May 13, 2025

VIA ELECTRONIC TRANSMISSION

The Honorable Mike Johnson
Speaker of the House
H-232, The Capitol
Washington, D.C. 20515

The Honorable John Thune
Senate Majority Leader
S-309, The Capitol
Washington, D.C. 20515

The Honorable Hakeem Jeffries
House Minority Leader
H-204, The Capitol
Washington, D.C. 20515

The Honorable Chuck Schumer
Senate Minority Leader
S-230, The Capitol
Washington, D.C. 20515

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

On behalf of the undersigned physician organizations, we thank you for your previous bipartisan efforts in support of Medicaid and the Children's Health Insurance Program. These programs remain essential lifelines for low-income and vulnerable Americans. As physicians with front-line experience in both private practice and hospital-based settings, our members understand the critical role Medicaid plays in ensuring access to care. While we share the goal of improving Medicaid's sustainability and effectiveness, we urge Congress to work closely with frontline physicians and other stakeholders to craft balanced solutions that strengthen the program and preserve continuity of care for low-income patients.

We appreciate that the recently released legislative text includes important provisions aligned with many of the policy priorities outlined in this letter. In particular, the proposed reforms in Medicare physician payments are urgently needed to preserve access to care for seniors, especially in rural and underserved communities. The introduction of a permanent annual inflation adjustment represents an important first step in addressing the underlying instability of the Medicare payment system.[1] We also recognize the inclusion of commonsense program integrity reforms to reduce improper payments and improve data reliability, such as requiring states to verify deaths and prevent duplicate enrollment across states regularly. Federal watchdog agencies have long recommended them.[2, 3]

[1] While the proposed update is a positive step, it does not resolve the underlying instability in the Medicare payment system or substitute for long-term structural reform. The MEI-based adjustment reflects only a portion of actual practice cost growth and is further diminished by ongoing statutory reductions, including sequestration and budget-neutrality adjustments. Without a sustainable reimbursement framework, physician-led practices, particularly small and independent ones, will remain on a path where selling or closing becomes the only viable option. Ensuring predictable, adequate payment is essential to preserving competition, supporting small businesses, and delivering patient-centered care in lower-cost, community-based settings.

[2] U.S. Department of Health and Human Services, Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States, A-05-20-00025, September 19, 2022, https://oig.hhs.gov/reports/all/2022/nearly-all-states-made-capitation-payments-for-beneficiaries-who-were-concurrently-enrolled-in-a-medicaid-managed-care-program-in-two-states/.

[3] U.S. Department of Health and Human Services, Office of Inspector General. Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths. Audit Report A-04-21-09005. November 24, 2023. https://oig.hhs.gov/reports/all/2023/multiple-states-made-medicaid-capitation-payments-to-managed-care-organizations-after-enrollees-deaths/.

However, we remain concerned that several Medicaid proposals could disrupt coverage for vulnerable populations by shifting significant costs to states without a clear, evidence-based path to maintaining continuity of care. Employment status alone is not a reliable indicator of access to health coverage, as many low-wage workers are ineligible for Medicaid and lack affordable employer-sponsored insurance. A sustainable solution requires a multi-pronged approach that offers multiple, affordable pathways to coverage.

Meaningful reform is centered on delivering care smarter. One path forward is through reimbursement structures that reward value, efficiency, and improved patient outcomes. This includes supporting innovative, bipartisan efforts to expand access to telehealth and alternative payment models, promote the use of health savings accounts, integrate nutrition into Medicaid policy, and more.[4, 5] In this drive towards delivering smarter care, we note that the implementation of alternative payment models and value-based care models remains a persistent challenge. Despite years of effort, the U.S. Centers for Medicare and Medicaid Services has struggled to adopt quality metrics and reimbursement methodologies that reflect the realities of clinical practice. To accelerate progress, we urge Congress to support proposals that directly engage medical specialty organizations and that leverage real-world evidence, such as those enabling clinician-led registries to access and link with Medicaid and Medicare claims data.[6] This would support longitudinal research, quality improvement, and the development of smarter reimbursement models that reduce waste while improving patient outcomes.

Few opportunities in health policy offer as much promise as prevention, eliminating the need for costly, lifelong care by addressing conditions that are mostly or entirely avoidable. Diet-related chronic conditions, such as obesity, type 2 diabetes, cardiovascular disease, asthma, and certain cancers, are prevalent among Medicaid beneficiaries and contribute substantially to healthcare expenditures. One analysis estimated that just four nutrition-related chronic diseases among working-age adults cost the U.S. economy $16 trillion from 2011 to 2020, nearly 9% of GDP, when factoring in direct medical costs, lost productivity, and wages.[7] Implementing Medicaid-focused strategies that emphasize nutrition, disease prevention, and proactive care could alleviate this burden. Cardiovascular conditions, including heart disease and stroke, are among Medicaid's most expensive categories, driven by high prevalence and costly inpatient care.[8] Early intervention and sustained management of these conditions can significantly reduce expenditures, especially since untreated hypertension and related complications are leading causes of hospitalizations and long-term disability among Medicaid beneficiaries.

A compelling example of prevention's potential is spina bifida, a neural tube defect that can cause lifelong disability, severe kidney problems, paralysis, and infant mortality.[9] Following a 1992 public health recommendation, the FDA mandated folic acid fortification of enriched grains in 1998, leading to a sharp

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[4] U.S. Representative Dan Crenshaw, "Crenshaw, Schrier, Smucker, Pettersen Introduce Bipartisan Bill to Expand Access to Direct Primary Care Through Medicaid," February 11, 2025, https://crenshaw.house.gov/2025/2/crenshaw-schrier-smucker-pettersen-introduce-bipartisan-bill-to-expand-access-to-direct-primary-care-through-medicaid.

[5] David Raths, "North Carolina Plans to Expand Medicaid SDOH Pilot Statewide," Healthcare Innovation, April 5, 2024, https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/news/55002542/north-carolina-plans-to-expand-medicaid-sdoh-pilot-statewide.

[6] American Association of Neurological Surgeons and Congress of Neurological Surgeons, "AANS and CNS Support the Access to Claims Data Act of 2024," September 25, 2024, https://www.aans.org/advocacy/articles/aans-and-cns-supports-the-access-to-claims-data-act-of-2024/.

[7] Tara O'Neill Hayes and Rakeb Asres, The Economic Costs of Poor Nutrition, American Action Forum, March 9, 2022, https://www.americanactionforum.org/research/the-economic-costs-of-poor-nutrition/.

[8] Liang, L., Moore, B. J., and Soni, A., National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2017. Statistical Brief #261. Rockville, MD: Agency for Healthcare Research and Quality, July 2020. https://www.ncbi.nlm.nih.gov/books/NBK561141/.

[9] University of Alabama at Birmingham, Department of Neurosurgery, Neurosurgery addresses spina bifida prevention in Alabama's Hispanic community, by Savannah Kirchner, July 24, 2024, https://www.uab.edu/medicine/neurosurgery/news-events/department-news/neurosurgery-addresses-spina-bifida-prevention-in-alabama-s-hispanic-community.

decline in cases.[10, 11] However, corn masa flour, a staple in many Hispanic households, is not subject to the same requirement. This policy gap contributes to disproportionately high rates of spina bifida in Hispanic communities, despite clear evidence that folic acid supplementation before and during pregnancy can reduce risk by up to 70%.[12] One study found that infants with spina bifida in North Carolina's Medicaid program incurred nearly $33,000 in first-year costs, compared to $3,900 for unaffected infants.[13] Of the 166,000 Americans living with spina bifida, nearly two-thirds now survive into adulthood and frequently rely on public insurance and multidisciplinary care.[14] Many also depend on full-time caregiving from family members, limiting employment opportunities and increasing long-term financial burden. Extending folic acid fortification to corn masa flour could prevent hundreds of new cases each year, improve health equity, and save Medicaid and other federal programs billions in avoidable health care costs.

Finally, it's important to recognize that coverage does not guarantee access to care. Medicaid continues to be plagued by unreasonably low payments to physicians.[15] Patient access to care is frequently limited to the few physicians willing and able to accept insufficient payments to provide care under Medicaid. Further, managed care plans, which account for nearly half of Medicaid spending, have repeatedly denied or limited medically necessary services.[16] A 2023 OIG report found that one in eight prior authorization requests were denied, sometimes far more, while most states lacked adequate oversight or external review.[17] Additional investigations by federal and state agencies have confirmed persistent gaps in how plans manage authorizations and appeals, characterized by limited transparency and inconsistent accountability.[18] In some cases, public agencies have had to intervene and provide services that were denied by managed care plans.[19] National experts also note that low-income patients are less likely to

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[10] U.S. Food and Drug Administration, Food standards: amendment of standards of identity for enriched grain products to require addition of folic acid, Federal Register. 1996;61(41):8781–8797, https://www.govinfo.gov/content/pkg/FR-1996-03-05/pdf/96-5014.pdf.

[11] U.S. Centers for Disease Control and Prevention, "Update on Overall Prevalence of Major Birth Defects — Atlanta, Georgia, 1978–2005," Morbidity and Mortality Weekly Report 64, no. 1 (2015): 1–5, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a2.htm. *See also* Lynn M. Waitzman, Scott D. Grosse, and Curtis S. Yoon, "Revised National Estimates of the Economic Costs of Spina Bifida in the United States," Birth Defects Research Part A: Clinical and Molecular Teratology 106, no. 11 (2016): 794–805, https://pubmed.ncbi.nlm.nih.gov/26790341/, *See also* U.S. Centers for Disease Control and Prevention, "Spina Bifida and Anencephaly Before and After Folic Acid Mandate — United States, 1995–1996 and 1999–2000," Morbidity and Mortality Weekly Report 53, no. 17 (2004): 362–365, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5317a3.htm.

[12] U.S. Centers for Disease Control and Prevention, Spina Bifida: Data and Statistics, https://www.cdc.gov/spina-bifida/data/index.html.

[13] Lijing Ouyang, Scott D. Grosse, and J. Kevin Thibadeau, "Healthcare Expenditures of Children and Adults with Spina Bifida in a Privately Insured U.S. Population," *Birth Defects Research Part A: Clinical and Molecular Teratology* 79, no. 7 (2007): 552–558, https://doi.org/10.1002/bdra.20377.

[14] Illinois Spina Bifida Association, Survey Reveals Insurance and Government Assistance Gaps for Spina Bifida Families, September 22, 2020, https://i-sba.org/stories/2020/9/22/survey-reveals-insurance-and-government-assistance-gaps-for-spina-bifida-families-9n8gt#:~:text=Key%20findings%20of%20the%20survey,include. These individuals require lifelong, multidisciplinary care from neurosurgeons, urologists, orthopaedic surgeons, primary care physicians, physical medicine and rehabilitation specialists, neurologists, dermatologists, and others to manage complex complications.

[15] Medicaid and CHIP Payment and Access Commission, "Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services," January 2025, access May 12, 2025. https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf.

[16] Kaiser Family Foundation, "Distribution of Medicaid Spending by Service," accessed May 11, 2025, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/.

[17] U.S. Department of Health and Human Services, Office of Inspector General, High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care, OEI-09-19-00350, July 17, 2023, https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicaid-managed-care/.

[18] U.S. Government Accountability Office, *Medicaid Managed Care: Additional Federal Oversight Needed to Help Ensure Beneficiaries' Access to Covered Services*, GAO-24-106532, February 2024, https://www.gao.gov/products/gao-24-106532.

[19] Carrie Teegardin and Justin Price, "Georgia Children in Foster Care Struggle to Get Mental Health Services," *The Atlanta Journal-Constitution*, August 17, 2023, https://www.ajc.com/news/investigations/georgia-children-in-foster-care-struggle-to-get-mental-health-services-ajc-investigation/4GAO5F2SYJCCPAI7MMQS2ESLQY/.

appeal denials, further deepening disparities.[20] These findings underscore the urgent need for improved accountability, data transparency, and regulatory oversight across Medicaid managed care.

The policy recommendations outlined in this letter are not exhaustive. Still, they reflect the kind of practical, consensus-based solutions that emerge when legislation is developed in earnest collaboration with those who serve on the front lines. These physician-led, patient-centered priorities are grounded in real-world care delivery and a commitment to improving outcomes while strengthening the sustainability of our health system. We stand ready to work with you and the relevant committees to advance transformative and enduring bipartisan policies.

Sincerely,

American Association of Neurological Surgeons
Congress of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Society of Anesthesiologists
American Gastroenterological Association
American Academy of Allergy, Asthma & Immunology
American Academy of Emergency Medicine
American Academy of Hospice and Palliative Medicine
American College of Allergy, Asthma & Immunology
American College of Gastroenterology
American College of Rheumatology
American Geriatrics Society
American Orthopaedic Foot & Ankle Society
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Surgery of the Hand Professional Organization
American Society of Colon & Rectal Surgeons
American Society of Nuclear Cardiology
American Society of Transplant Surgeons
American Urological Association
Digestive Health Physicians Association
National Association of Spine Specialists
North American Neuromodulation Society
Society for Cardiovascular Angiography and Interventions
Society of Hospital Medicine

[20] Medicaid and CHIP Payment and Access Commission, *Denials and Appeals in Medicaid Managed Care*, March 2024, https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-2-Denials-and-Appeals-in-Medicaid-Managed-Care.pdf.