H.R. 1: ONE BIG BEAUTIFUL BILL ACT
MEDICAID RETROACTIVE ELIGIBILITY TALKING POINTS

On May 22, the House of Representatives passed the One Big Beautiful Bill Act (OBBB). LeadingAge urges NO to vote on OBBB in the Senate. The bill's overall negative impacts on older adults and the aging services ecosystem far outweigh its positives.

Medicaid retroactive eligibility is a federal policy that allows Medicaid to pay for health care services provided up to three months (90 days) before the date of a person's Medicaid application if the individual would have been eligible for Medicaid during that time. On House-passed H.R. 1, the *One Big Beautiful Bill Act* includes a provision to reduce Medicaid retroactive eligibility from 90 to 30 days beginning December 31, 2026.

If enacted, this policy change would pose serious financial and operational challenges to nursing homes and providers of home- and community-based services and create access barriers for the residents and families they serve. This would be particularly problematic in states without the ability to make the necessary technological, procedural, and staffing changes to accommodate the rapid implementation date of this policy.

Requested Policy Change

We request that the Senate exempt determinations for Medicaid applications approved for older adults and people with disabilities from the provision that reduces Medicaid retroactive eligibility from 90 days to 30 days.

The financial eligibility determinations for these groups are more complex and require gathering and submitting significant documentation. Applications require proof for multiple years of all accounts, deeds, trusts, or other related holdings. Working with applicants and their families to gather this necessary documentation can be extremely time-consuming. Without careful attention to detail from families, in a time of crisis, records are often incomplete, requiring additional time and communication. This is not the case for the traditional eligibility pathways as there is no requirement for the review of financial history.

Reducing retroactive eligibility would effectively shift financial risk from Medicaid to long-term care providers, residents, clients, and families. It would force providers to make more cautious admission decisions, creating barriers to access care for likely Medicaid-eligible seniors and people with disabilities. Over time, it could lead to a contraction of the long-term care safety net, especially in rural and underserved communities that already struggle with access.

Impacts on Patient and Resident Access

- **Reduced Access for Low-Income Individuals:** Medicaid is the largest payer of long-term care, covering over 60% of residents in nursing homes. If providers limit the admissions of Medicaid-pending residents or those with unknown financial status, those who can't pay privately may face longer waits or be turned away entirely.
- **Geographic Disparities:** In rural and underserved areas, where alternative care options are limited, this policy change could result in serious barriers to care for some patients and residents. A provider's closure due to financial strain could leave entire communities without access to nursing home care or home and community-based services regardless of their ability to pay privately.
- **Increased Financial Burden on Families:** Families may be asked to cover costs for the non-covered retroactive period, which could result in higher debt.

Financial Impacts on Care Providers

- **Loss of Reimbursement for Care:** Many residents need nursing care after a sudden illness or hospital stay and apply for Medicaid after they have been admitted to a long-term care provider. If the retroactive eligibility is reduced, nursing homes could lose 60 days of reimbursement for the care they have already provided. At an

average daily Medicaid reimbursement of approximately $244 per day[1], this could mean a loss of $14,640 per resident if two months of coverage is rejected.

- **Higher Uncompensated Care Costs:** Providers would likely have to absorb more care costs for residents who are ultimately Medicaid-eligible but whose application was not submitted within the shortened timeframe. This disproportionately affects nursing homes and long-term care providers with high Medicaid occupancy—often nonprofit, rural, or safety-net providers—that already operate on slim margins.
- **Increased Bad Debt and Billing Complexity:** Providers may need to write off unpaid balances or attempt to bill residents or families directly, which is often unsuccessful and time-consuming. This increases administrative costs and reduces net revenue, especially for smaller or less-resourced facilities.

Operational Impacts on Care Providers

- **Staffing and Resource Allocation:** To offset lost revenue, providers may be forced to reduce staff hours, delay capital improvements, or eliminate services like activities programming. This could have negative impacts on care quality and resident experience.
- **Tighter Admissions Policies:** To compensate for these potential outcomes, providers may need to implement more stringent screening for future residents that may be eligible for Medicaid, potentially delaying or denying admissions if financial eligibility is uncertain.
- **Delayed Discharges from Hospitals:** Nursing homes with stricter admissions policies for Medicaid-pending patients or those with undefined future payers could create additional bottlenecks in hospital discharge planning, particularly for medically complex or low-income patients. This could contribute to hospital capacity issues and potentially harm patient outcomes.

Impacts on State Administrative Burden

- **Increase in Submission of Incomplete Long-Term Care Applications:** Healthcare providers will begin Medicaid applications as early as practicable for all individuals with unknown financial status. This will result in significant administrative burden for states with many applications submitted that were never going to be income eligible, though in the absence of additional information from an individual or family, were submitted to hold an applicant's date of application for eligibility.
- **Higher State IT Costs:** States could be on the hook for increased IT costs to support additional applications or seek IT changes to accommodate an influx.
- **More Appeals and Additional Administrative Review:** Incomplete applications that are closed or denied for lack of supporting documentation will all be subject to appeal and further administrative review- increasing costs for states and providers.

[1] According to the Medicaid and CHIP Payment Access Commission (MACPAC), the average nursing facility Medicaid-covered cost per day in 2022 was $243.61. This cost was rounded up to $244 for the purpose of this calculation.