Medicaid managed care trends

What health plans should know about potential policy impacts from the new Trump Administration

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While policymakers have sought to reduce Medicaid program costs for years, significant reforms are gaining momentum under the new Trump Administration. Previous proposals and legislative priorities to reduce Medicaid spending have focused on limiting federal funding and changing eligibility requirements (e.g., Medicaid Works programs). This is not surprising, given Medicaid's significance in federal and state budgets. The federal government funded $610 billion in Medicaid spend in federal fiscal year 2023, representing 70% of total program spending.[1] Medicaid is also the leading cost driver for all state budgets on an annual basis.[2]

A recent House Budget Committee agenda details the spending reform proposal known as Making Medicaid Work for the Most Vulnerable.[3] The reform would cut Medicaid's federal funding by $2.3 trillion over 10 years—a reduction of 27% from current projections for that period. The proposed changes to Medicaid financing tactics, which were foreshadowed in Project 2025, would negatively impact state governments, their residents, and the healthcare ecosystem in general.

It is likely that there will be more clarity on the future of Medicaid financing over the next several weeks and months as Congress works through the next spending bill. This brief reflects potential policy changes and industry impacts as of late February 2025.

Why it matters to health plans

Medicaid MCOs cover 74% of Medicaid recipients through Medicaid managed care

More than 150 health plans are contracted with states as managed care organizations (MCOs), overseeing administration of healthcare services, and serving as stewards of state and federal taxpayer dollars.[4] In our recent brief, we highlighted how state Medicaid agencies use Medicaid managed care as a favored mechanism to administer their programs and to achieve state priorities, leveraging MCOs to address health related social needs (HRSN), remediate state workforce challenges, and bolster program integrity.

For many health plans, especially many local and regional plans, Medicaid managed care is a primary source of revenue and key component of a comprehensive government programs product strategy, considering potential member churn between Medicaid, Affordable Care Act (ACA) marketplace, and Dual Special Needs Plans (D-SNPs). Changes to how Medicaid is funded would have a material impact on all aspects of the nation's healthcare system, most immediately to beneficiaries and providers dependent on Medicaid, as well as on the MCOs that support them.

Federal cuts to Medicaid spending will require states to make tough decisions to address budget shortfalls—or reduce program budgets altogether. This may result in eligibility restrictions, changes in covered populations, and reduction of covered benefits. States will likely have a range of solutions to address potential cuts to Medicaid funding, pending passage of federal regulations. Some states, however, may embrace proposed policy changes, as seen by a resurgence in Medicaid Works legislation in states including Arkansas, Indiana, and Ohio.[5,6,7]

MCOs should begin taking steps to prepare for potential changes to their Medicaid operating models and growth plans, even if changes made at the federal level do not impact states in the immediate term.

This brief explores proposed Medicaid policy changes by the Trump Administration and the impacts to health plans as the primary vehicle of this critical safety net program.

Key things to know about the proposed Medicaid policies

PROPOSED POLICIES TO CUT MEDICAID SPENDING

Understanding how potential policy changes may impact states starts with understanding how Medicaid is financed today. States pay for Medicaid in part through federal funds, as determined by the Federal Medical Assistance Percentage (FMAP). State "match rates" for traditional Medicaid populations and services are based on average per capita income, going no lower than 50%. This means states such as Maryland, New York, and California receive a 50% match on Medicaid expenditures. States like Mississippi, Alabama, and West Virginia, meanwhile, receive a match rate close to 75%.

Certain populations and benefits, like ACA expansion and family planning services, are matched at different levels. Federal match dollars are unlimited to support fluctuations in enrollment and medical costs and to account for changes in economic conditions.[8] Additionally, nearly every state uses provider tax revenue to cover some of its share of Medicaid expenditures.[9]

Proposed changes to Medicaid financing policies, as described on subsequent pages, would fundamentally change the Medicaid program.

1. **Block grants and per capita funding**
2. **Medicaid work requirements**
3. **Eliminating ACA enhanced payments**
4. **Provider tax restrictions**

Overview of potential policy themes impacting Medicaid financing

POTENTIAL POLICY THEME

Block grants and per capita funding

DESCRIPTION

- Per capita spending caps would be assigned based on historical Medicaid spending patterns and paid on a per-enrollee basis—but they would not fluctuate based on changes in cost of care.[10] States with restrictive Medicaid eligibility and benefits (e.g., non-expansion states), lower provider reimbursement, and aging populations would be most impacted.
- Block grants would provide states with a fixed amount of federal dollars to fund Medicaid programs. Block grants do not account for enrollment fluctuations—creating challenges in times of economic downturn.
- Both funding methods are diversions from the current FMAP model, in which an increase in state spending on Medicaid corresponds to a proportional increase in federal funding dollars. This structure inherently accounts for changes in enrollment and rising medical costs.

POTENTIAL STATE IMPACTS

- All states would receive less federal funding, most negatively impacting those with a higher FMAP, such as Mississippi, West Virginia, Alabama, New Mexico, and Kentucky[11].
- To combat budget shortfalls, states may reduce covered benefits for “non-essential” services, such as dental and vision, home and community-based services (HCBS), and HRSN.
- States may limit eligibility based on statutory minimum incomes, impacting children and pregnant women, and cut non-required populations, like those with certain disabilities or over 65.

Overview of potential policy themes impacting Medicaid financing

POTENTIAL POLICY THEME

Medicaid work requirements

DESCRIPTION

- Medicaid work requirements dictate a set number of monthly working hours for adult beneficiaries to maintain eligibility. States have struggled to implement these programs due to the complexity of verifying work-related activities and accurately tracking employment data.
- The previous Trump Administration approved more than 13 Medicaid Works programs (including in Arkansas, Arizona, and Utah). These programs have since been withdrawn by states or were rescinded by the Biden Administration. Georgia currently has the only active program.
- A 2023 report by the Congressional Budget Office (CBO) estimated that if Medicaid eligibility was tied to 80 hours of work-related activities per month, federal spending would decrease by $109 billion over a 10-year period.[12]

POTENTIAL STATE IMPACTS

- The CBO report estimated about 1.5 million adults would lose coverage, state costs would increase, and employment status of Medicaid recipients would remain unchanged.
- States would have increased administrative costs to validate work-related activities and employment.
- States would see a shift in their Medicaid risk pool, as mostly healthy adults would be disenrolled, leaving behind those with qualifying age or health conditions—likely leading to a higher cost of care.

Overview of potential policy themes impacting Medicaid financing

POTENTIAL POLICY THEME

Eliminating ACA enhanced payments

DESCRIPTION

- States that expanded Medicaid coverage to the low-income adult population (i.e., individuals that do not have otherwise qualifying health conditions) via ACA expansion currently receive additional federal Medicaid funding via an increased FMAP of 90%, regardless of the state's general match rate.
- Proposals to decrease FMAP dollars for the ACA expansion population would reduce available state dollars and decrease the incentive for states to include low-income adults in their covered Medicaid populations.

POTENTIAL STATE IMPACTS

- ACA expansion coverage would almost immediately end in states with "trigger laws" (Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah, and Virginia). Combined, these states' expansion population is ~3.7 million.[13]
- States may also disenroll the expansion population to combat the budget shortfall.
- More than 20 million Americans are covered by ACA expansion eligibility provisions—and therefore are at risk of losing Medicaid coverage.

Overview of potential policy themes impacting Medicaid financing

POTENTIAL POLICY THEME

Provider tax restrictions

DESCRIPTION

- All states except Alaska tax providers to supplement state Medicaid funding and avoid cutting into other budgetary dollars. States also receive FMAP match dollars for these taxes under current models.[14]
- States apply one or more taxes between 3.5% and 5.5% to providers (e.g., nursing facilities, hospitals, and even MCOs) to help cover Medicaid spending. For providers, these taxes are applied to net patient revenues, and MCOs are taxed against capitation revenue dollars. Medicaid provider taxes make up about 17% of state Medicaid dollars.[15]
- The House Budget Committee proposes restrictions on state flexibilities to apply provider taxes. This would create federal savings of $175 million over a 10-year period.

POTENTIAL STATE IMPACTS

- Removing provider taxes would significantly cut state budgets for Medicaid, compounding financial challenges with the policies above.
- Many states fund ACA expansion through provider taxes and would need to reassess financial sustainability of this population.
- States use Medicaid provider tax revenue to reinvest in safety net providers. Cuts would likely lead to reductions in reimbursement rates, directly impacting the providers that depend on these funds the most while also exacerbating provider participation challenges.

Potential Medicaid financing impacts to MCOs

As the main vehicle for administering Medicaid programs, MCOs could face unprecedented financial headwinds—with potential downstream impacts to member and provider experience.

MCO IMPACTS	DESCRIPTION
Revenue reduction	■ Changes in eligibility and disenrollment could decrease revenue as a result of fewer covered lives. ■ Reduced Medicaid capitation rates could also result in lower revenue, which has potential to impact integrated programs (e.g., D-SNPs) as well.
Financial instability	■ Changes in enrollment and covered benefits could cause member churn and create unpredictable utilization, requiring plans to rethink care management strategies. ■ Changes in eligibility may create higher risk. This could potentially create margin pressure as cost of care increases and revenue decreases. ■ Changes in economies of scale (e.g., vendor contracts) and shared service operating models could increase costs across government program products, and potentially across the broader health plan. ■ Waiver program cuts could lead to higher healthcare costs as a result of transitioning HCBS populations to institutions.
Negative brand perception	■ Reduced benefits coverage and/or funding for HRSN programs may result in declining health outcomes and member dissatisfaction. ■ Eligibility and benefit limitations could lead to a negative perception of the health plan and brand as a whole.
Provider abrasion	■ Changes in eligibility and benefits could result in confusion in provider offices. ■ Provider dissatisfaction could stem from changes to covered benefits, potential increases in prior authorizations to manage medical expense, and potential reductions in reimbursement rates due to state budget pressures. ■ Potential reductions in provider payments for Medicaid, including rural and safety net providers, could lead to provider dissatisfaction and exacerbate provider participation challenges in Medicaid.

Impacts beyond Medicaid products: Provider abrasion and dissatisfaction with Medicaid reimbursement rates and covered benefits could influence providers' contracting strategies, potentially affecting negotiations with health plans in other lines of business. Dissatisfied members are less likely to re-enroll in the same health plan, even if offered through other coverage options like the exchange.

What health plans should do

Plans must prepare for potential policy changes, which will likely be in place for multiple years, after action is taken by the administration. These recommendations are based on the potential policy changes outlined in this brief; health plans' strategies can and should adapt as more information becomes available and policies are more formally implemented. There are likely to be very near-term actions required (i.e., in Q1-2 2025) as well as longer-term implications for 2026 and beyond.

1. STAY INFORMED

- Stay apprised of upcoming policy changes at the state and federal level to proactively prepare and mitigate negative downstream impacts.
- Strengthen state agency partnerships, gaining strategic alignment and policy influence.
- Leverage industry associations and other local and federal legislative connections to voice concerns and collaborate on solutions to challenges resulting from policy changes.

2. CONDUCT FINANCIAL PLANNING AND RISK MANAGEMENT

- Ensure adequate financial reserves are available to cushion the impact of potential short-term funding reductions—especially as plans continue to recover from the COVID-19 public health emergency.
- Perform financial impact modeling to determine sustainability of operating models and internal programs (e.g., staffing, HRSN) in scenarios of reduced revenue. Assess risk and develop mitigation strategies.
- Invest in fraud, waste, and abuse (FWA) and other payment integrity capabilities to manage costs and get ahead of forthcoming regulations.

3. RAMP UP MEMBER AND PROVIDER ENGAGEMENT

- Keep members informed of upcoming changes and connect them to state agencies and community resources to address unmet needs.
- Maintain strong connections with members to support retention and satisfaction to become the health plan of choice for existing enrollees.
- Promote positive provider experience by providing appropriate resources and tools to efficiently deliver care. Facilitate dialogue and collaborate with providers to offer support through upcoming changes to maintain positive working relationships across all lines of business.

4. FOCUS ON QUALITY AND ADMINISTRATIVE EFFICIENCY

- Further develop and refine care coordination capabilities and quality programs to improve member outcomes, create efficiency, and reduce waste.
- Build and enhance analytic models that track the effectiveness of targeted quality programs (e.g., health equity and HRSN) with the goal of ensuring continued investment in improved outcomes and reductions in waste.
- Assess near-term opportunities to optimize administrative costs, and identify efficiencies within current model to prepare for potential financial headwinds.

5. DIVERSIFY REVENUE STREAMS

- Diversify revenue and explore other revenue streams to reduce reliance on Medicaid funding—especially if the health plan is primarily focused on Medicaid and related programs.
- Consider opportunities for vertical integration with providers or efficiencies in administrative technologies.

Prepare now to navigate upcoming Medicaid funding changes

Proposed policy changes may fundamentally alter how Medicaid is administered and disrupt standard components of current managed care models. However, it is not enough for health plans to react to immediate change; a long-term view is essential for stability and success. Plans should be thinking about changes to operations, while leveraging policy influence and key relationships at local and federal levels.

Keeping a pulse on proposed policy changes, enactment timelines, and sentiments across the broader healthcare community is key for health plans to proactively address new requirements and steadfastly address their members' needs.

In the face of potential decreases in covered lives and revenue, dedicating resources toward quality and outcome analytics, value-based arrangements with providers, and FWA/payment integrity capabilities can enhance health plans' performance—regardless of which policies come to fruition. It can also provide a first-mover advantage when policies are enacted. Therefore, health plans must act now, combining strategic foresight with operational agility to secure their future in a transforming Medicaid environment.

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