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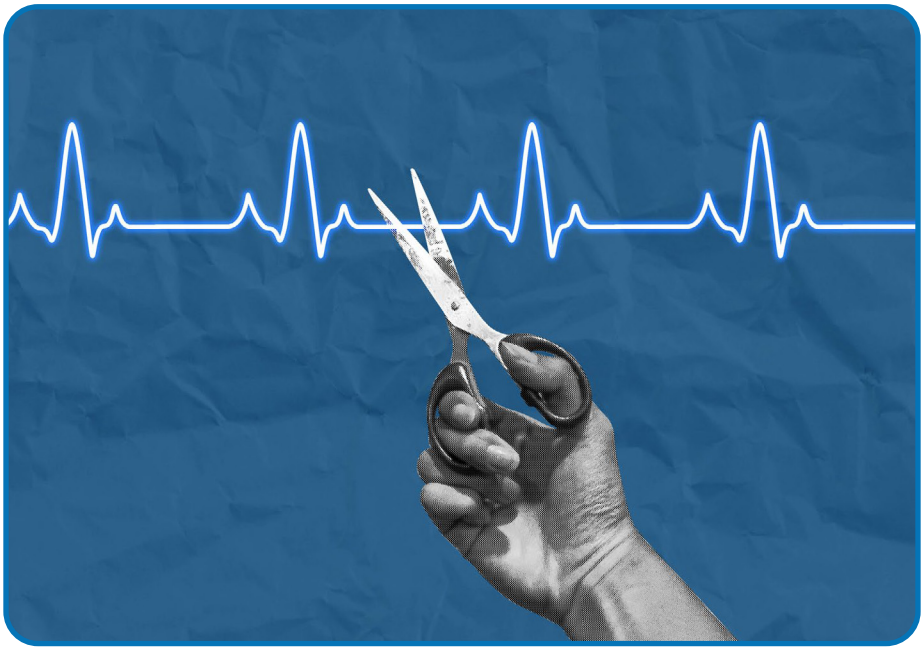
PULSE

CMS Signals Major Medicaid Cuts

The agency is currently targeting federal matching funds for certain state health programs, according to a letter it sent to states last month.

The Centers for Medicare and Medicaid Services (CMS) has announced plans to significantly reduce Medicaid spending by eliminating federal matching funds for certain state health programs, according to a recent article from Healthcare Finance News.



The agency is specifically targeting designated state health programs (DSHP) and designated state investment programs (DSIP), which CMS claims have been funded through "creative interpretations" of section 1115 demonstration authority. In a letter sent to states last month, CMS outlined its intention to deny new requests and discontinue existing arrangements for federal matching funds. The agency noted that these programs have seen dramatic growth, increasing from $886 million in 2019 to a projected $2.7 billion in eligible expenditures by 2025, representing what they describe as unsustainable federal spending without adequate state contribution.

This move aligns with recent congressional budget developments, where the Senate passed a blueprint expected to include Medicaid cuts. The House narrowly approved moving forward with the budget in a 216-214 vote. However, significant division exists among Republican lawmakers regarding the scope of cuts, with House Speaker Mike Johnson supporting program reductions while Senate Republicans express concerns about their House colleagues' proposed $1.5 billion in cuts over the next decade, according to The Hill.

In its letter, CMS highlighted several programs they consider problematic, including $241 million for non-medical in-home services in New York, $20 million for rural health care providers' high-speed internet in North Carolina, and various other state initiatives they argue don't directly benefit Medicaid beneficiaries. The agency referenced its own 2017 position under the Trump administration, which questioned the necessity of federal DSHP funding for state-operated programs.

The cuts face strong opposition from health care organizations.

"The American Hospital Association [AHA] urges Congress to take seriously the impact of reductions in healthcare programs, particularly Medicaid," AHA President and CEO Rick Pollack said. "While some have suggested dramatic reductions in the Medicaid program as part of a

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reconciliation vehicle, we would urge Congress to reject that approach. Medicaid provides healthcare to many of our most vulnerable populations, including pregnant women, children, the elderly, disabled and many of our working class."

The path to these cuts was further solidified through a Senate amendment to a House budget resolution, which directed the House Energy and Commerce Committee to cut at least $880 million in spending. The Congressional Budget Office has indicated that achieving this target would necessarily require significant Medicaid reductions, as the committee holds primary jurisdiction over the program, according to the article.~

What's Next?

CMS's decision appears to be driven by long-standing oversight concerns from congressional committees and the Government Accountability Office regarding whether these state programs properly align with Medicaid's intended beneficiaries and the established federal-state financial partnership. The agency's current stance suggests a significant shift in how federal Medicaid funds will be allocated to states, potentially affecting numerous health care initiatives across the country.

This development represents a major change in federal health care funding policy, with potentially far-reaching implications for state health care programs and the vulnerable populations they serve. However, the outcome of these proposed cuts remains uncertain as congressional negotiations continue.

Supreme Court Weighs Constitutionality of ACA Preventive Care Mandate

A key panel that mandates free preventive care under the Affordable Care Act, faces uncertain future.

The Supreme Court is currently hearing arguments in a pivotal case challenging the constitutionality of the Affordable Care Act's (ACA) preventive services requirement. At the heart of the dispute is the U.S. Preventive Services Task Force's authority to determine which preventive services must be covered at no cost to patients under the ACA.

The case originated from a lawsuit filed by individuals and small businesses who objected to the task force's 2019 recommendation requiring insurers to cover HIV-prevention drugs (PrEP). The plaintiffs argue that the preventive services requirement violates multiple constitutional principles, including the Appointments Clause, the nondelegation doctrine, and the Religious Freedom Restoration Act.

Since 2010, this provision has guaranteed coverage of evidence-based preventive services such as cancer screenings, tobacco cessation programs, contraception, and immunizations to more than 150 million Americans annually. The requirement has led to increased cancer screening rates, improved vaccination coverage, better access to contraception, earlier detection of chronic conditions, and reduced racial disparities in preventive care access.

"The task force's recommendations were challenged by a Texas business, Braidwood Management, that objected on religious grounds to covering certain preventive services, including the PrEP medications," according to CNN.

"Braidwood argued that because Congress demanded the task force's work be 'independent' that its members should have been appointed by the president and confirmed by the Senate."

The legal challenge centers on the appointment process for members of the Task Force, Health Resources and Services Administration, and Advisory Committee on Immunization Practices. The plaintiffs, including Braidwood, contend these members are principal officers who should be appointed by the president and confirmed by the Senate, rather than their current appointment method.

A district court partially agreed with the plaintiffs, and the 5th Circuit Court of Appeals affirmed the ruling while limiting its scope to the specific plaintiffs involved. The Biden administration appealed this decision to the Supreme Court in September, continuing the defense of the preventive services requirement that began under the Trump administration.

The case has drawn significant attention from health care stakeholders, with numerous organizations filing briefs in support of maintaining the preventive services requirement. These include the American Public Health Association, the Susan G. Komen Breast Cancer Foundation, the Chronic Illness and Disability Partnership, and various state attorneys general and health care advocacy groups.

What's Next?

While the Supreme Court appears likely to uphold the Obamacare mandate, the outcome of this case could have far-reaching implications for health care access in the U.S. If the Supreme Court rules in favor of the plaintiffs, it could potentially eliminate guaranteed coverage for preventive services that millions of Americans currently receive without cost-sharing, potentially creating new barriers to essential preventive care.

NEWS & NOTES

Health Plans' Digital Experience Falls Short of Consumer Expectations

Despite increasing reliance on digital platforms, health insurance providers are struggling to meet member expectations for their websites and mobile apps, according to J.D. Power's 2025 U.S. Healthcare Digital Experience Study. Customer satisfaction scores for health plan apps lag significantly behind other industries, with commercial plans averaging 653 and Medicare Advantage plans scoring just 597 out of 1,000 points —well below the satisfaction levels seen in wealth management (794), property insurance (700), and automotive finance (672). The study reveals that ease of finding information is the most crucial factor in digital satisfaction, yet health plans fail to deliver on this basic requirement 39% of the time.

Hospital CFOs Grapple with Trump's Tariff Policies and Supply Chain Uncertainty

Hospital executives are adopting a "wait and see" approach to President Trump's volatile tariff policies, which are creating uncertainty in healthcare supply chains and budgeting processes, according to Healthcare Finance News. With approximately half of medical supplies, devices, and pharmaceuticals sourced from China, and Trump's recent announcement of tariffs reaching 145% on Chinese imports, health care leaders are particularly concerned about potential cost increases. While pharmaceuticals are currently exempt from tariffs, Trump has indicated they may be included in future policies. The administration has paused higher tariffs on most countries for 90 days while pursuing bilateral trade deals. The impact of these policies extends beyond immediate supply chain concerns, affecting hospitals' overall financial health. CFOs are particularly focused on both short-term expenses and long-term implications for inflation and pricing. According to Fitch Ratings, market volatility presents significant challenges to not-for-profit hospitals' balance sheet stability. With 40% of hospital systems operating in the red, health care leaders are reviewing supplier contracts and considering cost-cutting measures. Major health care companies like Johnson & Johnson are already factoring tariff costs into their financial forecasts, with J&J estimating $400 million in tariff-related expenses for 2025.

Washington Governor Signs Medical Debt Legislation

The bill, a focus for ACA state advocates this session, will take effect July 27.

Washington state's medical debt legislation was signed by Gov. Bob Ferguson last month.

ACA International expected the legislation would pass this session and be signed by the governor, which made it an advocacy priority for unit lobbyists and Washington members of the Northwest Collectors Association.

State advocates' work on Washington Senate Bill 5480 resulted in an updated definition of medical debt in the legislation, which creates important precedent as other states continue to consider legislation on medical debt credit reporting.

The association's advocacy was in part focused on updating the definition of medical debt in the bill, ACA previously reported.

In a recent amendment, medical debt was redefined as "a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices, or to such person's agent or assignee, for the provision of such medical services, products, or devices."

Overall, the bill seeks to protect consumers by removing barriers created by medical debt.

It would:

- Declare a medical debt void and unenforceable if it is reported to a consumer credit reporting agency or credit bureau.
- Prohibit specific entities from reporting medical debts to a consumer credit reporting agency or credit bureau, on pain of committing a violation of the Consumer Protection Act.

The bill will take effect July 27.

DATAWATCH

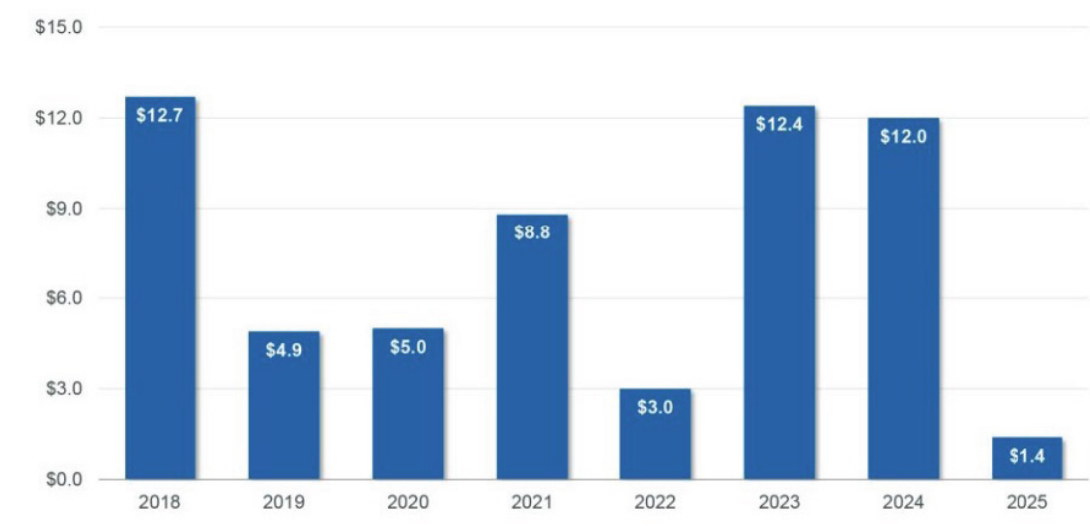
Hospital M&A Activity Dips Amid Economic Uncertainty

Kaufman Hall's latest quarterly M&A report reflects "market volatility and economic uncertainty surrounding tariffs and potential policy changes from the new administration."

Only five transactions were announced in the first quarter, according to the report. This is lower than the COVID-19-era's seven transactions in Q3 2021.

There were no "mega mergers" in the first quarter of 2025 (mergers in which the smaller party has annual revenues in excess of $1 billion), and the average size of the smaller party was $279.3 million—roughly half of the average seller size recorded for 2024.

Total Q1 Transacted Revenue ($ in billions) by Year, 2018 - 2025



Source: M&A Quarterly Activity Report: Q1 2025. https://tinyurl.com/5eufjd34

PULSE

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