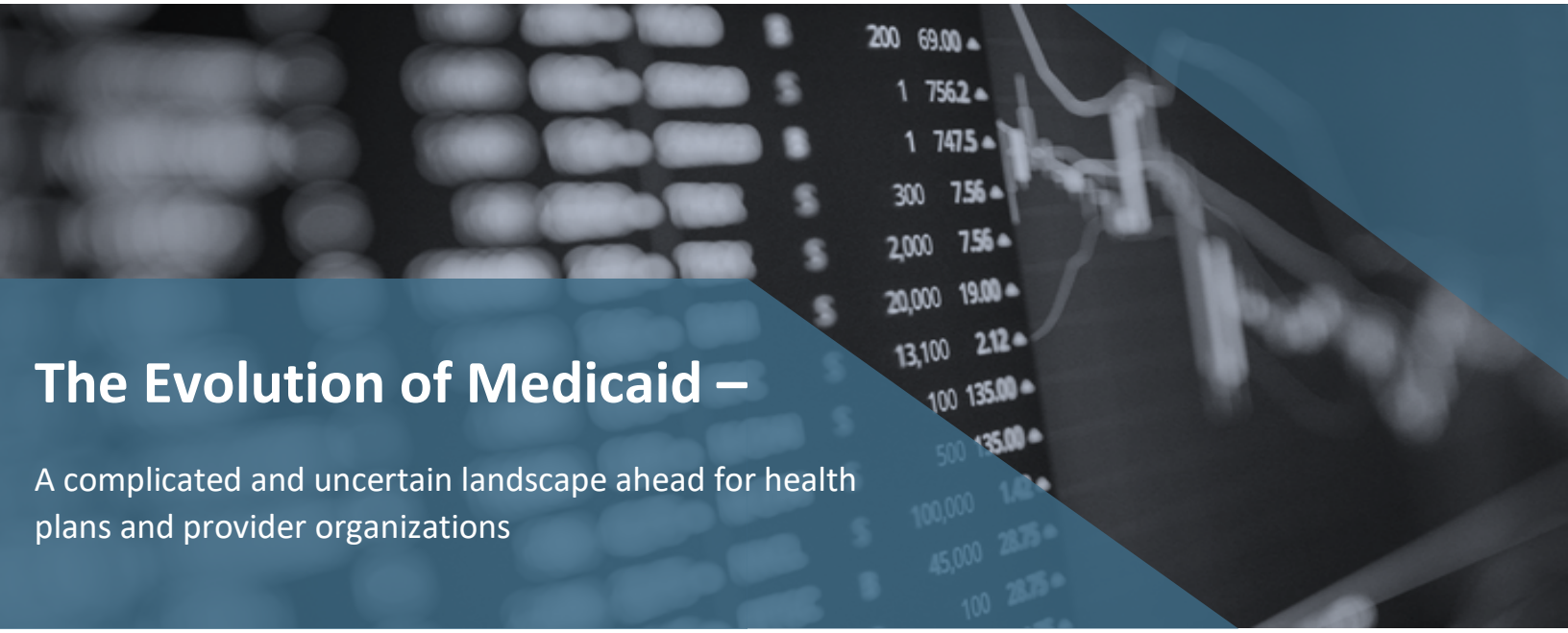

The Evolution of Medicaid –

A complicated and uncertain landscape ahead for health plans and provider organizations

Since the start of 2025, many factors are at play that could affect Medicaid coverage, financing, and access to care. Medicaid is the primary program providing comprehensive health and long-term care to one in five individuals living in the U.S. There is talk as well as ongoing expectations that changes will likely be proposed through executive actions by the Administration and as part of a tax and spending debate in Congress. Even without Congressional action, the Administration can make significant programmatic changes through executive action. Cuts and/or significant changes to the Medicaid program would impact more than 80 million people who rely of the program for health insurance, including individuals from all walks of life, including middle class as well as older adults who rely on it for long term care benefits.

There are both immediate and longer-term changes that set forth an uncertain and multi-dimensional framework for health plans and provider organizations to consider as they think about individuals served and ways to plan for and/or mitigate the health care consequences for the diverse groups of individuals served who may be at risk.

The purpose of this briefing is to highlight several potential changes and impacts that could have major implications for Medicaid coverage, financing and access to care, providing a small window for proactive and targeted efforts aimed at shoring up current programs and access to care, as well as heading off related challenges to ongoing health status for the diverse populations at risk.

Federal Funding Cuts and Financing Reforms

The House of Representatives is considering $2.3 trillion in Medicaid cuts from policy changes that include: imposing a per capita cap on federal Medicaid spending, reducing the federal government's share of costs for the Affordable Care Act (ACA) expansion group, imposing Medicaid work requirements, reducing the minimum federal matching rate for Medicaid expenditures, and repealing the incentive for states to newly adopt the Medicaid expansion that was passed in the American Rescue Plan Act. These policy changes would fundamentally alter how Medicaid financing works and federal spending reductions of this magnitude would put states at significant financial risk, likely forcing them to cut the number of people covered, cover fewer benefits, and cut payment rates for physicians, hospitals, and nursing homes.

Health plans and provider organizations should begin to engage in dialogue in anticipation of these risks and consider both the consequences in terms of impacts (who, what, when and where) and how to be prepared.
For health plans, these changes raise significant strategic considerations. The potential loss of federal matching dollars,

along with lower Medicaid reimbursement could translate into greater financial instability, increased cost burdens on commercial lines of business, and further pressure on provider networks. Proactively modeling financial exposure, strengthening contingency plans, and advocating for sustainable reimbursement structures will be essential to navigate these evolving funding challenges. Understanding pressure on provider networks can enable getting a leg up on working with them to consider changes to contractual structures and reimbursement and how to shore up on-going sustainability of provider networks.

Work Requirements for Medicaid Eligibility

During the current Congressional session, work requirements for Medicaid eligibility are under consideration.

Previously, 13 states received 1,115 waiver approvals to condition Medicaid coverage on meeting work and reporting requirements. However, the waiver ended in 2019 when a federal court found the work requirement approval unlawful. Several states have continued to pursue work requirement waivers despite data showing that most Medicaid adults are working or face barriers to work. Among adults with Medicaid who are under age 65 and do not have Medicare or Supplemental Security Income (SSI), 91% are working, or are not working due to an illness, caregiving responsibilities, or school attendance.

Health plans and provider organizations need to recognize that individuals impacted come from all walks of life and impacts of changes such as these will impact people differently and over time. There is an opportunity to dig further into enrolled and served populations to get a better grasp on subpopulations who will be differentially impacted not just by cuts, but by other actions and related programs and services whose funding may be jeopardized.

With regard to work requirements, *while increased state autonomy may prompt more localized Medicaid program design, it also requires careful oversight to ensure that eligibility changes do not create unintended coverage gaps and/or disruptions in care continuity. As eligibility policies evolve, health plans need to focus on compliance readiness, patient advocacy and sustainable care models. Understanding how eligibility volatility affects specific populations will be essential for development of member retention tactics and adapting product offerings accordingly.*

Other Waivers and Administrative Changes

Beyond work requirements, the Section 115 waiver policy instituted eligibility restrictions including permitting states to charge premiums and lock out enrollees who are disenrolled for unpaid premiums. Waiver priorities shift across presidential administrations and the new administration's waiver priorities will likely differ significantly from those of the previous administration; however, it is unclear how the they will treat certain waivers promoted and approved by the previous administration, such as those focused on addressing health-related social needs, multi-year continuous eligibility primarily for children, and leveraging Medicaid to help individuals leaving incarceration transition to the community. The current administration could choose not to approve waivers that remain pending, rescind existing waiver guidance, and withdraw approved waivers, creating an uncertain and changing landscape for Medicaid coverage.

There could also be a delay in the implementation of new regulations or issuance of new rules related to access, managed care, and enrollment processes.

The previous administration finalized a number of major Medicaid regulations designed to promote quality of care and advance access to care for Medicaid enrollees as well as to streamline eligibility and enrollment processes in Medicaid and the Children's Health Insurance Program (CHIP). These rules are complex and are set to be implemented over several years. Congress may consider legislation to overturn these rules, but even without legislation, the current administration could delay implementation of certain provisions or could issue new regulations that would undo these final rules.

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Finally, the federal government could issue guidance and implement policy to make it more difficult for people to obtain and/or maintain coverage, which would reduce enrollment and limit access to care. This could also include encouraging states to conduct eligibility verification processes in between annual renewal periods. This seems entirely consistent with the ongoing narrative around the need to combat fraud and abuse in so-called publicly funded entitlement programs.

To be better prepared for rule making *whose immediate impacts may not be entirely obvious as first, health plans and provider organizations can begin to incorporate into their business and strategic planning processes the expectation that individual coverage for care may change mid-year and/or be chipped away at over time. Health plans should assess their readiness – adapting operations, strengthening compliance, and refining member engagement strategies to navigate an unpredictable policy landscape.*

State Budget Constraints and Priorities, Operational Shifts for Managed Care Organizations (MCOs)

While states have made a number of Medicaid investments in recent years, including expanding access to behavioral health services, improvements to Medicaid reimbursement rates (particularly for long-term care), and leveraging Medicaid to help address social determinants of health (and otherwise reduce health disparities), expectations of reduced revenue collections beyond 2025 may dampen enthusiasm for further investments in Medicaid and could even prompt spending reductions for these expansions and programs.

Reduced state revenues may be tied to implementation of state tax cuts, the expiration of pandemic-era federal funding, and other macroeconomic uncertainties. Any reductions in federal Medicaid spending would put further pressure on state budgets and lead to program cuts.

Health plan and provider organizations need to be cognizant of related state funded programs and impact if funding for these programs dries up as a result of state budget concerns and/or reduction of Federal financing. As a case in point, Medicaid policy changes might have significant implications for MCOs, particularly in expansion states. As of July 2022, 39 expansion states relied on MCOs to manage newly eligible adults. With funding uncertainties, MCOs will face constraints that will put pressure on providing these additional services with fewer resources. MCOs are expected to provide more value-based services, and with provider networks also buckling under the pressure of reduced margins, plans will need to grapple with potential network adequacy concerns (as providers fail to renew value-based capitated contracts under these financial constraints) and balance the demand for more value-added benefits with cost containment strategies that will not compromise quality of care.

Proactive Planning is Critical

To stay ahead of the curve, health plans should proactively engage with regulators and policy makers to advocate for sustainable reimbursement models while implementing efficiency-driven solutions, such as:

- Expanding value-based care initiatives with the aim of reducing longer term costs via preventive services and developing a communication and engagement plan to help members transition to other coverage options, as needed.
- Reevaluating provider contracts to align payment models within the context of new reimbursement realities.
- Engage in predictive analytics to anticipate membership shifts and cost implication in a changing eligibility environment.
- Understanding how eligibility volatility affects specific populations presents both risks and opportunities, where proactive planning is especially critical. This should include modeling of financial and operations risks via “what if” scenarios to anticipate potential administrative cost increases and begin to shift spending to variable costs where possible.

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Federal funding cuts and financial reforms:

Will Congress enact major cuts to federal Medicaid funding and changes to how the Medicaid program is financed? What will federal cuts in Medicaid mean for people enrolled in the program, states, and providers? How will the impact of any federal policy and funding changes vary across states?

Work requirements:

Will Congress pass legislation to allow or require work and reporting requirements in Medicaid? If Congress does not include work requirements in legislation, which states will pursue work and reporting requirement waivers under a second Trump administration? How will such policies affect coverage?

State budget constraints and priorities:

What are current projections for state revenue growth? How will changes in state fiscal conditions affect states' ability to continue to pursue and maintain recent investments in Medicaid for behavioral health, longterm care, reimbursement rates, social determinants of health, and efforts to reduce disparities? How will federal Medicaid policy changes affect state budgets?

Other waivers and administrative changes:

Beyond work requirements, what waivers will be encouraged and approved under the second Trump administration? Will the administration withdraw any approved waivers or rescind Biden administration waiver guidance? What will happen with major access and eligibility/enrollment regulations finalized under the Biden administration? How will other administrative guidance affect coverage?

The Well Solutions Group and DataWELL Informatics bring together accomplished professionals with Medicaid program experience. The potential changes to Medicaid could have a dramatic impact on health plan Medicaid business/membership. We can work with payers to model how these changes may impact coverage and/or access to care as well as developing cost containment strategies to ensure continued viability of the Medicaid line of business.

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