February 25, 2025

The Honorable Jason Smith
Chair
House Committee on Ways and Means
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
Washington, DC 20515

The Honorable Mike Kelly
Chair
House Ways and Means Subcommittee on Tax
Washington, DC 20515

The Honorable Mike Thompson
Ranking Member
House Ways and Means Subcommittee on Tax
Washington, DC 20515

Re: Impact of Budget Reconciliation on Older Adults and Aging Services Providers

Dear Chairman Smith, Chair Kelly, Ranking Member Neal, and Ranking Member Thompson:

We write to you today concerning the critical work the members of the House Ways and Means Committee will soon begin as you receive and act upon the reconciliation instructions included in any fiscal year 2025 budget resolution.

LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, home-based care, and other organizations serving older adults, people with disabilities, and their families.

The legislative package that emerges from budget reconciliation will be critical to the well-being of America's older adults and families, and our nonprofit and mission-driven community-based members call on Congress to ensure the needs of older adults and the people who serve them are met.

To that end, this letter highlights items that our members, nonprofit aging services providers, consider essential to include in budget reconciliation as well as policies we believe are imperative to leave out of any reconciliation package because of the harm they would impose on providers and the older adults they serve.

Repeal the CMS Nursing Home Federal Minimum Staffing Rule

Congress must use this opportunity to repeal the Biden administration's misguided federal minimum staffing rule for nursing homes, which is unrealistic given current workforce shortages and funding inadequacy. According to the Centers for Medicare and Medicaid Service's (CMS's) own estimates, more than 79% of nursing homes will be required to hire additional registered nurses and nurse aides to

comply with the rule. Nurse aides, who are the backbone of aging services, are in short supply. Further, the Health Resources and Services Administration projects a workforce shortage of more than 350,000 registered nurses in 2026 alone. Regulations and enforcement, even with the best intentions, just can't change the math.

Existing workforce shortages already result in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in post-acute, long-term care facilities. Further, home care and hospice providers – already navigating their own workforce challenges – will be short even more workers if they move to nursing homes. Shuffling the relatively small number of direct care workers available between settings will not solve the problem. Furthermore, holding nursing homes to a standard that is impossible to meet and then fining them for not meeting that standard will threaten quality, not improve it.

The Congressional Budget Office (CBO) has scored this proposal as costing the U.S. Department of Health and Human Services $22 billion dollars to implement over ten years. The rule's repeal will roll back damaging policy and help realize savings to achieve the budget resolution's instructions for deficit reduction. Though well-intentioned, the rule's mandate in its final form is simply not feasible given current workforce shortages and a lack of funding to recruit, train and retain nurses and nurse aides.

Reject Proposals that Threaten the Ability Nonprofits to Fulfill Their Missions

Preserve Tax Exemption for Municipal Bonds

We are gravely concerned about the potential elimination of tax exemption on municipal bonds, which, if included, would severely limit community-based nonprofit organizations' access to capital and inhibit their ability to finance projects, including affordable housing for low-income older adults.

Aging services providers across the continuum rely on tax exempt bond financing in a variety of ways, including for expansion of existing senior living campuses to accommodate more residents, enhancement of service offerings to meet community needs, upgrades and renovations to existing buildings, refinancing of existing debt; and development of new projects to meet the growing and evolving demand for senior living options.

To expand the supply of affordable housing, state and local governments sell tax-exempt bonds and use the proceeds to finance low-cost mortgages for the production of apartments at rents affordable to households with low incomes. Multifamily housing bond developments must set aside at least 40% of their apartments for households with incomes of 60% of area median income (AMI) or less, or 20% for families with incomes of 50% of AMI or less. Each year, states use multifamily tax-exempt bonds to finance between 40,000 and 70,000 additional apartments, including many also financed with the Housing Credit.

LeadingAge members depend on tax-exempt bonds partnered with 4% Low Income Housing Tax Credits (Housing Credits) for the development of affordable housing. Private activity bonds finance more than half of all the affordable rental homes produced and preserved by the Housing Credit.

Eliminating or curbing the tax exemption for bonds would not reduce the need for affordable housing but would lead investors to demand higher interest rates, thus directly and negatively impacting the availability of lower-cost financing for affordable senior housing. The outcome would be higher borrowing costs for state and local governments, less investment in affordable housing, and fewer jobs.

Data from the University of Chicago Center for Municipal Finance show that municipal bond financing has supported Life Plan communities, retirement centers, nursing homes, senior housing and independent living, or multifamily housing in every State across the country.[1]

Tax exempt municipal bonds bring affordable capital to these projects because investors are willing to accept a lower rate of interest in exchange for that interest being exempt from taxation. If the tax-exemption is eliminated investors will demand a higher interest rate on municipal bonds, increasing the cost to source capital.

Without the tax exemption, we estimate aging services providers would see their borrowing costs increase significantly.

The trickle-down result would be that our member organizations would be forced to curtail the number of projects they undertake, preventing or hindering growth and reinvestment, and leaving fewer opportunities for nonprofit aging services organizations to serve their communities.

Some projects would simply not be viable. Others might proceed at higher cost, but with the result that consumers would pay more for housing, services and supports.

There would be significant implications not only for the cost of capital but also for access to capital. Given the higher cost of borrowing, organizations would face stricter credit standards, meaning greater difficulty in securing financing for many organizations or putting financing out of reach.

In short: the loss of tax-exempt status for these bonds would significantly impair nonprofits' ability to invest in creating and sustaining essential projects that serve older adults in their communities, including independent living, assisted living and memory care, nursing homes, and Life Plan communities, which offer a continuum of care to those they serve.

For these reasons, including that older adults are the fastest growing population of people experiencing homelessness and there is a nationwide shortage of affordable senior housing, we urge you to reject any proposals to eliminate or limit the tax exemption of state and local bonds.

Incentivize Charitable Giving

Proposals to remove the deduction for contributions to health organizations, or other charitable organizations, must be rejected. We urge the Committee to support and uphold the income tax deduction for charitable contributions, which generate resources that are indispensable for LeadingAge members to carry out their mission of service to older adults. Simply put, charitable giving is vital to thriving communities. An extensive body of research confirms its significant value and impact of the charitable sector. The deduction is cost-effective, and improves the quantity and quality of aging services, and benefits entire communities.

Employee Retention Tax Credit (ERTC)

The ERTC offered critical support for employers to retain employees on the payroll during shutdowns ordered by governments or while incurring significant revenue reductions due to the pandemic. For non-profit aging services organizations and businesses that would not have benefitted from a traditional income tax credit approach, this credit was a particular lifeline. The rules for this program evolved overtime and IRS guidance arrived late in the submission process. However, our aging service providers

[1] https://munifinance.uchicago.edu/congressional/

sought trusted experts to carefully evaluate whether this program applied to their situations before submitting a claim. Many of them are still waiting to receive the promised funds from this credit. While we understand that this program has been rife with bad actors, if Congress opts to end this program early, we ask that you do so after paying out legitimate claims submitted by January 31, 2024. These dollars will provide critical infusions of capital to aging service providers who are operating on slim to negative margins but are also major economic contributors to their communities.

Support Nonprofits as Partners in Community Support

Finally, we are concerned that Congress may seek to raise additional tax revenue from the nonprofit sector for the purpose of supporting other budget priorities.

We urge the Committee to support policies that empower nonprofit aging services providers and the broader charitable sector to continue and expand their vital, front-line work in supporting individuals and communities. Nonprofit and other mission driven organizations play a critical role across the United States in serving our nation's older adults. They are pillars of their communities, providing essential services including housing, support for activities of daily living and healthcare needs, life enrichment and much more.

Eroding the financial foundation of these organizations would have wide-ranging and rippling effects, including decreased access to critical housing, services and supports. We urge the Committee to reject policies that would restrict or eliminate existing tax exempt status, for example, or that would subject income earned by nonprofits to taxation beyond current law.

Build on What Works: Increase Low Income Housing Tax Credit Allocations

Our nation faces a critical and growing shortage of affordable housing. Today, more than 2.35 million older adult renter households with very low incomes spend more than half of their incomes for housing. Older adults often face long waiting lists for affordable housing and are the fastest growing population of people experiencing homelessness.

To build more affordable housing, including affordable senior housing, Congress must use this opportunity to increase Low Income Housing Tax Credit (Housing Credit) allocations by restoring the 12.5% cap increase that expired in 2021 and further increasing resources by 50%, and by providing basis boosts for rural properties and properties that serve people with extremely low incomes Expansion of the Housing Credit would help address America's affordable housing shortage. Very little new affordable rental housing can be built without the Housing Credit because it is financially infeasible to do so. However, the Housing Credit is limited by the amount of credits available, which is set by Congress.

Since its establishment in 1986, the Housing Credit has financed the development of four million affordable rental homes in urban, suburban, and rural areas. Older adults live in 37% of LIHTC apartments. The Housing Credit has supported more than 6.6 million jobs and generated over $746 billion in wages and business income.

Through reconciliation, Congress should increase Housing Credit allocations to states to provide more affordable homes across the country.

Conclusion

The need to do right by older adults in the reconciliation process has never been more important: by 2050, adults 65 years and older will comprise nearly a quarter of the U.S. population. It is essential that they have access to critically needed services and supports. Congress can help set us on the right track.

Thank you for your consideration, and we stand ready to provide any additional information you may need as you move forward with budget reconciliation legislation that addresses these critical issues.

Sincerely,

Katie Smith Sloan
President and CEO

cc: The Honorable John Thune, Senate Majority Leader
The Honorable Chuck Schumer, Senate Minority Leader
The Honorable Mike Johnson, Speaker of the House
The Honorable Hakim Jeffries, House Minority Leader

February 25, 2025

The Honorable Mike Crapo
Chairman
Senate Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Todd Young
Chair
Senate Finance Subcommittee on Health Care
U.S. Senate
Washington, DC 20510

The Honorable Michael Bennet
Ranking Member,
Senate Finance Subcommittee on Taxation and IRS Oversight
U.S. Senate
Washington, DC 20510

The Honorable John Barrasso
Chair
Senate Finance Subcommittee on Taxation and IRS Oversight
U.S. Senate
Washington, DC 20510

The Honorable Maggie Hassan
Ranking Members
Senate Finance Subcommittee on Health Care
U.S. Senate
Washington, DC 20510

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Through reconciliation, Congress should increase Housing Credit allocations to states to provide more affordable homes across the country.

Protect Medicaid Funding and Access

Medicaid provides safety-net insurance for qualifying older adults, people with disabilities, and other individuals with low incomes. Medicaid pays for costs associated with 62%[i3] of nursing home days and more than half[4] of all community-based services for older adults and individuals with physical and intellectual or developmental disabilities. Medicaid is administered in a partnership agreement between states and the federal government. Allowable costs incurred by states through the program are shared with the federal government through a split responsibility for covering the bill.

Proposals under consideration to change the way the federal government participates in the financial sharing of costs of Medicaid beneficiaries will cause ripples across the economy. Shifting costs to states by reducing or capping federal funding in the program will cause program restructuring in states, including reductions in provider rates and services and the closure of providers who provide stable employment and services in their communities. In many rural areas, Medicaid participating healthcare providers are the only sustainable long-term jobs. With provider closures, older adults will be unable to find a nursing home or aide services to help them out of bed, leaving them with no options or supports. Any cut to federal Medicaid dollars will have devastating impacts on older adults and those who serve them.

Per Capita Caps

Currently, states receive federal matching funds based on the cost of providing services to enrollees. If federal Medicaid financing switched to a per capita cap, states would receive a capped allotment per enrollee. The cap may increase by a set amount every year (CPI, chained CPI), but the increase is not tied to or set to keep up with actual costs.

It is important to note that Medicaid program costs do not trend with inflationary costs but rather are driven by enrollment numbers and average enrollee health needs. Costs do not trend with inflationary prices because rates are set by state agencies and are updated at each state's discretion. Medicaid rates paid by governments are not adjusted based on standard economic drivers like supply and demand the same way prices for other goods and services on the Consumer Price Index (CPI) fluctuate.

The medical components of the CPI have been cited as a possible inflationary factor; the CPI-M+1 was floated in past proposals. The CPI-M is wholly different from costs to provide Medicaid services and rather assesses increases in individual out of pocket costs for healthcare services, inclusive of costs for insurance premiums, co-pays, and over the counter pharmacological products. Increases in costs to individuals are market-driven by the insurance industry as they aggregate risk pools, premiums, out of pocket maximums, copays, formularies, among other factors. Medicaid program costs are not market driven costs but rather utilization driven as enrollees need more services or states enroll more eligible people.

Federal funding cuts under a per capita cap would be highly unpredictable and largely beyond states' control, not necessarily reflecting factors such as rising medical care prices, population aging and other demographic changes, and, possibly, natural disasters and epidemics. Factors like a new drug or procedure could lead to an unexpected increase in costs that would be highly variable across states.

Medicaid enrollees who use Medicaid long-term services and supports (LTSS) due to chronic illness or disability have health care costs around nine times higher than other enrollees. Adults aged 85 and older

are more likely to use LTSS, so states expecting to have growing shares of older adults are more likely to substantially exceed a per capita cap for the aged 65 or over eligibility group.

States would not be rewarded for efficiency; because a per capita cap is initially based on current per person costs, a per capita cap is going to lock in existing differences in spending across states. States with lower initial per-enrollee costs would continue to receive less federal funding than states with higher initial costs.

If per capita caps had been implemented in 2018, almost all states would have exceeded their caps in one or more years between 2018-2022. Some state specific data can be found here.

Federal Medical Assistance Percentage (FMAP) Changes

Every state gets a different FMAP with a minimum floor of 50%, but all states get a 90% FMAP for the Medicaid expansion population. FMAP changes would be devastating to state budgets and would cause potential massive losses in coverage or reductions in services, benefits, or rates that would devastate providers of care for older adults.

Provider and Managed Care Organization (MCO) Taxes

Reductions in the hold harmless threshold for provider taxes, or elimination thereof, would be detrimental to state budgets, providers in the Medicaid program, and beneficiaries receiving coverage and services. States have legally deployed the use of provider and managed care taxes to raise revenues for their Medicaid programs including to fund programs related to quality and to help nursing homes afford to take on more clinically intensive patients that have nowhere else to go. CMS approvals and renewals of state programs have come under both Democrat and Republican administrations with the generated revenues serving constituents without regard for politics. Just recently, Governor Landry from Louisiana asked President Trump to "follow the law" and have CMS approve Louisiana's supplemental payment programs and Florida's requests around provider taxes.[1] These funds serve as critical pieces of state financing of their Medicaid programs and cannot be changed significantly without adequate lead time to allow for the establishment of new baselines or funding streams that could supplant the revenues currently garnered through provider taxes.

Proposals to limit financing in the Medicaid program won't result in less people needing services, but it will result in less access to an aide to help an older adult eat, an adult day center for a dementia-diagnosed parent so the caregiver can continue to work, or a nursing home for our neighbor when they need it.

Work Requirements

Of the 72 million individuals currently enrolled in Medicaid, around 20 million[2] of them would be subject to work requirement reporting if assumptions from prior proposals remain. Including mandatory work requirements for accessing health insurance through Medicaid has not been demonstrated to increase participation in the labor market or significantly change eligibility for Medicaid. The requirement would

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[1] Governor Jeff Landry on X: "Biden @CMSGov holdovers are weaponizing medicaid to punish republican states for their immigration policies, ignoring Trump-appointed judges. With @RobertKennedyJr taking office soon, I wrote to @realDonaldTrump to thank him and ask him to instruct CMS to follow the law. #lagov https://t.co/TMNHZ6EFmP" / X

[2] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/?utm_campaign=KFF-Medicaid&utm_medium=email&_hsenc=p2ANqtz-9MacWTNWbrw1tpX5EuDaIFwOHilYMW6jlmn2dvnljGL_1DFYirmNU0jmfIUMU9XbM6opdGWW1q-vpKhqaOn__Jfa7ZJA&_hsmi=345705566&utm_content=345705566&utm_source=hs_email

impose significant bureaucratic burden both on states and workers and increase the scope of government surveillance on an already under-resourced population. Individuals in this eligibility category are making an average of less than $21,000 a year and often face barriers to access the internet in rural areas or afford it urban locales severely limiting their options for completing reporting on their employment status. Even people who have tried to complete reporting have found a broken and frustrating system.[3]

State Responses to Federal Medicaid Cuts

States would have to fill in massive budget holes if federal funding to the Medicaid program were cut. Even if a cut, such as the change to the expansion FMAP proposal, does not seem to directly impact aging services it would because the cost of the cut would have to somehow be absorbed by state budgets. That type of hole cannot just be filled in via more "efficiency." The only way that states will be able to plug that gap is via:

1. **More state taxation.** President Trump and Congressional Republicans have repeatedly emphasized that one of their main goals is to lower the tax burden. Cutting federal funding for Medicaid could actually result in increased state taxes to sustain the program – thus undoing the promise to the American people regarding a lower tax burden. Older adults, including many older adults in rural areas, are already pressed by local tax affordability in some states; transitioning tax burdens to states will inevitably harm older adults.

2. **Transferring existing state general funds to Medicaid, defunding other popular and important programs.** Federal funding makes up one-third of state budgets. If federal cuts to Medicaid are enacted, states would have to make decisions between Medicaid funding and other important priorities like education and public services.

3. **Cutting benefits or services.** Around eight million older adults and people with disabilities rely on Medicaid (over six million in the home and community and over 1.4 million in nursing homes; remainder in other institutional settings like ICFs). Long-term services and supports (LTSS) – in nursing homes or in the home and community – are not covered by any other payers – only private pay or Medicaid. Medicare covers short term, skilled care in a skilled nursing facility or via home health if a person meets the eligibility criteria but not long- term care in either setting. Home and community-based services are optional services and, therefore, more likely to be targets for reduction or elimination. Our members that provide personal care, assisted living, adult day, home care, and care management under the Medicaid program are already struggling with both sustainability and the ability to serve all the people who need care. Federal Medicaid cuts would place these services at significant risk of cuts because they are optional benefits.

   Even if HCBS services are not eliminated due to any proposed federal cuts, it is expected that there would be new or longer waiting lists. HCBS waiting lists are already prevalent, but enhanced federal cuts would create longer wait lists as well as waiting lists for populations that do not currently have waiting lists for services. HCBS services benefit packages could also be scaled back at a time when the number of people needing these services is growing. While nursing home services are a mandatory Medicaid service and cannot have waiting lists if HCBS services were cut or eliminated, nursing homes could see increased demand that they could not meet.

[3] https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles

4. **Cut rates.** Overall, Medicaid pays for 62% of all nursing home days overall. Nursing homes are a mandatory Medicaid benefit that states must provide. but there is already a gap between the cost of care for nursing homes and Medicaid rates.[4] If there is a federal Medicaid cut, this would trickle down to provider rate cuts and LeadingAge members would experience cuts. This would lead to provider closures, which would result in unmet need, job losses, and loss of businesses that contribute to local economies.

Balancing the ten-year budget cycle on the back of the Medicaid program is not a good tradeoff for the American people.

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Data from the University of Chicago Center for Municipal Finance show that municipal bond financing has supported Life Plan communities, retirement centers, nursing homes and multifamily housing in nearly every State and Congressional district across the country.[5]

[4] https://aspe.hhs.gov/reports/assessing-medicaid-payments-costs-nursing-homes
[5] https://munifinance.uchicago.edu/congressional/

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Thank you for your consideration, and we stand ready to provide any additional information you may need as you move forward with budget reconciliation legislation that addresses these critical issues.

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President and CEO

cc: The Honorable John Thune, Senate Majority Leader
The Honorable Chuck Schumer, Senate Minority Leader
The Honorable Mike Johnson, Speaker of the House
The Honorable Hakim Jeffries, House Minority Leader

February 25, 2025

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
Washington, DC 20515

The Honorable Buddy Carter
Chair
House Energy and Commerce Subcommittee on Health
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
House Energy and Commerce Subcommittee on Health
Washington, DC 20515

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We write to you today concerning the critical work the members of the Senate Finance Committee will soon begin as you receive and act upon the reconciliation instructions included in any fiscal year 2025 budget resolution.

LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, home-based care, and other organizations serving older adults, people with disabilities, and their families.

The legislative package that emerges from budget reconciliation will be critical to the well-being of America's older adults and families, and our nonprofit and mission-driven community-based members call on Congress to ensure the needs of older adults and the people who serve them are met.

To that end, this letter highlights items that our members, nonprofit aging services providers, consider essential to include in budget reconciliation as well as policies we believe are imperative to leave out of any reconciliation package because of the harm they would impose on providers and the older adults they serve.

Repeal the CMS Nursing Home Federal Minimum Staffing Rule

Congress must use this opportunity to repeal the Biden administration's misguided federal minimum staffing rule for nursing homes, which is unrealistic given current workforce shortages and funding inadequacy. According to the Centers for Medicare and Medicaid Service's (CMS's) own estimates, more than 79% of nursing homes will be required to hire additional registered nurses and nurse aides to comply with the rule. Nurse aides, who are the backbone of aging services, are in short supply. Further, the Health Resources and Services Administration projects a workforce shortage of more than 350,000

registered nurses in 2026 alone. Regulations and enforcement, even with the best intentions, just can't change the math.

Existing workforce shortages already result in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in post-acute, long-term care facilities. Further, home care and hospice providers – already navigating their own workforce challenges – will be short even more workers if they move to nursing homes. Shuffling the relatively small number of direct care workers available between settings will not solve the problem. Furthermore, holding nursing homes to a standard that is impossible to meet and then fining them for not meeting that standard will threaten quality, not improve it.

The Congressional Budget Office (CBO) has scored this proposal as costing the U.S. Department of Health and Human Services $22 billion dollars to implement over ten years. The rule's repeal will roll back damaging policy and help realize savings to achieve the budget resolution's instructions for deficit reduction. Though well-intentioned, the rule's mandate in its final form is simply not feasible given current workforce shortages and a lack of funding to recruit, train and retain nurses and nurse aides.

Protect Medicaid Funding and Access

Medicaid provides safety-net insurance for qualifying older adults, people with disabilities, and other individuals with low incomes. Medicaid pays for costs associated with 62%[i3] of nursing home days and more than half[4] of all community-based services for older adults and individuals with physical and intellectual or developmental disabilities. Medicaid is administered in a partnership agreement between states and the federal government. Allowable costs incurred by states through the program are shared with the federal government through a split responsibility for covering the bill.

Proposals under consideration to change the way the federal government participates in the financial sharing of costs of Medicaid beneficiaries will cause ripples across the economy. Shifting costs to states by reducing or capping federal funding in the program will cause program restructuring in states, including reductions in provider rates and services and the closure of providers who provide stable employment and services in their communities. In many rural areas, Medicaid participating healthcare providers are the only sustainable long-term jobs. With provider closures, older adults will be unable to find a nursing home or aide services to help them out of bed, leaving them with no options or supports. Any cut to federal Medicaid dollars will have devastating impacts on older adults and those who serve them.

Per Capita Caps

Currently, states receive federal matching funds based on the cost of providing services to enrollees. If federal Medicaid financing switched to a per capita cap, states would receive a capped allotment per enrollee. The cap may increase by a set amount every year (CPI, chained CPI), but the increase is not tied to or set to keep up with actual costs.

It is important to note that Medicaid program costs do not trend with inflationary costs but rather are driven by enrollment numbers and average enrollee health needs. Costs do not trend with inflationary prices because rates are set by state agencies and are updated at each state's discretion. Medicaid rates paid by governments are not adjusted based on standard economic drivers like supply and demand the same way prices for other goods and services on the Consumer Price Index (CPI) fluctuate.

The medical components of the CPI have been cited as a possible inflationary factor; the CPI-M+1 was floated in past proposals. The CPI-M is wholly different from costs to provide Medicaid services and rather assesses increases in individual out of pocket costs for healthcare services, inclusive of costs for insurance premiums, co-pays, and over the counter pharmacological products. Increases in costs to individuals are market-driven by the insurance industry as they aggregate risk pools, premiums, out of pocket maximums, copays, formularies, among other factors. Medicaid program costs are not market driven costs but rather utilization driven as enrollees need more services or states enroll more eligible people.

Federal funding cuts under a per capita cap would be highly unpredictable and largely beyond states' control, not necessarily reflecting factors such as rising medical care prices, population aging and other demographic changes, and, possibly, natural disasters and epidemics. Factors like a new drug or procedure could lead to an unexpected increase in costs that would be highly variable across states.

Medicaid enrollees who use Medicaid long-term services and supports (LTSS) due to chronic illness or disability have health care costs around nine times higher than other enrollees. Adults aged 85 and older are more likely to use LTSS, so states expecting to have growing shares of older adults are more likely to substantially exceed a per capita cap for the aged 65 or over eligibility group.

States would not be rewarded for efficiency; because a per capita cap is initially based on current per person costs, a per capita cap is going to lock in existing differences in spending across states. States with lower initial per-enrollee costs would continue to receive less federal funding than states with higher initial costs.

If per capita caps had been implemented in 2018, almost all states would have exceeded their caps in one or more years between 2018-2022. Some state specific data can be found here.

Federal Medical Assistance Percentage (FMAP) Changes

Every state gets a different FMAP with a minimum floor of 50%, but all states get a 90% FMAP for the Medicaid expansion population. FMAP changes would be devastating to state budgets and would cause potential massive losses in coverage or reductions in services, benefits, or rates that would devastate providers of care for older adults.

Provider and Managed Care Organization (MCO) Taxes

Reductions in the hold harmless threshold for provider taxes, or elimination thereof, would be detrimental to state budgets, providers in the Medicaid program, and beneficiaries receiving coverage and services. States have legally deployed the use of provider and managed care taxes to raise revenues for their Medicaid programs including to fund programs related to quality and to help nursing homes afford to take on more clinically intensive patients that have nowhere else to go. CMS approvals and renewals of state programs have come under both Democrat and Republican administrations with the generated revenues serving constituents without regard for politics. Just recently, Governor Landry from Louisiana asked President Trump to "follow the law" and have CMS approve Louisiana's supplemental payment programs and Florida's requests around provider taxes.[1] These funds serve as critical pieces of state financing of their Medicaid programs and cannot be changed significantly without adequate lead time to allow for the establishment of new baselines or funding streams that could supplant the revenues currently garnered through provider taxes.

[1] https://t.co/TMNHZ6EFmP" / X

Proposals to limit financing in the Medicaid program won't result in less people needing services, but it will result in less access to an aide to help an older adult eat, an adult day center for a dementia-diagnosed parent so the caregiver can continue to work, or a nursing home for our neighbor when they need it.

Work Requirements

Of the 72 million individuals currently enrolled in Medicaid, around 20 million[2] of them would be subject to work requirement reporting if assumptions from prior proposals remain. Including mandatory work requirements for accessing health insurance through Medicaid has not been demonstrated to increase participation in the labor market or significantly change eligibility for Medicaid. The requirement would impose significant bureaucratic burden both on states and workers and increase the scope of government surveillance on an already under-resourced population. Individuals in this eligibility category are making an average of less than $21,000 a year and often face barriers to access the internet in rural areas or afford it urban locales severely limiting their options for completing reporting on their employment status. Even people who have tried to complete reporting have found a broken and frustrating system.[3]

State Responses to Federal Medicaid Cuts

States would have to fill in massive budget holes if federal funding to the Medicaid program were cut. Even if a cut, such as the change to the expansion FMAP proposal, does not seem to directly impact aging services it would because the cost of the cut would have to somehow be absorbed by state budgets. That type of hole cannot just be filled in via more "efficiency." The only way that states will be able to plug that gap is via:

1. **More state taxation.** President Trump and Congressional Republicans have repeatedly emphasized that one of their main goals is to lower the tax burden. Cutting federal funding for Medicaid could actually result in increased state taxes to sustain the program – thus undoing the promise to the American people regarding a lower tax burden. Older adults, including many older adults in rural areas, are already pressed by local tax affordability in some states; transitioning tax burdens to states will inevitably harm older adults.

2. **Transferring existing state general funds to Medicaid, defunding other popular and important programs.** Federal funding makes up one-third of state budgets. If federal cuts to Medicaid are enacted, states would have to make decisions between Medicaid funding and other important priorities like education and public services.

3. **Cutting benefits or services.** Around eight million older adults and people with disabilities rely on Medicaid (over six million in the home and community and over 1.4 million in nursing homes; remainder in other institutional settings like ICFs). Long-term services and supports (LTSS) – in nursing homes or in the home and community – are not covered by any other payers – only private pay or Medicaid. Medicare covers short term, skilled care in a skilled nursing facility or via home health if a person meets the eligibility criteria but not long- term care in either setting.

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[2] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/?utm_campaign=KFF-Medicaid&utm_medium=email&_hsenc=p2ANqtz-9MacWTNWbrw1tpX5EuDaIFwOHiIYMW6jlmn2dvnljGL_1DFYirmNU0jmfIUMU9XbM6opdGWW1q-vpKhqaOn__Jfa7ZJA&_hsmi=345705566&utm_content=345705566&utm_source=hs_email

[3] https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles

Home and community-based services are optional services and, therefore, more likely to be targets for reduction or elimination. Our members that provide personal care, assisted living, adult day, home care, and care management under the Medicaid program are already struggling with both sustainability and the ability to serve all the people who need care. Federal Medicaid cuts would place these services at significant risk of cuts because they are optional benefits.

Even if HCBS services are not eliminated due to any proposed federal cuts, it is expected that there would be new or longer waiting lists. HCBS waiting lists are already prevalent, but enhanced federal cuts would create longer wait lists as well as waiting lists for populations that do not currently have waiting lists for services. HCBS services benefit packages could also be scaled back at a time when the number of people needing these services is growing. While nursing home services are a mandatory Medicaid service and cannot have waiting lists if HCBS services were cut or eliminated, nursing homes could see increased demand that they could not meet.

4. **Cut rates.** Overall, Medicaid pays for 62% of all nursing home days. Nursing homes are a mandatory Medicaid benefit that states must provide. but there is already a gap between the cost of care for nursing homes and Medicaid rates.[4] If there is a federal Medicaid cut, this would trickle down to provider rate cuts and LeadingAge members would experience cuts. This would lead to provider closures, which would result in unmet need, job losses, and loss of businesses that contribute to local economies.

Balancing the ten-year budget cycle on the back of the Medicaid program is not a good tradeoff for the American people.

Conclusion

The need to do right by older adults in the reconciliation process has never been more important: by 2050, adults 65 years and older will comprise nearly a quarter of the U.S. population. It is essential that they have access to critically needed services and supports. Congress can help set us on the right track.

Thank you for your consideration, and we stand ready to provide any additional information you may need as you move forward with budget reconciliation legislation that addresses these critical issues.

Sincerely,

Katie Smith Sloan
President and CEO

cc: The Honorable John Thune, Senate Majority Leader
The Honorable Chuck Schumer, Senate Minority Leader
The Honorable Mike Johnson, Speaker of the House
The Honorable Hakim Jeffries, House Minority Leader

[4] https://aspe.hhs.gov/reports/assessing-medicaid-payments-costs-nursing-homes