0.8%	Adopted	Adopted	No trigger law	Yes	391,003	137,000 (11%)
CT	$39.15	0.3%	Adopted	Adopted	No trigger law	No	344,810	96,000 (13%)
DC	$325.31	1.8%	Not adopted	Adopted	No trigger law	Yes	78,036	37,000 (28%)
DE	$34.39	0.3%	Not adopted	Adopted	No trigger law	Yes	97,816	26,000 (13%)
FL	N/A	N/A	Not adopted	Not adopted	No trigger law	Yes	2,251,432	685,000 (15%)
GA	$18.89	0.2%	Adopted	Not adopted	No trigger law	Yes	1,143,434	405,000 (16%)

State	Average school-based Medicaid spending per pupil, 2020–24	Average federal school-based Medicaid spending as a share of total K–12 revenue, 2020–24	School-based Medicaid expansion status[a]	ACA Medicaid expansion status[b]	Medicaid expansion trigger law status[b]	State uses Medicaid managed care model[c]	Medicaid enrollment among children, Dec. 2024[d]	Number of children in poverty, 2024 (poverty rate)[e]
HI	$9.31	0.1%	Not adopted	Adopted	No trigger law	Yes	129,252	33,000 (12%)
IA	$117.21	1.3%	Not adopted	Adopted	Has a trigger law in place that requires some action to mitigate the fiscal impact of the loss of federal funds if the enhanced federal matching rate drops	Yes	250,172	98,000 (14%)
ID	$108.35	1.7%	Not adopted	Adopted	Has a trigger law in place that requires some action to mitigate the fiscal impact of the loss of federal funds if the enhanced federal matching rate drops	Yes	136,702	51,000 (11%)
IL	$41.53	0.3%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	1,138,647	375,000 (14%)
IN	$13.72	0.2%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	673,597	254,000 (16%)
							206,243	
KS	$64.56	0.7%	Not adopted	Not adopted	No trigger law	Yes	493,392	87,000 (13%)
KY	$26.25	0.3%	Adopted	Adopted	No trigger law	Yes	562,340	192,000 (19%)
LA	$68.51	0.8%	Adopted	Adopted	No trigger law	Yes	129,252	264,000 (25%)
MA	$18.99	0.1%	Adopted	Adopted	No trigger law	Yes	510,971	149,000 (11%)
MD	$46.75	0.4%	Adopted	Adopted	No trigger law	Yes	482,812	143,000 (11%)
ME	$245.73	2.1%	Not adopted	Adopted	No trigger law	No	118,540	30,000 (13%)
MI	$171.61	1.7%	Adopted	Adopted	No trigger law	Yes	750,011	373,000 (18%)

State	Average school-based Medicaid spending per pupil, 2020–24	Average federal school-based Medicaid spending as a share of total K–12 revenue, 2020–24	School-based Medicaid expansion status[a]	ACA Medicaid expansion status[b]	Medicaid expansion trigger law status[b]	State uses Medicaid managed care model[c]	Medicaid enrollment among children, Dec. 2024[d]	Number of children in poverty, 2024 (poverty rate)[e]
MN	$63.65	0.6%	Adopted	Adopted	No trigger law	Yes	581,991	121,000 (10%)
MO	N/A	N/A	Adopted	Adopted	No trigger law	Yes	465,013	207,000 (15%)
MS	N/A	N/A	Not adopted	Not adopted	No trigger law	Yes	313,884	166,000 (25%)
MT*	$110.06	1.2%	Not adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	No	71,743	25,000 (11%)
NC	$45.14	0.7%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	1,076,406	382,000 (17%)
ND	$26.52	0.2%	Adopted	Adopted	No trigger law	Yes	46,739	23,000 (13%)
NE	$35.15	0.4%	Not adopted	Adopted	No trigger law	Yes	137,766	57,000 (12%)
NH	$65.97	0.5%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	71,080	16,000 (7%)
NJ	$130.04	0.8%	Not adopted	Adopted	No trigger law	Yes	553,953	236,000 (12%)
NM	$141.27	1.5%	Adopted	Adopted	Has a trigger law in place that requires some action to mitigate the fiscal impact of the loss of federal funds if the enhanced federal matching rate drops	Yes	282,468	95,000 (22%)
NV	$12.55	0.2%	Adopted	Adopted	No trigger law	Yes	278,242	99,000 (15%)
NY	$67.12	0.4%	Not adopted	Adopted	No trigger law	Yes	1,781,671	697,000 (18%)
OH	$54.84	0.5%	Not adopted	Adopted	No trigger law	Yes	971,120	417,000 (16%)

State	Average school-based Medicaid spending per pupil, 2020–24	Average federal school-based Medicaid spending as a share of total K–12 revenue, 2020–24	School-based Medicaid expansion status[a]	ACA Medicaid expansion status[b]	Medicaid expansion trigger law status[b]	State uses Medicaid managed care model[c]	Medicaid enrollment among children, Dec. 2024[d]	Number of children in poverty, 2024 (poverty rate)[e]
OK	$3.19	0.0%	Not adopted	Adopted	No trigger law	Yes	434,704	179,000 (19%)
OR	$4.33	0.0%	Adopted	Adopted	No trigger law	Yes	293,267	106,000 (13%)
PA	$83.93	0.7%	Not adopted	Adopted	No trigger law	Yes	1,158,323	396,000 (15%)
RI	$122.77	1.0%	Not adopted	Adopted	No trigger law	Yes	90,629	33,000 (16%)
SC	$14.64	0.2%	Adopted	Not adopted	No trigger law	Yes	531,448	208,000 (18%)
SD	$10.61	0.1%	Not adopted	Adopted	No trigger law	No	65,577	24,000 (11%)
TN	N/A	N/A	Adopted	Not adopted	No trigger law	Yes	676,075	297,000 (19%)
TX	$118.66	1.5%	Not adopted	Not adopted	No trigger law	Yes	2,837,351	1,354,000 (18%)
UT	$31.47	0.5%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	137,553	79,000 (9%)
VA	$27.52	0.3%	Adopted	Adopted	No trigger law	Yes	655,612	216,000 (12%)
VT	N/A	N/A	Not adopted	Adopted	No trigger law	No	53,691	10,000 (9%)
WA	$5.56	0.0%	Adopted	Adopted	Has a trigger law in place that requires termination of the expansion if the enhanced federal matching rate drops	Yes	779,575	185,000 (11%)
WI	$133.92	1.4%	Adopted	Not adopted	No trigger law	Yes	480,235	148,000 (12%)
WV	$94.87	1.0%	Not adopted	Adopted	No trigger law	Yes	165,101	73,000 (22%)
WY	N/A	N/A	Not adopted	Not adopted	No trigger law	No	37,153	12,000 (10%)

Note: ACA = Affordable Care Act; N/A = data not available (AL, FL, MS, MO, TN, VT, and WY).

[a] "School Medicaid Expansion Map," Healthy Students, Promising Futures, accessed April 9, 2026, https://healthystudentspromisingfutures.org/map-school-medicaid-programs/#0, March 2026 data.

[b] "Status of State Action on the Medicaid Expansion Decision: September 2025," KFF, accessed April 17, 2026, kff.org/affordable-care-act/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D. This information is presented to shed light on likely state responses to H.R. 1.

[c] "Medicaid Managed Care Tracker," KFF, accessed April 9, 2026, https://www.kff.org/data-collections/medicaid-managed-care-tracker/.

[d] "Centers for Medicare & Medicaid Services (CMS), *December 2025: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (CMS, 2026).

[e] "Children in Poverty in United States," Annie E. Casey Foundation, Kids Count Data Center, accessed April 9, 2026, https://datacenter.aecf.org/data/tables/43-children-in-poverty#detailed/2/2-53/false/1096,2545,1095,2048,1729,37,871,870,573,869/any/321,322.

Notes

[1] "December 2025 Medicaid & CHIP Enrollment Data Highlights," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/december-2025-medicaid-chip-enrollment-data-highlights.

[2] "National School Lunch and School Breakfast Program Demonstration Projects to Evaluate Direct Certification with Medicaid," US Department of Agriculture, Food and Nutrition Service, accessed April 8, 2026, https://www.fns.usda.gov/cn/direct-certification-medicaid-demonstration-project.

[3] "Implementation Dates for 2025 Budget Reconciliation Law," KFF, accessed April 8, 2026, https://www.kff.org/medicaid/implementation-dates-for-2025-budget-reconciliation-law/.

[4] "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate," Congressional Budget Office, July 21, 2025, https://www.cbo.gov/publication/61569.

[5] See Phillip L. Swagel, "Distributional Effects of Public Law 119-21," letter to Brendan F. Boyle and others, August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Distributional-Effects.pdf. For an overview of the provisions contained in H.R. 1, see "Health Provisions in the 2025 Federal Budget Reconciliation Law," KFF, last updated August 22, 2025, https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/#2ca666ac-5d15-4454-8973-241566e22bb5. The formal Congressional Budget Office scoring can be found at "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," Congressional Budget Office, July 21, 2025, https://www.cbo.gov/publication/61570.

[6] For example, recent Urban Institute projections on the reduction among enrollees in Medicaid expansion states do not account for disenrollment of children resulting from parental coverage loss, but they recognize that accounting for this reality would increase projected coverage losses (Buettgens et al. 2026).

[7] Patti Boozang, Elizabeth Dervan, and Tara Straw, "How H.R. 1 Impacts Coverage for Non-Citizens," State Health and Value Strategies, September 5, 2025, https://shvs.org/how-h-r-1-impacts-coverage-for-non-citizens/.

[8] See Phillip L. Swagel, "Estimates for Medicaid Policy Options and State Responses," letter to Ron Wyden and Frank Pallone, May 7, 2025, https://www.cbo.gov/system/files/2025-05/Wyden-Pallone_Letter.pdf. We are beginning to see early signals of how states will respond. For example, leaders in Idaho and North Carolina have announced they will cut provider reimbursement rates, Colorado's governor announced that the state will stop covering certain dental care, and Montana and New Hampshire are exploring cost-sharing premiums. See Akash Pillai, Elizabeth Williams, and Robin Rudowitz, "Medicaid and Upcoming State Budget Debates," KFF, January 23, 2026, https://www.kff.org/medicaid/medicaid-and-upcoming-state-budget-debates/; and Celli Horstman and Akeiisa Coleman, "States Are Planning Their Responses to H.R. 1 Cuts in Medicaid—Will Enrollees Lose Benefits?" The Commonwealth Fund blog, October 14, 2025, https://www.commonwealthfund.org/blog/2025/states-responses-hr-1-cuts-medicaid-funding.

[9] This is in line with previous years. See Emily Katz Sayag, "How SNAP and Medicaid Changes Will Impact State Education Budgets," National Conference of State Legislatures, October 3, 2025, https://www.ncsl.org/state-legislatures-news/details/how-snap-and-medicaid-changes-will-impact-state-education-budgets.

[10] "Children in Poverty in United States," Annie E. Casey Foundation, accessed April 8, 2026, https://datacenter.aecf.org/data/tables/43-children-in-poverty. Population Reference Bureau analysis of data from the US Census Bureau, Census Supplementary Survey and American Community Survey table B17001.

[11] Riley Judd and Justin Theal, "New Federal Medicaid Policies Compound State Budget Pressures: State Fiscal Debates to Watch in 2026," Pew, January 13, 2026, https://pewtrsts.org/4blPKgQ.

[12] "Expenditure Reports from MBES/CBES," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes.

[13] "School Medicaid Expansion Map," Healthy Students, Promising Futures, accessed April 8, 2026, https://healthystudentspromisingfutures.org/map-school-medicaid-programs/.

[14] "Medicaid Enrollment and Unwinding Tracker," KFF, April 24, 2026, https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/.

[15] "Medicaid Reimbursement Policy for School-Based Telehealth," National Academy for State Health Policy, May 5, 2021, https://nashp.org/state-tracker/medicaid-reimbursement-policy-for-school-based-telehealth/.

[16] "Total Medicaid MCOs, 2024," KFF, accessed March 7, 2026, https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&selectedDistributions=total-medicaid-mcos&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; and "Managed Care: Enrollment Report," Medicaid.gov, accessed April 8, 2026, https://www.medicaid.gov/medicaid/managed-care/enrollment-report.

[17] Elizabeth Hinton, Jada Raphael, and Abby Sachar, "10 Things to Know About Medicaid Managed Care," KFF, March 23, 2026, https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/.

[18] The following states were excluded from our analysis because of unavailable data: Alabama, Florida, Mississippi, Missouri, Tennessee, Vermont, and Wyoming (n = 7).

[19] Alexander Gabriel, Andra Wilkinson, Brandon Stratford, et al., "Early Evidence of Medicaid's Important Role in School-Based Health Services," Child Trends, December 14, 2020, https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services.

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