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healthcare financial management association

June 26, 2025

The Honorable John Thune
Senate Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

Re: *Closing Recommendations to Mitigate Certain Effects and Unintended Consequences of the Largest Reform to Federal Medicaid in Program History*

Dear Leader Thune and Speaker Johnson:

First and foremost, HFMA and its members would like to thank you for your dedication to the financial sustainability of the Medicaid program. As you know, during the recent exchange open enrollment period for 2025, a record 24.3 million Americans signed up for health insurance on federal and state-based marketplaces. Fueled by enhanced premium subsidies extended in 2022, this represented a 13% increase over the prior year (2024) and more than double the same three years prior to that (2021).[1] Ensuring Medicaid is available for those who need it is of equal concern to our industry, profession and the communities we serve. While reasonable minds may differ on approaches to stabilize the program – i.e., eliminating waste, fraud, and abuse – our membership is pleased to see throughout the debate a bipartisan focus on prioritizing and protecting vulnerable populations among us, such as expectant mothers, their children, low-income seniors and individuals living with disabilities, among others.

As you enter the homestretch of policy deliberations, HFMA would like to take a final opportunity to contribute ideas that can mitigate certain effects and unintended consequences of various Medicaid reform proposals without material impacts to legislative scoring. To be clear, these recommendations make no attempt to dispute specific policy choices as proposed. Rather, we humbly request an opportunity to respond to their design and implementation. As evidenced by the recent COVID-19 pandemic, the U.S. healthcare financing and delivery system is not constructed to absorb external shocks. We appreciate your consideration.

I. Work Requirements.

As you know, peer-reviewed literature and empirical evidence on the efficacy of work requirements as a condition of Medicaid eligibility are incomplete. For instance, a recent *Health Affairs* article detailing the experience of the Arkansas Works program cited confusion and lack of awareness as common barriers to Medicaid enrollment across Arkansas, including among vulnerable populations.[2] Likewise, previous scoring by the Congressional Budget Office has estimated that Medicaid work requirements would not increase employment but would increase

[1] Exchange enrollment hits new high for 2025 - Modern Healthcare
[2] Reporting Requirements Matter (A Lot): Evidence From Arkansas's Medicaid Work Requirements | Health Affairs

coverage losses.[3] Simultaneously, implementing work requirements represents a huge undertaking for many states that do not presently have administrative infrastructure or resources to comply. While current legislative proposals have included $100 million in grants for states to upgrade such systems, experience suggests this will not be enough. For example, Georgia, which was granted a Section 1115 waiver by the Centers for Medicare & Medicaid Services (CMS) to pilot work requirements, spent more than $50 million on administration and upgrading its Medicaid systems.[4]

To mitigate anticipated implementation challenges, **HFMA recommends as follows**:

- Extend implementation until no later than December 31, 2030, if the state is demonstrating a good faith effort to comply with work requirements and submits progress in compliance or describes other barriers to compliance. This will ensure a window of five (5) full years (2026-30) for provider organizations to absorb the impact of anticipated coverage losses and adjust to shifting community utilization patterns.
- For states that are unable to demonstrate a good faith effort to comply with work requirements, extend implementation until no later than December 31, 2028. This will ensure three (3) full years (2026-28) for provider organizations to absorb the same.
- Increase grant funding for states to invest in and/or develop necessary infrastructure to administer work requirements as a condition of eligibility.
- Maximize exemptions for all populations deemed vulnerable or at risk, such as removing age conditions for exemptions of parents with children.

II. Eligibility and Enrollment Final Rule, Redeterminations for the Expansion Population, and Other Proposed Enrollment Changes.

Ensuring that eligible Medicaid beneficiaries have a fair and reasonable opportunity to enroll in the program is essential for a successful national safety net. This year, already, CMS has proposed shortening the Affordable Care Act (ACA) annual enrollment period by one month and reducing the budget for health insurance navigators by 90%. Moreover, current legislative proposals propose shortening the open enrollment and special enrollment period(s) for the health insurance marketplace; shortening retroactive coverage periods for new Medicaid recipients; and delaying implementation of and/or prohibiting material provisions of the Eligibility and Enrollment final rule, among other provisions. As you know, the effects of these changes will be compounded in the near-term by a looming expiration of ACA enhanced premium subsidies on December 31, 2025. According to the Congressional Budget Office, 2.2 million consumers are expected to lose their health insurance in 2026 if enhanced premium subsidies are not extended.[5]

To mitigate the impact of eligibility and enrollment change, **HFMA recommends as follows**:

[3] CBO's Estimate of the Budgetary Effects of Medicaid Work Requirements Under H.R. 2811, the Limit, Save, Grow Act of 2023

[4] Medicaid work requirements pose huge challenges for states

[5] Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits

- Enact a one (1) year extension of enhanced premium subsidies (calendar year 2026-27) to accommodate recipients who have budgeted for the same and other insurance dynamics wherein 2026 rates have been established.
- Thereafter, enact a phased-in approach over a four (4) year period (calendar years 2027-30) to terminate enhanced premium subsidies.
- Provide grant funding for states to invest in and/or develop necessary infrastructure to assist recipients in securing enrollment, if the state is demonstrating a good faith effort to comply with federal program requirements, such as work requirements.
- Restore and increase the federal budget for health insurance navigators.

III. Provider Taxes, State-Directed Payments, and Supplemental Payments Such as the Disproportionate Share Hospital Program.

As you know, various Medicaid financing arrangements have evolved over several decades based on federal and/or state designs to offset insufficient reimbursement. With respect to provider taxes, for instance, Senator Susan Collins recently remarked: "The problem with provider taxes is the reason they were done, is that Medicaid reimbursements were too low. So, are they a gimmick? Yes, but they are a gimmick that has been necessary for states to use in order to be able to come anywhere close to reimbursing for the actual cost, and that's why 49 out of the 50 states use provider taxes."[6] State directed payments, too, have grown in popularity in recent years. According to a recent MACPAC presentation, approximately one-third of hospitals' Medicaid payments from Medicaid managed care organizations are now from state directed payments.[7] Likewise, recent delays in legislated reductions to federal Disproportionate Share Hospital (DSH) payments underscore growing reliance on supplemental payment programs to finance Medicaid. Taken together, current legislative proposals to modify status quo Medicaid financing arrangements are expected to have an outsized effect, particularly with respect to rural providers. For instance, this month, a report from the Center for Healthcare Quality and Payment Reform found that one-third of all rural hospitals are presently at risk of closure.[8]

To mitigate the impact of Medicaid finance reform, **HFMA recommends as follows**:

- Delay by three (3) years (calendar years 2026-28) any material changes to or prohibitions against current state Medicaid financing, including but not limited to provider taxes, state directed payments, and DSH supplemental payments.
- During the same period, enact a national bipartisan commission to study the future of Medicaid, the health needs of the anticipated beneficiary population – including commensurate financing needs – and recommend revisions to and/or limitations against DSH and non-DSH supplemental payment programs, directed payment regulations, and other state-level financing designs such as provider taxes.

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[6] GOP Lawmakers Zero In On Work Reqs, Cutting Back Provider Taxes, Eligibility Checks | InsideHealthPolicy.com

[7] 02_February-Slides_Hospital-Non-DSH-Supplimental-Payment-and-Directed-Payment-Targeting-Analyses_.pdf

[8] Rural_Hospitals_at_Risk_of_Closing.pdf

- Should these recommendations of the national bipartisan commission fail to achieve legislative approval by U.S. Congress by December 31, 2028, enact an immediate phase-in of desired policy reform over a three (3) year period (calendar years 2029-31).

We appreciate your consideration of these closing recommendations to mitigate certain effects and unintended consequences of the largest reform to federal Medicaid in program history. HFMA and our members stand ready to assist you with any expertise or support that you may request. If you have additional questions, you may reach me or Andrew Donahue, Director of Policy at (708) 492-3341. The Association and I look forward to working with you.

Sincerely,

Richard L. Gundling, FHFMA, CMA
Senior Vice President, Professional Practice
Healthcare Financial Management Association

About HFMA

The Healthcare Financial Management Association is the nation's leading membership organization for more than 135,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a not-for-profit, nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards. We lead the financial management of healthcare.