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MEDICAID CUTS WILL DEVASTATE NURSING HOME RESIDENTS

Medicaid is the primary payer for nursing home care. Medicaid pays directly for residents' care and provides financial support that enables many residents to use their Medicare benefit as well. The budget resolution passed by the House of Representatives on February 25, 2025, which requires $880 billion in cuts in the Medicaid program over a 10-year period in order to make tax cuts enacted in 2017 permanent and to pay for border security,[1] would be devastating for nursing facility residents, states, and nursing facilities.

Medicaid is critical for nursing home residents because the United States does not have a comprehensive program to pay for long-term care services. Medicare covers skilled nursing facility care for a limited category of people – those needing skilled nursing (not custodial) or skilled rehabilitation care – and only for a limited period of time (not more than 100 days in a benefit period).[2] Private insurance is limited and generally does not cover nursing home care at all.[3] As a result, people who need nursing home care, but who are not covered by Medicaid, must pay the facility's full charges out-of-pocket as private-pay residents. With limited state exceptions, nursing homes can charge private-paying residents whatever they choose. Once residents have exhausted their private funds and depending on their state's rules, they may qualify for Medicaid coverage.

Medicaid also helps low-income Medicare beneficiaries (called "dually eligible beneficiaries") who live in nursing facilities through various Medicare Savings Programs.[4] Medicaid also helps pay Medicare premiums, coinsurance, and copays. In 2021 Medicaid helped ten million people pay their Medicare premiums and eight million people cover their Medicare coinsurance and copays.[5]

Nursing home care is expensive. The average annual costs for a nursing home bed ranged from $104,025 for a semi-private room to $116,800 to a private room in 2023.[6] These charges are far

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[1] Catie Edmondson, Andrew Duehren, Maya C. Miller and Robert Jimison, "House Passes G.O.P. Budget Teeing Up Enormous Tax and Spending Cuts," *The New York Times* (Feb. 26, 2025), https://www.nytimes.com/2025/02/25/us/politics/mike-johnson-budget-resolution-vote.html; Phil Galewitz, "GOP Takes Aim at Medicaid, Putting Enrollees and Providers at Risk," *KFF Health News* (Feb. 21, 2025), https://kffhealthnews.org/news/article/medicaid-budget-cuts-republicans-trump-agenda-providers-enrollees-at-risk/.

[2] 42 U.S.C. §1395d(a)(2)(A).

[3] In 2021, 80,000 people filed claims for private long-term care insurance benefits, although 7.1 million people paid premiums. Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports (LTSS)" (Jul, 8, 2024, https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

[4] Medicare.gov, "Medicare Savings Programs," https://www.medicare.gov/basics/costs/help/medicare-savings-programs (site visited Feb. 22, 2025).

[5] MACPAC, "Report to Congress on Medicaid and CHIP," p. 68 (June 2024), https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-WEB-508.pdf.

[6] Priya Chidambaram and Alice Burns, KFF, "10 Things About Long-Term Services and Supports (LTSS)" (Jul. 8, 2024), https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

beyond the means of most people aged 65 and over, whose average median income in 2023 was $36,000.[7]

Medicare pays for limited nursing home care. More than 1.2 million people live in nursing facilities and most rely on Medicare or Medicaid or both. However, while the Medicare program pays for many residents at the beginning of their stay,[8] it covers their stays only briefly and usually for far fewer than the 100 days available in a benefit period. On average, in 2022, Medicare paid for only 28 days of care in a benefit period.[9] Residents can get additional Medicare coverage in a subsequent benefit period, but only if they have not been in an acute care hospital or skilled nursing facility for at least 60 consecutive days (or, if they are in a skilled nursing facility, but not receiving Medicare-covered skilled care for at least 60 consecutive days).[10] **Nationwide, Medicare was the primary payer for only 13% of all nursing home residents**.[11]

Nursing home residents rely on Medicaid. Many residents remain in a nursing home far longer than the few weeks covered by Medicare. As a result, for most residents who remain in a facility after their Medicare coverage ends, high private-pay rates mean that Medicaid quickly becomes their primary payer for long-term care. KFF (formerly the Kaiser Family Foundation) reports that **in 2024, Medicaid was the primary payer for 63% of nursing home residents**.[12] In five states (Alaska, Georgia, Louisiana, Mississippi, and West Virginia) and the District of Columbia, more than 70% of residents relied on Medicaid.[13]

Nursing home residents using Medicaid already pay out of pocket for a considerable portion of the charges for their care. Nursing home residents are required to contribute virtually all of their income toward the cost of their nursing home care, usually retaining only a small monthly personal needs allowance.[14] In addition, states can recapture the cost of a Medicaid resident's

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[7] *Id.*

[8] The National Nursing Home Survey reported in November 2010, that in 2004, 543,100 of 1,492,200 residents used Medicare at the time of admission. At the time of their interview, however, only 189,400 were using Medicare. Many residents had shifted to Medicaid. 518,700 residents used Medicaid at admission, but by the time of their interview, 890,200 relied on Medicaid. Table 8, "Number of nursing home residents by selected resident characteristics according to all sources of payment at time of admission and at time of interview: United States, 2004," http://www.cdc.gov/nchs/nnhs/nnhs_products.htm (click on Series 13, No. 167). This 2010 report is the most recent National Nursing Home Survey.

[9] Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program*, 109, Chart 8-5 (July 2024), https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf.

[10] 42 C.F.R. §409.60.

[11] "*Distribution of Certified Nursing Facility Residents by Primary Payer Source," KFF* (2024*),* *https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*

[12] *Id.*

[13] *Id.*

[14] Nursing home residents receiving Medicaid and those receiving Medicaid-financed home and community-based services are the only Medicaid beneficiaries who have a second financial determination made *after* they are found eligible for Medicaid. In the "post-eligibility" financial determination, the state determines how much of his or her income the Medicaid beneficiary must contribute to the cost of nursing home or community based care. All income must be contributed, with limited deductions for health insurance premiums, costs of maintaining the home while a spouse or dependent child lives there, and a monthly personal needs allowance of $30 (which some states supplement). 42 C.F.R. §§435.832, 436.832 ("Post-eligibility treatment of income of institutionalized individuals; Application of patient income to the cost of care").

nursing home care by placing a lien on the resident's property and by collecting from the resident's estate after the resident's death.[15] Only long-term care Medicaid beneficiaries are required to repay the Medicaid program in this way for Medicaid benefits they received.

States rely on Medicaid to pay for nursing home care. At the state level, more than half of all Medicaid spending supports health care for people who are old or have disabilities or both.[16] The subset of Medicaid beneficiaries who need long-term services and supports, including nursing home care, are among beneficiaries for whom the highest total Medicaid payments are made. Although they are only 6% of Medicaid enrollees, they use 34% of federal and state Medicaid spending.[17]

Medicaid is critical for all states. However, Medicaid cuts could most significantly affect the poorest states because, as shown in the map below, federal financial support for Medicaid – through federal funds called Federal Medicaid Assistance Percentages (FMAP) – is highest in states with the lowest per capita incomes. About three-quarters of Medicaid funding in the poorest states comes from federal payments.

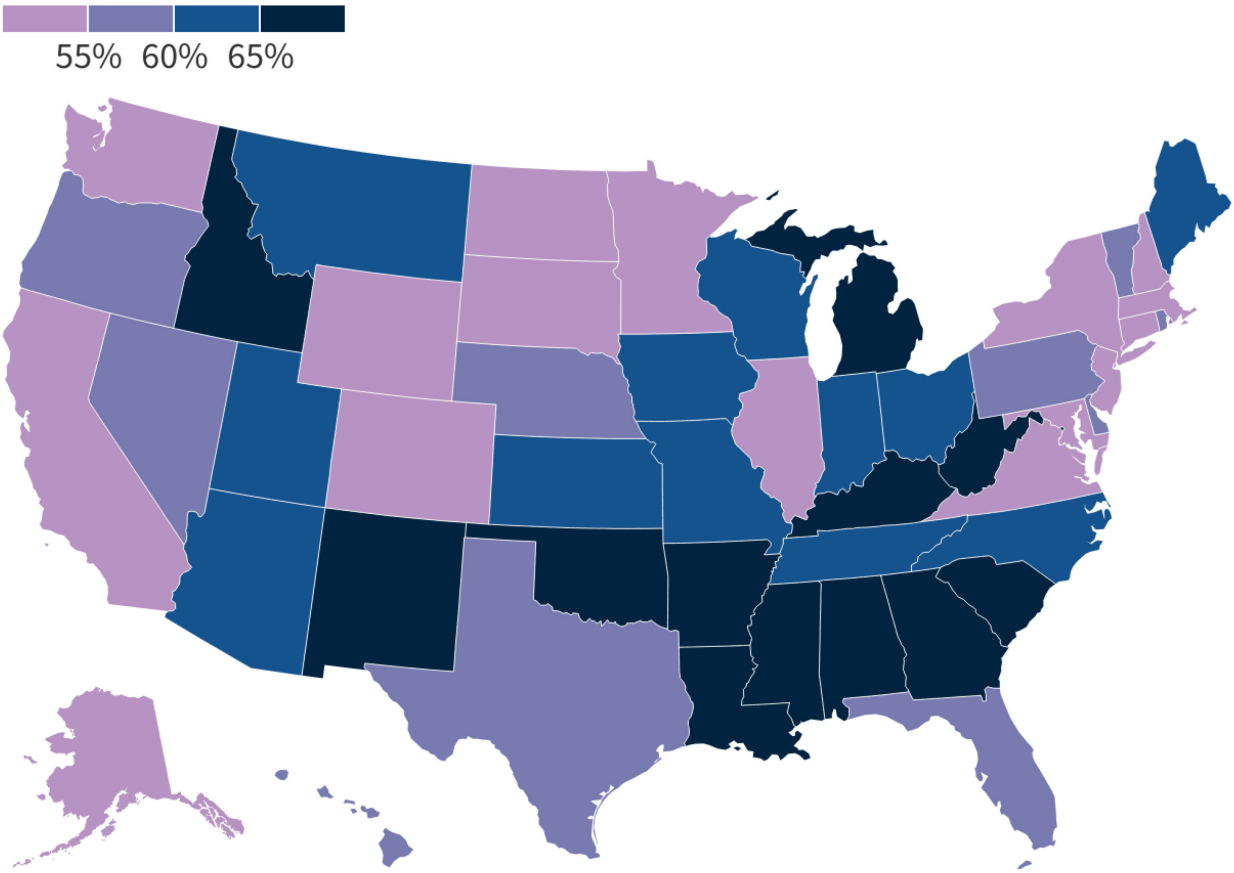
It will be difficult, if not impossible, for states to cover nursing home care for their residents at current levels if Congress enacts the drastic changes that would be required to reach $880 billion in Medicaid cuts. These changes could include reducing the federal match amount, instituting "per capita caps," reducing benefit periods, changing eligibility rules, and more..

[15] 42 U.S.C. §1396p.
[16] Rhiannon Euhus, Alice Burns, and Robin Rudowitz, KFF, "5 Key Facts about Medicaid Eligibility for Seniors and People with Disabilities," Figure 1, KFF (Feb. 7, 2025).
[17] Priya Chidambaram and Alice Burns, KFF, "10 Things About Long-Term Services and Supports (LTSS)" (Jul. 8, 2024), https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

Figure 1

States With Lower Per Capita Incomes Have a Higher Federal Matching Rate for Medicaid

Federal Medicaid Assistance Percentages (FMAPs) for Traditional Medicaid Spending Effective for FFY 2026



Note: FFY = federal fiscal year. These rates are in effect October 1, 2025 - September 30, 2026. These FMAPs are determined by a formula set in statute and are for services used by people eligible through traditional Medicaid, which includes individuals who are eligible as children, low-income parents, because of disability, or because of age (65+). The formula is designed so that the federal government pays a larger share of program costs in states with lower average per capita income.

Source: Federal Register, November 29, 2024 (Vol 89, No. 220), pp 94742-94745

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Nursing facilities rely on Medicaid to cover the majority of their residents. Nearly two-thirds of their residents rely on Medicaid to pay for their stay. Nursing facilities cannot remain in business without a strong Medicaid program. The types of Medicaid cuts that would be needed to reach $880 billion could include block grants, reduced eligibility for beneficiaries, limited benefit

periods, per capita caps, cuts to provider reimbursement, and other drastic changes that would wreak havoc on the institutional level of care that many people need.

Conclusion

Cuts of $880 billion in the Medicaid program cannot be achieved solely by eliminating "fraud, waste, and abuse," as some claim is possible. The result of such massive cuts, however they are structured and described, is, inevitably, decimation of the Medicaid program.

For nursing home residents, the result of massive cuts would, at best, shift the costs of nursing home care to residents, their families, states, and facilities. The reality, however, is that residents, families, states, and facilities cannot bear such enormous new costs. Quality of care at nursing facilities would suffer greatly from Medicaid cuts and some people would not be able to access medically necessary long-term care at all. Cuts to Medicaid are literally a matter of life and death for nursing home residents.

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