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ISSUE BRIEF

How Medicaid Funding Caps Would Harm Older Adults

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Medicaid is a lifeline for older adults and our communities. As a state-federal partnership, Medicaid guarantees federal financial support to every state to provide essential health and long-term care to older adults and other people with limited income and savings. As the number of older adults who need long-term care grows and state Medicaid costs increase, the federal government helps meet those rising costs by matching a percentage of each dollar the state spends.

Congress is considering proposals to restrict or cap federal Medicaid funding to states. Instead of guaranteeing federal financial support for necessary medical assistance for older adults and other people with limited income and savings, these proposals would set limits on the federal share of costs, shifting costs and financial risks to states. As a result, states would be forced to cut services and enrollment. This issue brief discusses how Medicaid funding caps, including block grants and per capita caps, would harm the millions of older adults who rely on the program.

MEDICAID PROVIDES VITAL LONG-TERM CARE AND MEDICARE COST-SHARING ASSISTANCE FOR OLDER ADULTS

The Medicaid program provides medically necessary health and long-term care that low-income older adults otherwise cannot afford. Over seven million Americans age 65 and older and nearly eleven million from ages 50 to 64 rely on Medicaid every year.[1] Medicaid coverage is particularly important for older adults who need services not covered—or not adequately covered—by Medicare. Specifically, Medicaid is vital for older adults who need assistance with daily activities such as eating, bathing, dressing, and getting in and out of bed. The long-term assistance that they need, whether provided at home or in a nursing home, is typically paid for by Medicaid, and not Medicare. In fact, more than 6 in 10 nursing home residents rely on Medicaid.[2]

Medicaid also helps over 12 million older adults and people with disabilities pay their Medicare premiums and out of pocket costs.[3] Dually eligible Medicaid and Medicare beneficiaries live on limited fixed incomes with few assets. They would not be able to afford Medicare without Medicaid assistance.[4]

Medicaid programs combine federal and state funding, with the federal government paying for 68% of total Medicaid expenses.[5] Federal Medicaid law requires states to cover certain mandatory benefits—such as inpatient and outpatient hospital services, physician services, rural health clinic services, emergency and non-emergency medical transportation, Medicare cost-sharing, and nursing home services. States have discretion to add additional services, such as Home- and Community- Based Services (HCBS), dental, vision, and hearing. These services are not covered by Medicare, making Medicaid the only coverage option for many low-income older adults.

A CAPPED FUNDING SYSTEM WILL HARM STATE MEDICAID PROGRAMS AND ENROLLEES

Types of Fixed Funding Levels

"Block grants" and "per capita caps" are two related but different mechanisms for cutting Medicaid by restricting federal funding at a certain level.

Under a block grant, a state would receive a lump sum with great discretion on how to spend it. Most block grant proposals would base each state's payment of federal funds on the state's past Medicaid expenditures, with some type of inflation adjustment for subsequent years. Crucially, funding would not keep up with health care costs, or with the number of persons needing assistance. Because of the likelihood that funding would be insufficient to maintain previous coverage levels, a state would be given wide discretion to determine which persons to cover, which services to provide, and which eligibility standards to follow.[6] Consequently, states would likely cut coverage for particular types of enrollees and/or services in response to inadequate funding levels.

A per capita cap is similar, except that the set amount would be paid on a per-beneficiary basis. Some annual increase would be assessed, but likely at a rate lower than the health care inflation rate.[7] Under many per capita cap proposals, federal payments would distinguish between types of Medicaid enrollees. For example, the federal government would pay the state a certain amount for each child eligible for Medicaid, and a different amount for each eligible senior. However, the funding levels under per capita caps would still be structured to decrease federal funding overall and would fail to consider necessary increases and adjustments to state Medicaid spending, due to factors such as changes in demographics, health care needs, and delivery systems. In addition, under a per capita cap structure, the state receives no benefit from spending under the cap, but nonetheless is penalized when spending over the cap.[8] In short, per capita caps shift costs to states and put pressure on state budgets. Since states must balance their budgets annually, taking on additional costs would incentivize--and eventually force--states to limit or eliminate enrollment and services.

Unfairness of a Capped Funding System

A capped or restricted funding system would unfairly reduce a state's Medicaid funding, which in turn would deprive low-income seniors of needed health care. Moreover, numerous federal protections would evaporate due to the simultaneous elimination of important federal Medicaid standards for services and service delivery. Older adults

would be harmed by lost eligibility and services, unaffordable financial obligations, and a reduced quality of care. Here are three ways arbitrarily capping the federal funding levels would be unfair.

1. **Coverage would no longer be based on medical necessity.** Like Medicare and other health insurance programs, Medicaid covers health care needs based on medical necessity. However, under a fixed funding level system, medical necessity would often be superseded by external financial considerations, as the capped federal reimbursement would require states to impose significant cuts on eligibility, coverage, or both. Federal Medicaid funding would be insufficient to meet enrollees' needs, which would result in states denying coverage for medically necessary services and vital programs such as Medicaid HCBS. [9]

2. **State Medicaid programs would be prevented from making necessary improvements.** By using previous years' Medicaid expenses as a base for the cap, there is an implicit assumption that the state's expenses during those years were in the proper proportions. This assumption, however, may well be incorrect. If previous years expenses were inadequate to meet need, increased payments now may simply indicate a state's efforts to bring its Medicaid program up to necessary standards. If, for example, a per capita cap had been in place from 2019 to 2022, 35 out of 41 states would have exceeded their cap and been forced to cover significantly higher costs.[10] Even with a higher growth rate for enrollees age 65+, 28 states would have exceeded the cap for older adults within three years. An additional eight states (36 total) would have exceeded the higher growth rate cap for people with disabilities.[11]

3. **Federal funding won't keep up with rising health care needs of an aging population.** A cap system also fails to account for aging of the population. Consider a state's "aged" eligibility category, composed of persons age 65 or older. If more older individuals enroll in coverage, or the average age of enrollees increases, the health care needs of the Medicaid population would increase. Caps on funding, however, would not take the changed beneficiary population into account. Similarly, the Medicaid population could increase due to natural disaster, recession, a public health emergency, or other factors. In these circumstances, a state would be financially penalized and likely cut services to account for the reduced funding.[12]

CUTS TO STATE MEDICAID PROGRAMS WOULD HARM OLDER ADULTS

Of course, the greatest harm of a capped system will ultimately fall on low-income persons, including seniors, who rely on Medicaid for health care. A capped structure will guarantee that costs will shift to states and states will have insufficient funding to meet those costs. States almost certainly will react to insufficient funding by cutting their Medicaid programs. Older adults and people with disabilities in particular should expect to have their Medicaid coverage reduced, since these groups tend to have higher needs.

- **Cuts in Optional Eligibility and Services.** Federal Medicaid law distinguishes between mandatory and optional eligibility groups, and mandatory and optional services. A significant amount of Medicaid spending is "optional" under the law—either because it is provided to a person in an optional coverage group, or is an optional service, or both.[13] HCBS, dental, vision, and hearing, for example, are optional services while nursing facility services are mandatory.

  In terms of eligibility, federal law requires mandatory coverage for adults age 65+ and people with disabilities receiving Supplemental Security Income (SSI). However, most states have expanded eligibility for nursing

home coverage and HCBS using optional pathways.[14] Notably, the vast majority of nursing home residents and HCBS recipients are covered through an optional eligibility group. Several states have also opted to expand Medicaid for older adults up to or above 100% of the federal poverty level and expanded eligibility for the Medicare Savings Programs (MSPs) for people dually enrolled in Medicaid and Medicare.[15] Capping Medicaid's funding at the federal level would force states to cut these optional programs, limiting not only healthcare, but eliminating access to long-term care and help with Medicare costs for millions of older adults.

- **Limiting Home and Community-Based Services.** As mentioned, HCBS are optional services. Medicaid law authorizes states to limit HCBS to certain areas of the state, or to cap enrollment at a set level.[16] Approximately 34% of Medicaid spending goes to long-term services and supports (LTSS), a category that includes nursing home services and HCBS.[17] Because nursing facility services are a mandatory benefit, a state looking to shed Medicaid LTSS expenses is likely to cut HCBS first, resulting in elimination of programs, geographic limitations, and/or waiting lists. Without HCBS, older adults would either be forced to receive care in institutional settings, pay thousands of dollars for private care, or rely on unpaid family caregivers.
- **Decreased Access to Health Care Providers.** In order to cut expenses, state Medicaid programs also are likely to reduce reimbursement rates paid to health care providers. Because Medicaid rates already are low in comparison to other reimbursement sources[18], these reductions will drive some providers from the Medicaid program, and cause others to accept fewer Medicaid enrollees. Consequently, many older adults will not have access to services, or will confront an extremely limited choice of providers, creating additional barriers to health care access. This would further exacerbate the direct care workforce crisis for older adults in home and institutional settings, leading to longer waitlists and delayed access to care.[19]

CONCLUSION

The Medicaid program is 60 years old. Its current structure reflects decades of modifications, and a relatively nuanced balancing of consumer and provider needs, along with federal and state budgetary realities. Efforts to cap federal Medicaid funding could erase many, if not all, existing Medicaid protections and replace them with a lax process that gives the states inadequate funding, and tasks them with the requirement of developing new, state-specific Medicaid systems from scratch.

As explained above, Medicaid funding caps would cause significant harm to low-income older Americans. Proposed efforts rely on significant cuts to the Medicaid program to achieve federal savings. The touted "flexibility" of these proposals likely would be used not to innovate, but to eliminate important safeguards. Under these proposals, older adults and people with disabilities would lose services, be saddled with unaffordable financial obligations, and receive a lower quality of care.

ENDNOTES

1 Seniors & Medicare and Medicaid Enrollees, (Medicaid); James McSpadden et al., Medicaid in Midlife: A Profile of Enrollees Ages 50 to 64, (American Association of Retired Persons 2023).

2 Charlene Harrington et al., Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016, at 2, (Kaiser Fam. Found. 2018).

3 Maria T. Peña et al., A Profile of Medicare-Medicaid Enrollees (Dual Eligibles), (Kaiser Fam. Found. 2023).

4 Medicare Part B (which covers physician visits and other outpatient services) imposes a standard monthly premium of $185, an annual deductible of $183, and a 20% copayment. Medicare Part A (covering inpatient care) imposes a $1,676 deductible for each benefit period. 2025 Medicare Parts A & B Premiums and Deductibles, (Centers for Medicare and Medicaid Services 2024).

5 *See* Federal and State Share of Medicaid Spending, tbl. FY 2023, (Kaiser Fam. Found.).

6 Edwin Park, Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured, at 2, (Center on Budget and Policy Priorities 2016).

7 States will also be penalized even if the cap's inflation rate is identical to the actual national rate of health care inflation. Because health care inflation rates vary from state to state, some states' health care expenses will increase faster than the national rate of inflation, while other states' expenses will increase at a slower rate. Under a per capita cap mechanism, the higher-inflation states will suffer a financial penalty, while the lower-inflation states will receive no benefit for spending under the cap. Gideon Lukens and Elizabeth Zhang, Medicaid Per Capita Cap Would Harm Millions of People by Forcing Deep Cuts and Shifting Costs to States, (Center on Budget and Policy Priorities 2025).

8 Gideon Lukens and Allison Orris, Changing Medicaid's Funding Structure to a Per Capita Cap Would Shift Costs to States, Force Deep Cuts, and Leave Millions Uninsured, (Center on Budget and Policy Priorities 2023).

9 Garrett Hall and Tory Cross, Congressional Proposals to Cut Medicaid Would Harm Hardworking Families Relying on Key Services and Put Disabled People in Particular at Risk, at 3-6, (Families USA 2023).

10 Gideon Lukens and Elizabeth Zhang, Medicaid Per Capita Cap Would Harm Millions of People by Forcing Deep Cuts and Shifting Costs to States, (Center on Budget and Policy Priorities 2025).

11 *Id*.

12 Mara Youdelman, What Is a Block Grant and How Would It Impact Medicaid?, (Nat'l Health Law Program 2024).

13 Martha Heberlein, Analysis of Mandatory and Optional Populations and Benefits, at 12, (Medicaid and CHIP Payment and Access Commission 2017).

14 42 states have adopted the special income rule. Alice Burns et al., What Are the Primary Medicaid Eligibility Pathways for Dual-Eligible Individuals? (Kaiser Fam. Found. 2024).

15 Alice Burns et al., What Are the Primary Medicaid Eligibility Pathways for Dual-Eligible Individuals? (Kaiser Fam. Found. 2024).

16 42 U.S.C. § 1396n(c)(3).

17 *See* How Much Does Medicaid Spending Vary Across Enrollee Groups and States, fig. 13, 15, (Kaiser Fam. Found.).

18 Gideon Lukens and Elizabeth Zhang, Medicaid Per Capita Cap Would Harm Millions of People by Forcing Deep Cuts and Shifting Costs to States, (Center on Budget and Policy Priorities 2025).

19 Alice Burns et al., A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024, (Kaiser Fam. Found. 2024).