Statement for the Record
by the
Association of American Medical Colleges
before the
Energy and Commerce Committee
U.S. House of Representatives

May 13, 2025

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record on legislative proposals before the House Energy and Commerce Committee on May 13, 2025. Specifically, the AAMC is providing feedback on Subtitle D, Part 1 of the legislation, which contains a number of Medicaid policies impactful to the academic medicine community and the patients they serve.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC strenuously opposes policies that would finance non-health care priorities through cuts to federal Medicaid spending. The Medicaid program is a critical source of coverage and care for over 70 million Americans spanning all 50 states, the District of Columbia, and US territories, including women, children, people with disabilities, the elderly, and working adults. Medicaid is also a financial lifeline for safety-net providers, including teaching health systems and hospitals and their affiliated faculty physicians. AAMC-member teaching health systems and hospitals across the country rely on Medicaid to support their ability to care for low-income and underserved patients. By the numbers, our members comprise just 5% of hospitals nationwide, however they account for 29% of all Medicaid inpatient days.[1] This is why contemplated cuts to Medicaid have an outsized impact on our member institutions across the nation. Teaching health systems provide Medicaid enrollees with access to highly specialized services that are often unavailable in other settings, such as oncology services, trauma care, and treatment for rare and complex conditions. These statistics illustrate our members' shared commitment to caring for

[1] AAMC analysis of FY2022 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute's Office of Cancer Centers, 2022. AAMC membership data, December 2023.

Medicaid enrollees and the disproportionate impact of contemplated Medicaid cuts on teaching hospitals and communities they serve.

The AAMC appreciates the opportunity to comment on certain policies outlined in Subtitle D ("Health"), Part 1 ("Medicaid") of the draft legislation:

Sec. 44132: "Moratorium on new or increased provider taxes"

Although the legislation maintains existing provider taxes, the AAMC opposes this policy, as it would prevent states from establishing new provider taxes or revising existing provider taxes to help fund their Medicaid programs. The AAMC is deeply concerned by proposals seeking to limit states' ability to leverage provider-based funding sources, including provider taxes, to finance the non-federal share of Medicaid spending. Under current regulation, states can levy taxes on health care providers to help finance their Medicaid programs, *without increasing the tax burden on individual residents*. Every state (except for Alaska) uses these taxes to support their Medicaid program. Restrictions on states' use of provider taxes would force states to contend with serious budget gaps in the future, forcing them to either increase taxes, cut non-health care budget items, or else reduce Medicaid expenditures, resulting in lower payments to providers, more limited benefit offerings, and reduced enrollment. We expect that states' inability to introduce future provider taxes will result in revenue losses, causing them to restrict eligibility and enrollment. Changes to Medicaid financing do not occur in a vacuum and inevitably harm Medicaid enrollees through a loss of coverage, benefits, and access to providers. With this in mind, the AAMC urges the committee to preserve provider taxes as a mechanism for states to finance their Medicaid programs and reject future restrictions on these taxes.

Sec. 44133: "Revising the payment limit for certain state directed payments"

State-directed payments (SDPs) are an important tool that allow safety-net providers to better care for Medicaid enrollees. While we appreciate that the legislation grandfathers existing SDP arrangements, the AAMC must oppose this provision as it would lower the SDP ceiling from the average commercial rate (ACR) to the Medicare rate for future arrangements. Additionally, this policy would cap spending on an SDP arrangement to the level originally determined under the initial approval process, which would preclude states from revising these arrangements or increasing payments to providers during future approval processes. This would seriously stymie the ability of state lawmakers to modify or adjust SDPs to further quality and access goals.

The AAMC strongly supports states' use of SDPs as a strategy to support safety-net providers and strengthen network adequacy for Medicaid enrollees. It is widely acknowledged that Medicaid fails to reimburse providers adequately for the care they provide, creating serious financial challenges for providers who serve this population. SDPs are used by states to help to offset inadequate and under-market Medicaid payment rates by directing Medicaid managed care plans to provide additional reimbursement to a particular class of providers, depending on the unique needs of their Medicaid population. These payments allow states to tailor investments in their Medicaid programs and ensure that they are able to recruit a sufficient number and mix of

providers to serve their enrollees. Furthermore, because CMS has already finalized a policy to treat the ACR as the payment limit, reducing the SDP payment limit to Medicare rates would represent a substantial reduction to Medicaid payment levels compared to current rates and could undermine access and quality goals.

The AAMC urges the committee to maintain the ACR as the ceiling for SDPs, which allows states the flexibility to determine appropriate payment rates to ensure that Medicaid enrollees enjoy the same access to care as others in their communities. While we appreciate that the legislation would grandfather existing SDPs at the ACR, we have concerns about the legislative language and how this exemption would apply to reapprovals, given that the current ACR regulations permit SDPs of one to three rating periods, with written approval required for renewing SDPs upon their expiration. It is also unclear how future renewals of a grandfathered SDP or an amendment to an existing SDP would be treated by CMS in determining whether the SDP continues to be grandfathered.

In addition to these comments, the AAMC would like to highlight our concerns with **Secs. 44108, 44141,** and **44142** of the legislation, which would reduce Medicaid enrollment—particularly among the Affordable Care Act expansion population—through more frequent eligibility checks, cost-sharing for enrollees, and the introduction of work and community engagement requirements. Given Medicaid enrollees' limited financial resources, research shows that even modest levels of cost-sharing can present significant barriers to coverage and care, reducing enrollees' use of medically necessary services. Evidence from previous section 1115 waiver demonstrations reveals that cost-sharing increases the financial burden placed on Medicaid enrollees, resulting in forgone care and worse health outcomes.[2] The AAMC has similar reservations about Sec. 44142, which would require states to impose work and community engagement requirements on Medicaid enrollees. As other stakeholders have previously pointed out, most Medicaid enrollees between the ages of 19 and 64 already work, and the bureaucratic hurdles created by such requirements can lead to inappropriate coverage losses among this population.[3]

Taken together, we are concerned that these policies would result in coverage losses among the Medicaid population, which would significantly increase safety-net hospitals' burden of uncompensated care. To protect access to coverage and care, we urge policymakers to prioritize policies that ensure continuous eligibility, reduce coverage disruptions, ease administrative burden for patients and providers, and improve the overall experience of the Medicaid program.

The AAMC remains committed to working with the committee to ensure access to coverage and care. If you have any further questions, please contact AAMC Senior Director of Government Relations and Legislative Advocacy, Len Marquez, at lmarquez@aamc.org.

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[2] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[3] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/