May 13, 2025

The Honorable Brett Guthrie
Chairman
Energy & Commerce Committee
2125 Rayburn HOB
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
2322A Rayburn HOB
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Guthrie, Ranking Member Pallone, and Members of the Energy and Commerce Committee,

Re: Statement for the Record on Full Committee Markup of Budget Reconciliation Text

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers, LeadingAge writes today in opposition to many of the provisions offered as part of Committee's budget reconciliation bill that will be marked up on May 13. Our members serve older adults across the country and with a full spectrum of services and supports, such as senior housing, including affordable housing, assisted living and memory care, skilled nursing, home health, and hospice, and life plan communities that offer a continuum of housing and services to their residents.

Much of what is proposed in the Energy and Commerce Committee's Health title is deeply concerning to LeadingAge and our members and we urge the Committee to reconsider their proposals. The proposed level of Medicaid cuts, estimated to be upwards of $700 billion, and the at least 8.6 million people estimated to lose health insurance coverage will devastate communities, states, and people, including older adults and the providers who care for and serve them.

*Changes to retroactive coverage*

Applying for Medicaid is complicated; potentially never more so than when a health emergency or a long-term decline leads to the need for nursing home care. In a time of acute crisis, there is no way to proactively apply for Medicaid. Even in response to a longer term decline, many people are unaware that Medicare does not cover long term nursing home care and end up applying for Medicaid. For decades, Congress has guaranteed up to three months retroactive Medicaid coverage for eligible individuals in recognition that individuals may be unaware they are eligible or that the sudden onset of illness often prevents individuals from applying in advance.[1] This time is particularly critical for older adults who typically face high burdens to gather documents to verify their assets and undergo functional needs assessments to access long term care. Limiting retroactive eligibility also puts providers of long-term care in the position of deciding whether to accept beneficiaries in advance of their Medicaid approval – putting themselves at financial risk – or limit admissions to those who have already been approved for care which would cause a major access issue.

[1]Senate Report No. 92-1230, at 209 (Sept. 26,1972) (discussing section 255 of H.R. 1).

*Imposition of a moratorium on new or increased provider taxes and a change to the waivers of uniformity*.

We understand that the Committee has concerns about provider taxes as a mechanism for drawing down federal funds. State Medicaid programs will continue to have increasing Medicaid costs and the inability to adjust provider taxes to mirror any growth in cost or redirect the revenue to the parts of the program most in need will eventually lead to reductions in provider rates, services, or benefits over time. Similarly, modifying the criteria around the "generally redistributive" test – dollars raised from managed care organization (MCO) and other health care taxes help fund nursing home rates and home and community-based services – services that are essential for older adults and not paid for by other payers. If the Committee wants to discuss policies that enhance transparency around the federal funds drawn down via health care taxes or discuss different mechanisms to fund the parts of the Medicaid program they support, we would support such a policy discussion. Limiting the funds with no replacement will harm states and, ultimately, beneficiaries.

*Revising the home equity limit for determining long-term care services under the Medicaid program*.

Medicaid eligibility rules generally exempt the applicant's home as a countable asset. However, when evaluating eligibility for long term services and supports (LTSS), states are required to consider the value of the home above a designated threshold, which is indexed to inflation. This proposal both reduces for some states and freezes for all this home equity limit. Over time, the cap on home equity will continue to tighten, as the proposed legislation no longer links home equity to inflation. This would effectively force individuals to choose between forfeiting essential services or borrowing against their home's value and thus jeopardize their homeownership. This policy is being considered at a time when older adult homelessness is soaring – the Government Accountability Office (GAO) estimated that 146,000 older adults experienced homelessness in 2024, about 20% of all people experiencing homelessness.[2]

At LeadingAge, we represent providers of Medicaid home and community-based services (Medicaid HCBS) but often note that without affordable and accessible housing for older adults, expanding access to HCBS is not possible. If older adults lose their homes because they must borrow against their home's value to afford care, they will not be able to access Medicaid HCBS which might less costly and be their preference.

Furthermore, lowering the equity threshold would disproportionately impact low-income individuals, many of whom purchased their homes decades ago when property values were far lower. This issue is particularly acute for older Medicaid enrollees, who may be reliant on fixed incomes but have accumulated equity in their homes, which is their only remaining asset. This asset should not render them ineligible for the services and supports they need and potentially force them (and their dependents) to leave their home and communities.

*Community engagement requirements*

Community engagement or work requirements have been shown to be administratively burdensome and costly[3] both to states and to beneficiaries. Most people on Medicaid already

[2]https://www.gao.gov/blog/more-older-adults-are-homeless-what-can-be-done-help-vulnerable-population-unique-needs

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

work.[4] While we appreciate that the Committee outlined several potential exemptions, exemptions are complicated and will result in coverage losses of appropriate beneficiaries. For example, despite the bill's intention to exempt older adults, that exemption is for people over age 64. Many federal programs supporting older adults assist people 64 and younger. HUD-assisted affordable senior housing eligibility starts at 62; some other programs for older adults start at 55. It is estimated that more than 2 out of 3 residents in HUD assisted housing are dually enrolled in Medicare and Medicaid.[5] According to the Centers for Disease Control and Prevention, 55% of HUD-assisted older adults duals have five or more chronic conditions, compared to 43% of their non-HUD-assisted older adult duals peers. Many of these beneficiaries that may become duals and fit the profile of a dual but may be on Medicaid only (often via the expansion pathway) prior to turning 65 – and will have to show they are working or meet an exemption. We are concerned that this vulnerable population will lose vital Medicaid coverage that is helping them to stay in their homes – homes that are affordable whereas other options may not be.

There are also workers in the long-term services and supports field who rely on Medicaid via the expansion for their health insurance. Some workers may hold jobs at multiple employers. This is not our preference nor our goal, but it is a reality. Our provider members will likely have to verify employment and help their employees verify their employment across multiple employers – a situation ripe for administrative error and further complicated in rural areas where access to internet can be spotty, limiting the ability of individuals to submit their reporting documents via web portals. If staff lose coverage, they might not show up for work due to health problems or while they try to gather the paperwork to prove they are working. This is antithetical to the goal of the community engagement policy.

We are also concerned about the increased burden on states to administer work requirements and how that will impact their ability to fund and oversee other parts of the Medicaid program.

*Section 1115 waivers*.

States use 1115 waivers as a tool to innovate across many segments of the Medicaid program, including by wrapping additional services around high-cost and aging populations. This includes long term interventions to support housing stability and access to nutritional foods. These interventions are designed to prevent future adverse outcomes.

For older adults, many times the costs borne by the Medicaid program help offset acute care costs in Medicare by providing stable housing for older adults at-risk of homelessness. Preventing homelessness and ending it as quickly as possible when it does occur helps older adults stay healthy. The nation's shelter system is not designed to meet the needs of people with mobility and healthcare needs, including lack of access to refrigeration to store insulin and other medicine, slippery bathroom floors, and overall lack of mobility design for people who need walkers, wheel chairs, and other medical equipment to stay safe and healthy. Nutritious and palatable meals help moderate sodium and simple carbohydrate intake, providing healthier baselines and avoiding long-term pharmacologic dependence for hypertension, cholesterol, or other preventable conditions.

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[4] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements

[5] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/44236/HUDpic.pdf

Additionally, services like mental health and substance abuse treatment, money follows the person, and others might not meet a cost neutral standard but do meet budget neutrality since they are providing long term savings. We are concerned that these new cost-neutral requirements for 1115 waivers will stifle innovation at a time when our country is aging and innovation is critical to support this growing population.

*Increased eligibility checks*

Similar to the community engagement policy, we fear that increased eligibility checks will be a major burden on states and in conjunction with other policies proposed in this bill, will take time, money, and personnel that states will be lacking. Similar to community engagement requirements, we do worry about the older adult population such as those in HUD-assisted housing who might be utilizing Medicaid expansion for health coverage and therefore, would be subject to increased eligibility checks and may lose coverage due to the administrative burden. The sum of these policies will result in reduced access, rates, services, benefits, or all of the above.

We urge you to reject these polices and partner with us and others on policies to improve and strengthen the Medicaid program.

*Artificial Intelligence Oversight*

We are concerned by the provisions around artificial intelligence in Title IV, Subtitle C, Part 2. Specifically, Section 43201(c) authorizes a moratorium on state and local regulation of artificial intelligence models, artificial intelligence systems, or automated decision systems for 10 years. Artificial intelligence is developing at warp speed – we believe that keep options open for oversight at all levels of government which can respond to local need is critical. State and local governments can both be responsive to the needs developing in their communities and also may be able to move more nimbly than the federal government.

*Support for Moratorium on Staffing Rule*

We appreciate that the bill addresses the nursing home minimum staffing rule and bars implementation until 2035. We agree with Chair Guthrie that this rule tried to put a one size fits all policy on a diverse set of providers and will lead to nursing home closures and access challenges if not repealed.

To discuss these important issues further, please contact Linda Couch, senior vice president of policy and advocacy, at lcouch@leadingage.org or Mollie Gurian, Vice President of Policy and Government Affairs at mgurian@leadingage.org

Sincerely,

Katie Smith Sloan
President and CEO
LeadingAge

About LeadingAge: We represent more than 5,400 nonprofit aging services providers and other mission driven organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to

make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.