THE PARTNERSHIP FOR MEDICAID

May 9, 2025

The Honorable Brett Guthrie
Chair
Committee on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Bldg.
Washington, D.C., 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
2322A Rayburn House Office Bldg.
Washington, D.C., 20515

The Honorable Buddy Carter
Chair, Health Subcommittee
Committee on Energy & Commerce
U.S. House of Representatives
2432 Rayburn House Office Bldg.
Washington, D.C., 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
Committee on Energy & Commerce
U.S. House of Representatives
2111 Rayburn House Office Bldg.
Washington, D.C., 20515

CC: Speaker Johnson, Minority Leader Jeffries, Majority Leader Thune, and Minority Leader Schumer

RE: Medicaid Proposals in Reconciliation Bill

Dear Chairman Guthrie, Ranking Member Pallone, Chair Carter, and Ranking Member DeGette:

The members of the Partnership for Medicaid – a nonpartisan, nationwide coalition of organizations representing clinicians, health care providers, safety net health plans, and counties – are writing with our concerns with the cuts to Medicaid that may be considered by the Energy & Commerce Committee this month.

We are deeply concerned about any policy changes that will result in a reduction in coverage and access to care, an increase in the number of people uninsured, a rise in uncompensated care, and additional paperwork burden on enrollees, states, local health agencies, health plans and providers. Reductions in federal funding of Medicaid, or restrictions on states' ability to raise their share, come in different policies but have similar effects: a strain on state budgets that will result in cuts to coverage, benefits, or provider payment rates - which are already lower than those of Medicare and commercial payers.

Provider Taxes

States raise funds for their portion of Medicaid costs in a variety of ways. Provider taxes are health care-related fees, assessments, or other mandatory payments states place on health care providers to help finance the state's share of Medicaid expenditures. Provider taxes are outlined in law (PL 102-234) and regulated and approved by the Centers for Medicare and Medicaid Services (CMS). They must be broad-based and apply to all health care providers in a certain category.

If Congress places additional limits on provider taxes, states will face funding gaps and will likely make cuts to their Medicaid programs, including benefits and services across all eligibility categories. Reductions in states' ability to finance their programs put strain on state budgets and put benefits and services at risk, especially optional services that can prevent costly inpatient care, like home and community-based services, prescription drugs, and dental care. Proposals to further limit provider taxes only create estimated savings because of the resulting cuts to benefits, eligibility, or providers' payment rates.

Work Requirements

Most Medicaid enrollees are already working or face barriers to employment. Sixty-four percent of adults ages 19-64 that are not receiving disability benefits (through Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)) are working; 44% work full time and 20% work part time. Those that are not working cite caregiving (12%), illness or disability (10%), or school attendance (7%) as their reason for not working. The remaining 8% cite other reasons, including inability to find work.[1]

Work requirements increase the number of uninsured and create administrative burdens on states, beneficiaries, health plans, and providers, while not resulting in increased employment. A study published in *Health Affairs* showed that when Arkansas briefly implemented work requirements, 18,000 people lost coverage, despite the fact that more than 95% of the target population was working or qualified for an exemption. There were no increases in employment or community engagement. The study also found high costs of the program: implementation cost an estimated $26.1 million, with 17% covered by the state and 83% covered by the federal government. [2] Economic analyses have found that work requirements in SNAP cause people to lose benefits – especially those experiencing homelessness – without increasing employment.[3]

[1] Kaiser Family Foundation: https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/

[2] Health Affairs: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538

[3] American Economic Association: https://www.aeaweb.org/articles?id=10.1257/pol.20200561

The experience in Arkansas also showed that few enrollees or potential enrollees understood the work requirements. In Arkansas, 35% in the target group had not heard of the work requirement policy when polled. Similarly, Georgia's work requirements system remains profoundly under-enrolled – with fewer than 8,000 beneficiaries currently enrolled after 3 years, despite a target of enrolling 25,028 in the first year – and most applicants who expressed interest in the program ineligible, indicating a low understanding of program elements. Medicaid health plans will need to build capacity to support people as they strive to comply with the requirements. And our members report that when people do not understand their health insurance, they ask their health care providers. Implementing confusing work reporting requirements on enrollees will increase the burden on providers, to whom it will fall to help people understand and complete their paperwork.

Expansion FMAP

Reductions in federal financing will result in cuts to benefits and coverage for people covered by all parts of the Medicaid program. Some states will pull back on their expansion. Others will find other parts of Medicaid to cut – including optional services like adult dental, prescription drugs or home and community-based services, or payment rates to providers. Either way, reductions in federal financing means cuts to benefits and services.

The expansion of Medicaid that began in 2014 has reduced the number of uninsured, reduced the burden of uncompensated care on providers, and improved the health of enrollees.[4] Additionally, expansion was an economic benefit to states through job creation and increased state revenue[5]. Twelve states have laws that will end or reduce their Medicaid expansion if the federal share of financing is lowered.[6] The Medicaid expansion – which remains a lifeline for individuals making less than $22,000 per year – covers parents, people with disabilities, people experiencing homelessness, and other vulnerable populations in need. Although this policy does not explicitly target children, it will result in a reduction of federal Medicaid funding overall which will impact all Medicaid beneficiaries, including children.

Per Capita Caps for Expansion Populations

A per capita cap would create "per-enrollee" limits on federal Medicaid payments to a state. Implementing any per capita cap would significantly reduce state Medicaid funding, which would negatively impact access to care for all Medicaid beneficiaries. Per capita caps strip states

[4] Kaiser Family Foundation: https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/

[5] Robert Wood Johnson Foundation: https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html

[6] The 12 states are: AZ, AR, IA, ID, IL, IN, MT, NC, NH, NM, UT, and VA.

of the flexibility needed to implement cost-saving innovations and manage risk effectively. By imposing an arbitrary growth rate and spending ceiling designed to cut federal expenditures, this policy distorts market incentives and discourages investment in preventive care, leading to higher long-term expenses, costlier interventions, and increased uncompensated care burdens. If per capita caps fail to keep pace with healthcare inflation, states may be forced to shift costs onto providers or cut benefits, driving up private insurance premiums as providers seek to recover losses. Worse, these rigid funding limits fail to account for economic downturns, public health crises, or demographic shifts, leaving states scrambling to cover costs during recessions, pandemics, or opioid crises. Rather than fostering market-driven efficiency and accountability, per capita caps introduce instability, weaken state autonomy, and ultimately shift financial burdens back onto state taxpayers and local health systems.

Increased Eligibility Verification

During renewal, people often lose coverage because they are unable to produce the necessary paperwork in the required timeframes, even though they are eligible. Hourly employees and seasonal workers are particularly at risk. They are likely to experience income fluctuations that may raise their monthly incomes above the income threshold for short periods of time, even when their annual income remains below the threshold. Seasonal workers may also have address changes that mean that they do not receive renewal paperwork or do not receive it in time to meet renewal deadlines.

When people lose coverage, or do not understand health insurance paperwork, they turn to their health care providers for assistance in understanding their insurance and completing forms. Requiring more frequent eligibility verifications will result in more qualified people losing coverage and more paperwork burdens on families, states, and providers.

Retroactive Coverage

States are generally required to provide coverage of health care expenses incurred up to three months before a beneficiary enrolls, but only if the enrollee would have been eligible at the time that past services were provided. This coverage period helps those who face hospital bills or nursing home admissions and were not yet enrolled in Medicaid. It can also provide coverage of early medical appointments by pregnant women before they are able to enroll. Eligible people may not yet be enrolled in Medicaid due to recent loss of other coverage, paperwork delays, or misunderstanding of Medicaid eligibility, such as the common assumption that a nursing home will be covered by Medicare.

Retroactive coverage helps avoid uncompensated care for hospitals and medical debt for families, including NICU babies. Removing or restricting the reasonable three-month period of retroactive coverage will increase the financial burden on providers and families.

Lower FMAP Floor

The federal matching amount differs for each state, with the current statutory minimum of 50% and maximum of 83%. If Congress were to remove the FMAP floor, this would result in an overall reduction in federal matching funds to states, which would significantly strain states' abilities to fund their Medicaid programs. This would negatively impact beneficiaries and reduce access to care for all Medicaid populations.

DC FMAP

DC is unique in its limitations on ability to tax property and the large number of high earners who live just outside its borders but work in the city and use city services every day. A reduction from the statutory 70% FMAP to 50% would mean the loss of over $1 billion in revenue from the city, at a time when DC is already facing a budget crisis due to Congress' recent action on the continuing resolution. The cuts being considered for DC are far higher than for any other jurisdiction. Such a drastic cut will lead to cuts in not only Medicaid, but education, public safety, and other city services.

The Partnership for Medicaid stands ready to work with policymakers to identify sustainable strategies to strengthen Medicaid and improve on its promise of providing high quality coverage and access to care for populations in need. If you have questions or seek any additional information, please contact Paulo Pontemayor at the Catholic Health Association of the United States, First Co-Chair of the Partnership for Medicaid at ppontemayor@chausa.org.