THE AGILIAN 2025 MEDICAID PLAYBOOK

Adapting to massive change in the Medicaid Ecosystem

Chapter One:
Elimination of Federal Match Funding

SUMMARY

The anticipated elimination of federal match funding for Medicaid presents an urgent and overwhelming financial challenge for beneficiaries, payers, and providers. Experts expect 2025 will be the first time in history that Federal overall Medicaid spending declines.[1] This playbook addresses when and how these reductions are coming, and what Medicaid enterprises should do today to protect their beneficiaries.

"The Trump administration will cut tens of billions of dollars from Medicaid and it will happen faster than people imagine."

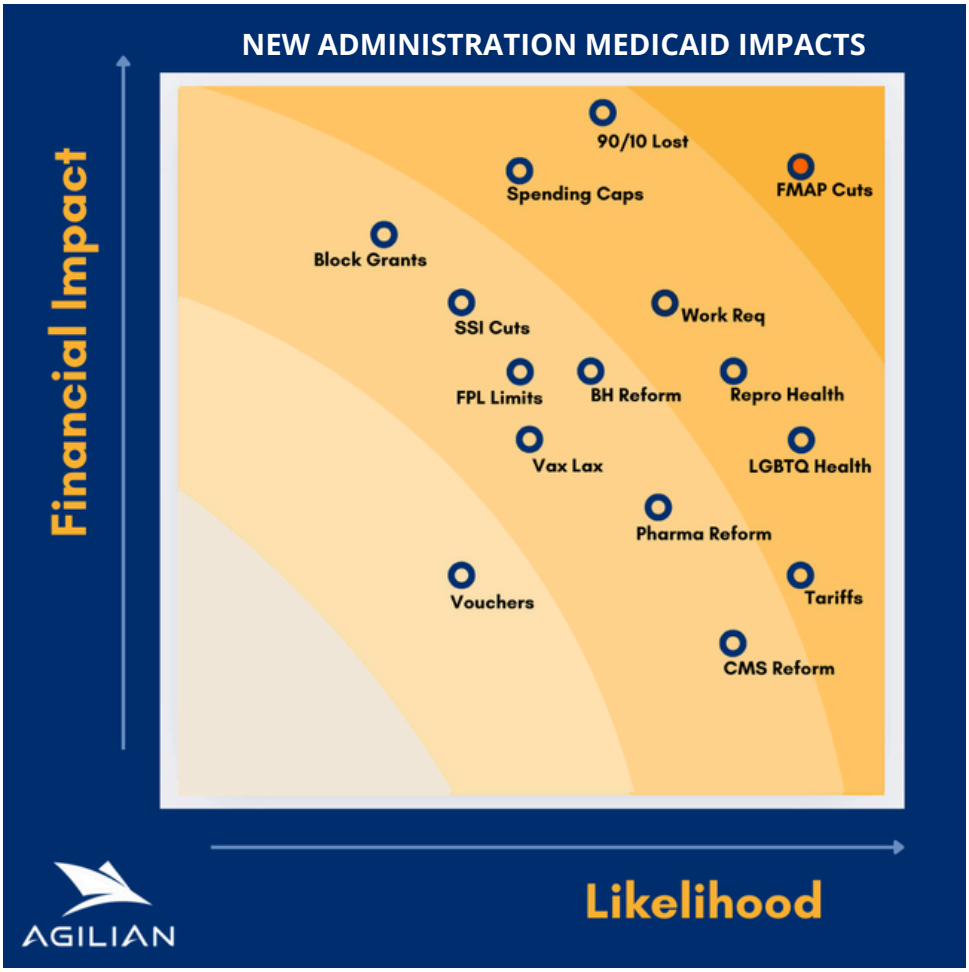
- Jamey Harvey, CEO of Agilian LLC

Elimination of Federal Match Funding Initiative Description

The new administration will attempt to cut Medicaid through multiple channels. Cuts that require legislation (like spending caps and elimination of the expansion match) will take time to develop. The more immediate threat is the unilateral cancelation of entire 1115 demonstration programs (waivers) or the specific programs and their expenditure authority. We are advising our clients to plan for a $60B reduction in Federal Medical Assistance Percentage (FMAP) funding for services within the next four months. This reduction (or savings if you prefer) will grow into hundreds of billions of dollars if Congress supports larger austerity measures.[2] To mitigate this disruption, beneficiaries, payers, and providers must take immediate and strategic actions.

MOST LIKELY IMPLEMENTATION APPROACH

The administration will immediately use Secretarial authority embedded in the Social Security Act to modify or cancel waivers outside of the standard Medicaid construct. These cuts are likely to be much more aggressive than in previous administrations. We expect they will target programs and geographies that align with other political priorities. (For example, cuts to Health Related Social Needs programs are a foregone conclusion.) It is critical that enterprises in the Medicaid ecosystem get ahead of this unprecedented contraction in funding.[3]



IMPACT SHOWN OVER A 12-MONTH TIME HORIZON

Larger initiatives, such as the elimination of the expansion FMAP, will require legislation to amend the Affordable Care Act (ACA). Expect this legislation to be attempted this year. Whether it succeeds or not depends, at least in part, on the response of the Medicaid Ecosystem, especially payer and providers, to protect their beneficiaries.[4]

CRITICAL ACTIONS FOR MEDICAID ENTERPRISES

Immediately map your state's waivers to your funding:

The first wave of funding cuts will almost certainly fall along waiver lines. While state waivers are complex and complicated, they are finite and knowable. Engage experts in the intricacies of State Medicaid waivers and their financing to know ahead of time what programs can be defunded; then use informed analysis based on President Trump's executive orders, Project 2025, and other conservative think tanks to project what will be defunded. Time is of the essence.[5]

Start lobbying for yourself and your beneficiaries as soon as possible:

Large Medicaid enterprises should engage their lobbyists to tell the story of what these cuts will do to the constituents in your state. Use the power of your brand and your status as an employer to protect your community. Smaller organizations can join forces through industry coalitions and add your voices to protect your highest priority waivers. Use the shock and backlash from initial cuts to lobby for pro-Medicaid federal legislation. Work together to delay, defer, or drag out the process until after the midterms, if possible.

Craft a compelling story to defend your programs in your state:

Canceling waivers is a blunt tool and is objectively messy. When you know what programs are at risk for you, construct a clear, compelling and concise story to educate lawmakers, state agencies, and industry lobbying groups (both Federal and State) as to what will happen to *their* constituents when the hammer falls. Focus on the unintended consequences of what happens when Federal power is exerted without considering local concerns, the priorities of state governments, and state specific fiscal issues.

Explore the possibility of alternative funding with State Regulators and partners:

Every state jurisdiction will have different attitudes, aptitudes, and capabilities to supplement the loss of federal funds. If your state is able to supplement lost FMAP funding with local funds, you need to start lobbying for your most vulnerable beneficiaries now. If your state is realistically unable to supplement lost FMAP funding, focus your time and effort on sources of alternative allowable funding such as grants, philanthropic funding, and public-private partnerships.

Call to Collaboration - “No inspiration like desperation”:

Well executed waiver analysis will uncover what parts of your business are on burning platforms, and which ones are likely safe. Either way, use the analysis to survey your ecosystem and supply chains for the organizations that are at risk around you. There will be unprecedented opportunities to work together as Medicaid reacts to this significant financial contraction. Partners should consider strengthening value based payment arrangements. Explore opportunities to renegotiate contracts, rate structures, and/or capitation. Work together to build flexibility to accommodate the possibility of ongoing downward rate revisions.

Play the cards you are dealt - “Never waste a good crisis”:

Most Medicaid enterprises know their organizations could be more efficient, modern, and agile than they are. In practice, organizational concerns frequently get in the way of making hard decisions and taking smart risks. This is an ideal time to advance projects that decrease administrative costs, create efficiency, and enhance revenue. Challenge the status quo of your operations. Consider offering retirement packages to loyal employees. Automate manual processes with emerging AI automation tools. Invest in recovering lost retention revenue caused by state data problems. Agilian has helped Medicaid MCOs recover tens of millions of dollars in lost services to Medicaid beneficiaries, at both large and small plans.

Opportunities for Consolidation:

Large players fortunate enough to be less dependent on waivers may have opportunities to absorb distressed enterprises to create a long-term competitive advantage. Look for opportunities to expand your geographic footprint; build out value-based care and payvider capabilities; or consolidate for structural advantages of scale. Small players can join forces with bigger players to take advantage of scale if you are at risk from the tide going out. Proactively engage organizations that could be a good match for your vision and the people you exist to serve.

INITIATIVE METHODOLOGY:

We consider FMAP cuts to be the most urgent and disruptive challenge facing Medicaid today.
These cuts will consist of many smaller initiatives—akin to a thousand small cuts—shaping both expectations and necessary actions for your enterprise.
We welcome your feedback on developing targeted playbooks for specific funding and coverage issues contributing to changes in the Medicaid funding ecosystem.
All initiatives are sourced from publications or public statements by the current Trump administration and are evaluated by our experts for Financial Impact and Likelihood.

LOOKING FOR MORE?

The Agilian 2025 Medicaid Playbook provides an analysis of potential Medicaid changes under President Trump's second administration. It examines the likely impact on beneficiaries, State Agencies, Medicaid Managed Care Organizations (MCOs), providers, and community-based organizations. The report identifies which proposed changes are most likely to occur, when, and critically, where to expect them to unfold first. Offering clear, actionable recommendations, the playbook will help local stakeholders prepare for the challenges and opportunities these shifts may bring. This Playbook is an essential guide for leaders seeking to remain effective and resilient in a rapidly changing Medicaid landscape.

Authored by Diane Gerrits (former Director CMS State Demonstrations and Waivers) and Jamey Harvey, the CEO of Agilian LLC, the playbook addresses the top 15-20 Medicaid initiatives implied by the current Trump administration policy descriptions including:

- Block Grants or per Capita Limits
- Implementation of Work Requirements
- 1115, 1915 (a, b, c) Waiver Cancellations
- Pharmaceutical Reform
- Reproductive Health Reversals
- Loss of Match Funding for Medicaid

In this period of ambiguity and volatility, Agilian has decided to release the playbook free of charge to stakeholders in the Medicaid Ecosystem.

If you would like to arrange a special private presentation with your organization or event on the topic of the Medicaid Playbook, please contact communications@agilian.com to learn more.

[1] Mostly Medicaid (2024) 'Impact of the 2024 United States Presidential Election Impact on Medicaid', presented at the Medicaid Policy Forum, Washington, D.C., 15 January

[2] Bixby, S., 2025. Republican spending cuts could deepen financial woes for federal budget. The Wall Street Journal. LINK [Accessed 6 February 2025].

[3] Brown, K.V. (2025) 'Trump has created health-care chaos', The Atlantic, 31 January. LINK [Accessed 7 February 2025].

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[5] Amaya, D. and Hinton, E., 2025. Medicaid 1115 Waiver Watch: Round-up of Key Themes at the End of the Biden Administration. KFF. LINK [Accessed 6 February 2025].

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Chapter Two:
Implementation of Work Requirements

SUMMARY

The implementation of Medicaid work requirements represents a significant policy shift with widespread implications for beneficiaries, payers, and providers. Experts predict that under the new administration, work requirements will be reinstated and aggressively expanded as a mechanism to reduce Medicaid enrollment and spending. This playbook outlines when and how these changes will occur and what Medicaid enterprises should do to safeguard their beneficiaries.

> "When we talk about these cuts, we're not just talking numbers— we're talking about real human impact. Millions of people could lose access to care, and that's something we can't ignore."
>
> -Jamey Harvey, CEO of Agilian LLC

The Return of Work Requirements

The administration is expected to move quickly to encourage Medicaid work requirements via executive and administrative actions. Federal guidance will empower states to impose work mandates, with waiver approvals anticipated to be fast-tracked through the Centers for Medicare & Medicaid Services (CMS). The most immediate changes will likely include the reinstatement of previously approved **Section 1115 demonstration waivers** that condition Medicaid eligibility on work or community engagement. Expect CMS to publish Work Requirement waivers templates, streamlined for easy approval, that may include the expansion of work requirements beyond able- bodied adults to include new populations.

We advise Medicaid enterprises in states that avail themselves of these waivers to prepare for a significant reduction in Medicaid enrollment upon the implementation of work requirements. According to the Center on Budget and Policy Priorities (CBPP), such requirements could jeopardize coverage for up to 36 million individuals nationwide. This reduction would disproportionately impact low-income individuals, caregivers, and people with chronic health conditions.

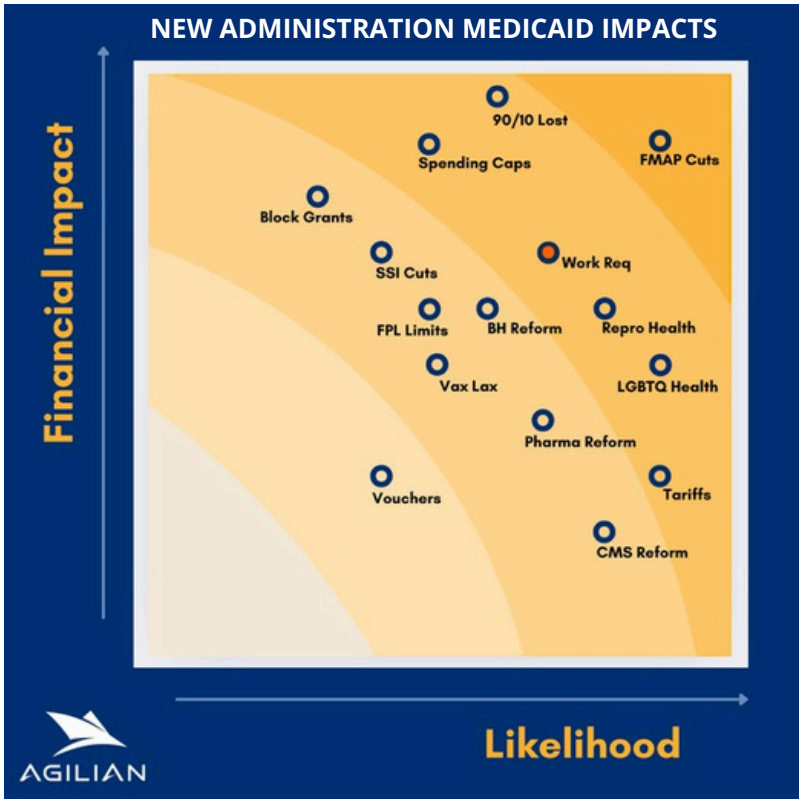
LIKELIHOOD OF WORK REQUIREMENTS BEING ENACTED

Given current political dynamics, Medicaid work requirements are highly likely to return. The most probable path forward includes:

1.**Almost certain:** CMS granting **Section 1115 demonstration waivers** and creating significant carrots and sticks for states to implement work requirements.

2.**Quite likely:** When the **budget reconciliation bill** comes out of committee, it may contain a federal-level work requirement. This process requires only a **simple majority** in the Senate and such a bill will likely pass.

Given the likelihood of CMS taking the lead in approving state-level waivers, states should start preparing now for the potential rollout of work requirements.



IMPACT SHOWN OVER A 12-MONTH TIME HORIZON

STATE-LEVEL PREPARATION FOR WORK REQUIREMENTS

States anticipating the reinstatement of Medicaid work requirements should begin conducting **scenario planning** to evaluate the impact on their Medicaid populations and administrative systems.

Key considerations include:

- **How Medicaid enrollees would be affected** – Understanding which populations would be most at risk for coverage loss.
- **The impact on state staff, business processes, and technology systems** – Work requirements would add a layer of complexity to Medicaid eligibility determinations.
- **How to build the capacity and infrastructure for reporting requirements** – Work requirement programs require enrollees to report their work hours, job searches, or community engagement activities monthly.
- **Integration with existing workforce development programs** – In the long term, Medicaid work requirements will probably require states to think about integration with Employment Services agencies. Some states may also choose to align Medicaid work requirements with **Temporary Assistance for Needy Families (TANF)** or **Supplemental Nutrition Assistance Program (SNAP)** employment training programs to ease implementation and compliance burdens.

IMPACT ON MEDICAID BENEFICIARIES

Many groups would likely be **exempt from work requirements**, including:

- People with disabilities
- Certain caregiving populations (e.g., parents of young children or those caring for family members with disabilities).
- Volunteers participating in other “qualifying activities” besides traditional work

However, despite these exemptions, work requirements have been found to disproportionately affect individuals with chronic health conditions, caregivers, and those facing barriers to employment, such as limited job opportunities or lack of transportation. A key concern is that administrative hurdles—such as **reporting requirements**—could cause even eligible individuals to lose coverage.[1]

LESSONS FROM PREVIOUS IMPLEMENTATIONS

Past attempts to implement Medicaid work requirements have faced significant challenges. For instance:

- **Arkansas:** In 2018, Arkansas' Medicaid work requirements led to over 18,000 beneficiaries losing coverage, primarily due to reporting challenges rather than failing to meet work criteria, and studies found no increase in employment as a result.
- **Georgia:** Georgia's Pathways to Coverage program, the only active Medicaid work requirement initiative, has resulted in lower-than-expected enrollment and higher costs, as restrictive eligibility criteria and administrative hurdles have limited access to coverage.

These experiences underscore the importance of designing policies that minimize coverage losses and administrative burdens.[2]

Want to know your state's work requirements and how they will affect your MCO?

CLICK HERE

to request a free state-level analysis from Agilian

MITIGATE DISRUPTION AND UNCERTAINTY

Medicaid enterprises must act decisively to prepare for, mitigate, and respond to the implementation of work requirements. The ability to rapidly adapt to changing eligibility rules will define success in this evolving Medicaid landscape.

- **Engage with policymakers and advocacy groups** to influence waiver design and advocate for exemptions for vulnerable populations.
- **Invest in technology and outreach strategies** to directly help beneficiaries navigate new reporting requirements.
- **Collaborate with other providers, managed care organizations (MCOs), and state agencies** to minimize coverage disruptions.
- **Train and equip your frontline staff** to help beneficiaries understand emerging work requirements and how to navigate new administrative processes.
- **Leverage the outreach and data disciplines** you developed during the Medicaid Unwinding to keep Medicaid beneficiaries covered for your services.

ADAPT TO YOUR LOCAL ENVIRONMENT

The reinstatement of work requirements presents both risks and strategic opportunities for Medicaid enterprises, with these factors varying by state. Consider these key questions to assess the impact on your organization and beneficiaries:

- **Who is most at risk?** Identify the populations most likely to be negatively affected by work requirements and explore strategies to protect them. **How do Medicaid funding changes**
- **impact your state?** If your Medicaid program has experienced cuts—such as waiver cancellations or federal funding reductions—could work requirement funding help offset these losses?
- **Can digital infrastructure help reduce barriers?** Assess whether existing digital systems can be leveraged to streamline compliance for beneficiaries. For example, if your state has a Health Benefits Exchange, is there a "local hub" available with the state employment agency? Could this be expanded to verify job applications and support work requirement compliance for beneficiaries?

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Authored by Sora Shin, Director of Client Relations, Agilian LLC and Jamey Harvey, CEO, Agilian LLC.

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[1] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/

[2] https://www.cbpp.org/research/health/medicaid-work-requirements-could-put-36-million-people-at-risk-of-losing-health

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Chapter Three:
Defunding Reproductive Health

SUMMARY

Federal and state-level policy changes regarding reproductive health funding may significantly impact Medicaid beneficiaries, providers, and payers. Recent actions by the current administration aim to restrict Medicaid funding to certain reproductive health providers, including those affiliated with Title X or that offer abortion-related services (regardless of funding source).[1] These actions could affect access to services such as contraceptive care, STI screenings and treatment, prenatal services, postpartum care, and cancer prevention. This playbook outlines the potential implications and presents proactive strategies for Medicaid enterprises to prepare and respond.

"Changes to funding don't occur in a vacuum—they affect access, care delivery, and the overall health ecosystem across the country."

- Jamey Harvey, CEO of Agilian LLC

Probable Policy Changes of Defunding Reproductive Health

Changes to reproductive health funding are materializing through a mix of administrative, legislative, and state-led mechanisms. Each channel presents a unique combination of timeline, impact, and legal complexity. The following summary reviews the most prominent anticipated changes to the current status of Medicaid coverage.[2]

1. Federal Executive Branch Regulations

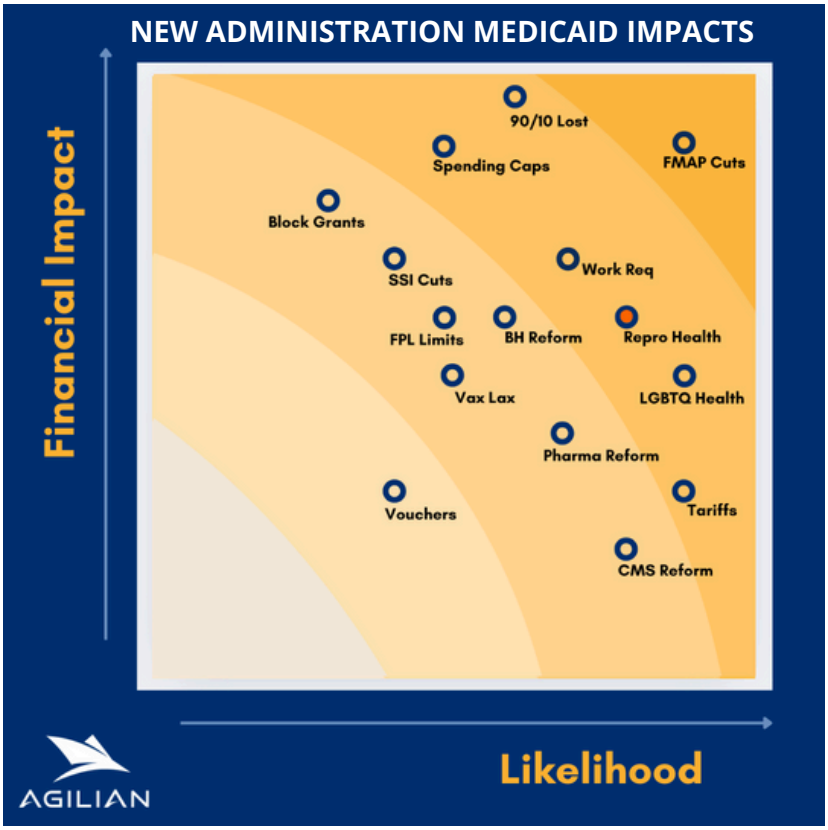
The Trump administration has undertaken several regulatory actions to influence Medicaid participation by reproductive health providers:

- **Executive Order Enforcing the Hyde Amendment:** On January 24, 2025, President Trump signed Executive Order 14182, reaffirming the Hyde Amendment's prohibition on the use of Medicaid and other federal funds for elective abortions. This order revoked prior executive actions that had expanded access to reproductive healthcare services.[3]

- **Freezing of Family Planning Grants:** In March 2025, the administration announced plans to halt $27.5 million in federal family-planning grants, including funds allocated to Planned Parenthood affiliates. This action affects services such as pregnancy testing, contraception, STI treatment, and infertility counseling funded under Title X.[4]

- **Reinstatement of Title X Restrictions:** Following the reinstatement of the global gag rule, the administration could also reintroduce the 2019 Title X "gag rule," which barred abortion referrals and required separation between Title X-funded services and abortion activities. While no formal rulemaking has been initiated, the policy direction signals a potential return to these restrictions.[5]

Implementation Timeline: These regulatory changes may proceed through streamlined administrative procedures and take effect within months of announcement, without requiring new legislation.[6] Executive action is already underway, with additional measures expected; Medicaid enterprises should anticipate further policy shifts that may disrupt access to preventive and family planning services.



IMPACT SHOWN OVER A 12-MONTH TIME HORIZON

2. Congressional Appropriations and Legislation

Congress may pursue policy changes through appropriations bills or the budget reconciliation process.

- **Proposed Funding Restrictions:** Major anti-abortion coalitions are lobbying Congress to include language in reconciliation that would block Medicaid funding to organizations that offer abortion services, including Planned Parenthood—even for services not directly tied to abortion.[7]
- **Broader Medicaid Cuts:** The House budget framework includes up to $880 billion in proposed Medicaid reductions, which would likely affect reproductive health coverage.[8]
- **Ongoing Senate Negotiations:** Senate Republicans are weighing adjustments to these proposals, though reproductive health remains a key topic of negotiation. Medicaid stakeholders should be prepared for continued uncertainty and rapid changes.[9]

3. State-Level Actions

States may initiate changes to reproductive health policy within Medicaid through a range of mechanisms.

- **Section 1115 Demonstrations:** These allow states to propose alternatives to federal Medicaid rules. Some may use 1115 demonstrations to exclude certain reproductive health providers or modify service delivery models.[10]
- **State Plan Amendments (SPAs):** SPAs can be used to restructure benefits, redefine service categories, or adjust reimbursement in ways that affect access to reproductive care.[11]
- **Provider Exclusion Policy:** States have also pursued administrative or legislative actions to exclude certain providers—such as Planned Parenthood—from their Medicaid programs, even when those providers offer services unrelated to abortion.[12]

Medina v. Planned Parenthood South Atlantic: This pivotal U.S. Supreme Court case could allow states to exclude providers like Planned Parenthood from Medicaid—even for non-abortion services such as cancer screenings and contraception. A ruling in favor of the state could set a precedent for broader provider exclusions.[13]

IMPACT & RISK PROJECTION

Anticipated changes to reproductive health funding are likely to cause significant disruptions across Medicaid service delivery, particularly for underserved populations. Restrictions on provider eligibility and funding could limit access to essential services, including contraception, STI screening and treatment, prenatal and postpartum care, and cancer prevention.

Despite a challenging policy landscape—especially considering projected executive branch actions—there are indicators of resilience. Protections for reproductive and maternal health care under Medicaid and Medicare have increasingly depended on a strategic mix of legal, legislative, and regulatory tools, particularly following the Dobbs decision.[14] Legal challenges citing constitutional protections, such as equal protection and due process, have proven timely and effective. Courts in states like California and Nevada have upheld Medicaid coverage by framing exclusions as discriminatory.[15]

Nevada District Court Ruling: A Nevada court ruled that denying abortion coverage under Medicaid violates the state's Equal Rights Amendment. This decision reinforces constitutional protections against sex-based discrimination and could serve as a model for litigation in other states.[16]

Moreover, some states are leveraging Section 1115 demonstrations to reinforce access to reproductive health services by covering family planning benefits, extend postpartum care, and support integrated maternal health initiatives. However, in more restrictive policy environments, similar authority has been used to curtail coverage or impose additional provider qualifications —demonstrating the highly variable role that 1115 demonstrations now play in shaping access across the country.[17]

In summary, if these changes should occur, Medicaid enterprises may expect, at minimum, the following categorical changes:

- Removal of some reproductive health providers from Medicaid networks
- Reduced access to vital support programs
- Potential delays in access to preventive care
- Adverse maternal health outcomes
- Increased burden on emergency and primary care systems
- Operational and compliance challenges for Medicaid Managed Care Organizations (MCOs)

ACTION PLAN FOR MEDICAID ENTERPRISES

Agilian suggests the following framework as one method of responsiveness to potential forthcoming coverage and funding concerns:

1. Prioritize and Protect High-Risk Populations:

- **Identify vulnerable groups:** Use demographic and claims data to pinpoint populations most at risk of reproductive health service disruptions—especially low-income women, teens, LGBTQ+ individuals, and rural communities.
- **Assess provider networks:** Identify clinics or partners at risk of funding loss or legal restrictions. Proactive action can prevent service disruption.
- **Scenario modeling:** Prepare for potential policy shifts by conducting modeling exercises that predict the impact of various scenarios, ensuring continuity of care and service access.

2. Utilize State Medicaid Tools and Flexibilities:

- **Collaborate with state agencies:** Support the initiation of Section 1115 demonstrations and SPAs to expand Medicaid coverage or mitigate service restrictions.
- **Advocate for reproductive care:** Push for Medicaid reforms that include expanded postpartum services, perinatal care, and integrated care models that address social determinants of health.
- **Align with maternal health equity:** Ensure Medicaid proposals emphasize the maternal health equity and cost-effectiveness of reproductive services to increase the likelihood of policy approval.

3. Build Continuity Plans for Threatened Providers

- **Alternative funding strategies:** Work to secure funding from foundations, local governments, and state-level appropriations to make up for federal funding losses.
- **Partnerships with FQHCs:** Strengthen partnerships with Federally Qualified Health Centers (FQHCs) and other safety-net providers to absorb service gaps and expand access.
- **Expand telehealth and mobile clinics:** Increase access to reproductive health services by deploying culturally appropriate telehealth, mobile clinics, and community health worker programs to ensure uninterrupted service.

4. Advocate and Coordinate with Policymakers:

- **Support state legislation:** Engage with legislators to advocate for policies that protect reproductive health services, including mental health services and out-of-state reproductive care, as seen in Connecticut's Senate Bill No. 7 (2025).[18]
- **Propose impact analysis:** Encourage policies that require demographic impact analysis before implementing Medicaid policy changes to ensure policies benefit marginalized groups and prevent further disparities.

5. Expand Cross-Sector Partnerships:

- **Strengthen cross-sector partnerships:** Build connections with schools, community clinics, and mobile units to broaden access points for reproductive health services.
- **Equip staff and promote patient retention:** Provide training for staff on Medicaid rule changes, patient navigation, and outreach techniques. Ensure patients in high-need populations stay engaged and utilize available Medicaid services.

Here at Agilian—as our agility-focused name implies—we firmly believe that a comprehensive strategy of both adaptive analysis and regulatory reform is the best, persistent defense for long-term public health strategy to benefit the ecosystem, providers, and beneficiaries for every facet of Medicaid policy and coverage.

Reach out to us to help you bolster your organization's resilience and increase your chances of member success during these unprecedented times.

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Chapter Four:

Moratorium on the 2024 Eligibility and Enrollment Final Rule

SUMMARY

The final rule, "Medicaid Program: Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Process" ("2024 Final Rule"), was a major step toward modernizing and simplifying Medicaid and CHIP programs. It aimed to unify enrollment processes, update application systems, and prevent unnecessary coverage loss. Despite these goals, the House passed a moratorium on its implementation via the federal budget reconciliation process, which is heading to the Senate for approval by July 4.[1]

Halting the rule mid-implementation risks historic levels of coverage loss, particularly for vulnerable populations like low-income families, dual eligibles, and people with disabilities. It will also shift costs from the federal government to states as more individuals lose coverage, delay care, and seek emergency services.

This chapter outlines the probable scenarios, their operational and clinical consequences, and a practical action plan for Medicaid enterprises to preserve coverage and system stability in a more restrictive regulatory environment.

> "Even though the money never gets to the beneficiaries, the care does. The cuts will be felt most where that care begins and ends—with the people."
>
> - Jamey Harvey, CEO of Agilian LLC

Proposed 10-Year Moratorium on 2024 Final Rule Implementation

Finalized by CMS, the 2024 Final Rule for Enrollment and Eligibility aimed to standardize Medicaid and CHIP renewal procedures, lower administrative hurdles, and prevent eligible individuals from losing coverage.[2] Key provisions included:

- Prohibiting in-person interviews for seniors and disabled enrollees
- Setting a 12-month minimum renewal frequency for most beneficiaries
- Providing enrollees clear notices and sufficient time to respond before terminations

CMS estimated that the 2024 Final Rule would improve equity and reduce churn, especially among low-income and medically vulnerable groups.

However, a 10-year moratorium on the 2024 Final Rule for Eligibility and Enrollment is fast becoming a reality. Postponing implementation aligns with the administration's broader goals of reducing federal regulatory oversight and leveraging massive federal Medicaid spending cuts to offset its tax policy goals.

While the federal budget reconciliation process seems the most likely path forward, the 2024 Final Rule for Eligibility and Enrollment can be altered using any of the following pathways (listed in order of probability).

Probable Action	Branch/Body	Status
Moratorium on implementation until January 1, 2035 via budget reconciliation process	Legislative	In Progress High probability of passing
Issue new rule that pauses the 2024 Final Rule implementation to a later date (e.g., January 1, 2035) if justified by administrative urgency	Executive via CMS	Probable if final budget reconciliation bill excludes this amendment
Issue new rule that rescinds the 2024 Final Rule under either the standard notice-and-comment process or via an interim final rule if justified by administrative urgency	Executive via CMS	Possible if administration believes final budget reconciliation bill doesn't go far enough to meet budgetary goals

IMPACT & RISK PROJECTION

According to a recent Congressional Budget Office (CBO) estimate requested by Senate and House leadership, pausing the implementation of the 2024 Final Rule alone would reduce federal Medicaid spending by $170 billion over ten years, driven entirely by the disenrollment of 2.3 million people by 2034. Under mounting fiscal stress, CBO expects many states to actively adopt policies that make enrollment "more challenging to navigate" to reduce spending.[3]

Moratorium Outcomes Poised to Accelerate Medicaid Disenrollment

If enacted, key protections established under the 2024 Final Rule for Eligibility and Enrollment will place millions of Medicaid beneficiaries at heightened risk of losing coverage through procedural terminations and administrative barriers. This risk is particularly acute for high-need populations: children, older adults, individuals with disabilities, and low-income individuals and families navigating unstable employment or housing.

Adoption of Six-Month Eligibility Redetermination

Final Rule Provision: The 2024 rule prohibits states from conducting eligibility redeterminations more than once every 12 months, ensuring coverage stability and reducing "churn" caused by frequent checks.

Possible Reversal: States regain authority to conduct eligibility checks as often as every six months.

Impact:

- States would regain discretion to redetermine eligibility mid-year, reintroducing a key cause of procedural disenrollment.
- Disproportionate harm to children, non-English speakers, individuals with disabilities, and those without stable housing or documentation.
- Increased state administrative burden and higher error rates in eligibility processing.

Reinstatement of In-Person Interview Requirements

Final Rule Provision: The 2024 rule prohibits mandatory in-person interviews for all Medicaid applicants, regardless of eligibility category.

Possible Reversal: States may reintroduce in-person requirements, particularly for non-Modified Adjusted Gross Income (MAGI) populations such as older adults or individuals with disabilities.

Impact:

- Applicants in rural areas, individuals without transportation, and those with mobility impairments may face insurmountable barriers to enrollment.
- Increased appointment delays, compounding disenrollment risks during renewals.
- Administrative burden increases for local offices already facing staffing constraints.

Shortened Response Time for Requests for Additional Information (RAI)

Final Rule Provision: The 2024 rule requires states to provide a minimum of 15 calendar days for applicants to respond to requests for additional information.

Possible Reversal: The rollback would permit shorter and inconsistently applied deadlines, increasing procedural disenrollments.

Impact:

- Applicants could lose coverage before they can gather documentation or navigate complex requests.
- Program integrity suffers if eligible individuals are terminated for non-response rather than ineligibility.
- Populations with limited digital access, transportation, or English proficiency would be particularly affected.

Elimination of the 90-Day Reconsideration Period After Procedural Denial

Final Rule Provision: The 2024 rule extends the reconsideration period for applicants denied due to non-response to an RAI request from 30 to 90 days.

Possible Reversal: The reconsideration period would revert to 30 days, limiting the window to restore coverage after procedural denials.

Impact:

- Many individuals who would have otherwise regained coverage with additional time will remain uninsured.
- Increased pressure on appeals and fair hearing systems.
- Disruptions in care continuity, especially for individuals with disabilities and chronic conditions.

While delaying the 2024 Final Rule implementation may reduce enrollment on paper, it shifts costs and inefficiencies into the broader health care ecosystem and will significantly impact those tasked with maintaining access, quality, and equity in care.

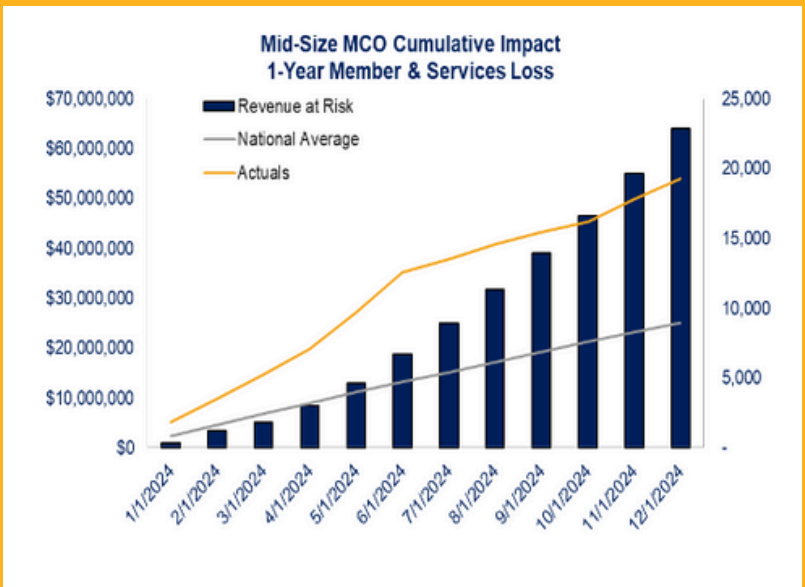

Figure 1: Cumulative one-year impact on mid-size MCOs if the Medicaid & CHIP Eligibility and Enrollment 2024 Final Rule is postponed until 2035

Impact on Medicaid Beneficiaries

Delaying the implementation of the 2024 Final Rule for Eligibility and Enrollment increases the risk that eligible individuals will lose coverage due to administrative barriers. For many, this loss will stem not from ineligibility, but from procedural and bureaucratic challenges.[4] The resulting effect is heightened Medicaid churn, where individuals frequently move on and off coverage over short periods. This instability disrupts access to essential healthcare services, limiting preventive and maintenance care and forcing many to delay or forgo necessary treatment due to lack of coverage. The consequences are especially severe for those with chronic conditions or disabilities, as well as for children and low-income families.[5]

Impact on the Medicaid Ecosystem

The 2024 Final Rule moratorium will have ripple effects across the Medicaid landscape, affecting not just beneficiaries but also the operational and financial stability of the entire ecosystem. These impacts will manifest most acutely across providers, Managed Care Organizations (MCOs), and state Medicaid agencies.

- **Providers:**
  - Providers will face a dual challenge:
    - Decline in Medicaid revenue as eligible patients lose coverage.
    - Rise in uncompensated care as those same patients continue to seek services without coverage.
  - Providers will also face workflow slowdowns due to more frequent eligibility verification, increasing claim rejections and billing delays.
  - Many will divert limited resources to cover essential care for uninsured patients, constraining their ability to expand services, maintain staffing levels, or invest in population health initiatives. Importantly, this will hit Federally Qualified Health Centers (FQHCs), safety-net clinics, and community health centers the hardest.
- **MCOs:**
  - MCOs will face intensified financial risk as rising disenrollments drive substantial revenue loss while elevating administrative costs from managing churn and more frequent re-enrollment (Figure 1).
  - Gaps in care coordination, missed follow-ups, and delayed treatments will result in avoidable emergency room visits or hospitalizations, ultimately increasing the total cost of care.
  - For members, coverage interruptions will raise serious health risks—particularly for those managing chronic conditions, behavioral health needs, or post-acute recovery.
- **States:**
  - State Medicaid agencies will incur higher administrative costs as they expand staffing, call center support, and system capacity to handle frequent and expedited eligibility reviews.
  - IT infrastructure will need updates to reflect shortened timelines and to support real-time eligibility monitoring.

ACTION PLAN FOR MEDICAID ENTERPRISES

As core provisions of the 2024 Final Rule for Eligibility and Enrollment are effectively repealed in all but language, Medicaid enterprises must act urgently to prevent unnecessary coverage loss, protect at-risk populations, and ensure operational resilience.

ACTIONS TO PREPARE

Audit Eligibility & Retention Process Now

- Evaluate internal data systems and **member re-verification pipelines** to reduce churn if eligibility checks become more frequent.
- Establish **routines for continuous monitoring** vs periodic.

Segment and Prioritize At-Risk Populations

- **Segment beneficiary populations** by program type and redetermination status (e.g., pending, overdue, submitted, or denied).
- **Identify those most vulnerable** to unnecessary administrative churn and **structure prioritized outreach and resolution efforts** to areas where they are most needed.
- Use behavioral data from long standing members to identify who are least likely to complete re-enrollment unaided.

Assess Eligibility Data

- **Evaluate the** organization and accuracy of your 834 files, redetermination records, and MMIS data.
- Identify **opportunities** where member statuses are inconsistent between systems.
- Build in **data quality checks to find common issues** like missing Medicaid IDs or outdated contact data.

Collaborate with State Agencies

- Work with community partners, care managers, and outreach teams to **connect with members** most at risk of losing coverage.
- **Prioritize outreach** based on member risk level.
- **Track outreach efforts in a shared system** to support follow-up, coordination, and team accountability.
- Develop **feedback loops from outreach logs to dynamically adjust strategy** based on which channels yield the best re-enrollment rates.

Deploy Coordinated Outreach

- Include data driven strategies for your community outreach teams aligned to eligibility.
- Be **ready to act quickly** when states open windows for addressing issues.

ACTION PLAN FOR MEDICAID ENTERPRISES

ADVOCATE NOW

Elevate State Impacts and Member Voices

- Coordinate **state-specific impact assessments** showing enrollment or fiscal effects, which can be shared with lawmakers, governors, and CMS.
- Facilitate **member storytelling campaigns** to show how proposed changes—like more frequent eligibility checks or cost-sharing—could lead to real harm.
- Submit this qualitative data in **written or live congressional testimony**, especially in Medicaid expansion states where losses may be steep.

Advocate for Flexibility in Implementation

- Advocate for changes that **delay, disrupt, and dilute the proposed changes** in the reconciliation bill.
- Push for **state-level waivers** or **delayed implementation** timelines for new requirements like work/community engagement or cost-sharing thresholds.

ACCOUNTABILITY AFTER CHANGES IMPLEMENTED

Create Transparent Impact Dashboards

- **Track and publicly report metrics** to hold state and federal agencies accountable for the impacts of changes:
  - Member loss from disenrollments or eligibility failures.
  - In-network provider losses from reduced funding.
  - Utilization disruptions tied to cost-sharing or administrative barriers.
- Use this as a tool for advocacy and **internal risk management.**

Engage State Legislatures in Oversight Planning

- Work with Medicaid directors and legislative health committees to build **state oversight mechanisms** for federal changes.
- Encourage **state-based mitigation strategies** to dampen policy impacts on the ground (e.g., coverage wraparounds or hardship exemptions).

LOOKING FOR MORE?

The Agilian 2025 Medicaid Playbook provides an analysis of potential Medicaid changes under President Trump's second administration. It examines the likely impact on beneficiaries, State Agencies, Medicaid Managed Care Organizations (MCOs), providers, and community-based organizations. The report identifies which proposed changes are most likely to occur, when, and critically, where to expect them to unfold first. Offering clear, actionable recommendations, the playbook will help local stakeholders prepare for the challenges and opportunities these shifts may bring. This Playbook is an essential guide for leaders seeking to remain effective and resilient in a rapidly changing Medicaid landscape.

Chapter 4 was authored by Trudy Loper, MPH and Sora Shin.

IMPACT SHOWN OVER A 12-MONTH TIME HORIZON

In this period of ambiguity and volatility, Agilian has decided to release the playbook free of charge to stakeholders in the Medicaid Ecosystem.

If you would like to arrange a special private presentation with your organization or event on the topic of the Medicaid Playbook, please contact communications@agilian.com to learn more.

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THE AGILIAN 2025 MEDICAID PLAYBOOK

Adapting to massive change in the Medicaid Ecosystem

Chapter Five:

Commanding the Chaos: Readiness is the New Compliance

SUMMARY

As of June 2025, the Senate's revised version of H.R.1 cements the direction of Medicaid policy change: tighter eligibility rules, more administrative costs pushed to states, and long-term structural changes. The cuts to Medicaid are deeper than the House-passed version. Even if certain provisions are softened or challenged, CMS and states can enact most changes through regulatory authority. Key parts of the Senate bill are designed to avoid legal challenges, making them more likely to stick.

Medicaid MCOs tracking policy is no longer enough. Action is required. Those who model risk exposure, shift resources to outreach and prepare for a rise in redetermination workloads will be in a stronger position. Those who delay will face exponential churn, operational drag, and reputational backlash from the communities they serve.

This chapter marks the shift from prediction to practice—where MCOs must lead through the complexity, not just understand it.

> "This is no longer a policy debate. It's an operational reckoning. And for MCOs, survival in this bureaucratic mess starts with deliberate, cohesive strategy."
>
> - Jamey Harvey, CEO of Agilian LLC

Administration's Three-Path Convergence to Medicaid Change

Medicaid transformation is no longer unfolding along a single policy track. The Administration is pursuing change through three (3) coordinated pathways:

- **Legislation**
- **Regulation**
- **Structural Shields (legal insulation)**

These paths are designed to reinforce each other – so if change stalls in one lane, it moves forward in another. Medicaid MCOs must monitor and respond to all three at once.

Path	Mechanism	Medicaid Policies Most Likely at This Level
Legislative Mandates	Changes written into law via budget reconciliation or appropriations bills	🟢 Work requirements, including parents of older children 🟢 6-month eligibility re-checks 🟢 PBM spread pricing ban 🟢 Provider tax cap, likely 3.5% 🟢 State-directed payment limits linked to Medicare 🟡 Cost-sharing increases for >100% FPL
Regulatory Expansion	CMS rulemaking authority, Section 1115 waivers, and sub-regulatory guidance	🟡 Gender-affirming care exclusions 🟡 Exclusions for undocumented immigrants 🟡 Tax policy changes affecting MAGI and indirectly Medicaid eligibility 🟡 Rural rate alignment and supplemental payment reduction via CMS rulemaking
Structural Shields	Legal mechanisms to block or delay court challenges - ensuring policies stick	🔒 Supreme Court as sole review venue 🔒 Limited standing for states, individuals, or advocacy orgs to challenge CMS 🔒 CMS waivers shielded from lower court injunctions

Probability for each policy: 🟢 High, 🟡 Medium, 🔒 Shielded

Implications for MCOs

You won't get one rollout. You'll get three at once. Legislative, regulatory, and judicial shifts will arrive at different times, each with enforceable impacts.

Even the legal uncertainty is planned. The Senate's bill limits who can sue and when, reducing MCOs' ability to rely on court delays.

Operational readiness must run parallel to policy. You'll be implementing while the rules are still evolving.

The Real-World Impact of What's Next

The fallout from these changes will not be evenly distributed. Based on current bill language, active regulatory proposals, and state-level implementation plans, we can project which Medicaid populations will feel the shockwaves first and where MCOs will face the greatest disruption.

Start of Impact	Who It Will Hit First	What Happens
Late 2025 - Early 2026	Low-income working parents with school-aged children	Coverage loss due to new work documentation requirements
Early-to-mid 2026	Rural enrollees and providers	Provider tax caps and payment alignments lead to provider exits and narrower networks
Mid-to-late 2026	LGBTQ+ individuals, especially youth	Gender-affirming care restrictions emerge through state waivers or reinterpretation
Rolling 2026	Mixed-status families and immigrants	Higher disenrollment due to stricter documentation and eligibility verification
2026+	Dual eligible, adults with chronic conditions	Gaps in care emerge due to reinstatement lags, confusion around tiered coverage

What MCOs Can Expect

- **Increased churn and reinstatement lag** for groups with complex documentation needs (e.g., single parents, multilingual households, those with unstable housing).
- **Care plan discontinuity,** especially in behavioral health, maternal health, and community-based care.
- **Delayed engagement** with high-risk enrollees due to fear or confusion—particularly in LGBTQ+ and immigrant communities.
- **Provider fatigue and attrition,** especially in rural settings where payment models are being overhauled.
- **Growth in uncompensated care costs,** particularly among hospital systems and safety net clinics.

Operational Fallout MCOs Can't Afford to Miss

The proposed federal changes to Medicaid eligibility and financing won't just shift policy; they will fundamentally reorder the operational burden for Medicaid Managed Care Organizations. These changes layer new complexity onto a system already strained by the Medicaid unwinding and exacerbated by outdated data exchange, fractured communications, and workforce shortages.

A recent Health Affairs commentary frames work requirements as a "shift in kind" that is redefining Medicaid from a public health entitlement to a conditional work-linked benefit. This isn't merely an ideological repositioning; it's a structural overhaul of eligibility logic, member retention, and compliance expectations.

For MCOs, this will result in five key issues:

Churn Acceleration. Work requirements, frequent eligibility redeterminations, and tighter documentation demands will cause eligible members to fall through administrative cracks.

- **Why it matters**:
  - Churn increases call center volume, reinstatement costs, and the likelihood of unbillable gaps in coverage.
  - Delays in care create long-tail claims spikes and greater acuity when members re-enter the system.
  - Financial risk increases, as plans must maintain readiness for members who return mid-year after disenrollment.

Revenue Loss and Risk Pool Imbalance. Disenrollment won't affect all members equally. Healthier, lower-cost members are more likely to lose coverage, leaving plans with a more complex and expensive risk pool.

- **Why it matters**:
  - Medicaid revenue is member-based. Even small increases in avoidable churn can create outsized financial loss.
  - Disproportionately losing healthier members raises the average cost of care.
  - The loss of healthier members erodes the balance that sustains performance incentives, risk adjustment payments, and plan viability.

Data Fragmentation Between States and MCOs. Most state eligibility systems are not built to ingest or honor MCO-generated data such as updated addresses or family composition, creating loops of misinformation.

- **Why it matters**:
  - Member data corrected by the MCO may be overwritten by the state, leading to lost contact, missed redetermination windows, and preventable terminations.
  - Redundant outreach and repeated document requests increase administrative costs, burden care managers, and dilute the impact of high-touch engagement strategies.
  - Operational staff are forced to spend more time troubleshooting disconnections rather than advancing member retention.

Provider Network Disruption. With provider tax caps, state-directed payment realignments, and value-based payment uncertainty, provider financing will become more fragile, particularly for rural and safety net systems.

- **Why it matters:**
  - Rural hospitals and community-based providers are often the backbone of care coordination, maternal health, behavioral health, and emergency services.
  - As payments flatten and administrative requirements rise, provider attrition or refusal to accept Medicaid could surge, weakening network capacity and exposing MCOs to regulatory penalties.

Increased Disparities and Equity Backsliding. Parents, caregivers, people of color, LGBTQ+ individuals, and those who don't speak English fluently will be hit hardest by these changes. These groups are more likely to be tripped up by language barriers, documentation requirements, intentional exclusions, and poor system design.

- **Why it matters:**
  - Equity-related disruption still drives avoidable churn, member confusion, and care delays, all of which hit outcomes and costs.
  - While CMS has backed off formal equity incentives, many states are maintaining or even expanding equity benchmarks in Medicaid contracts.
  - Plans that fail to reach or retain high-need, historically marginalized members risk worsening care gaps, rising per-member costs, and damage to their reputation with regulators, providers, and community partners.

If implemented as proposed, MCOs will be on the front lines of a system where paperwork – not eligibility – determines access to care.

Questions MCOs Should Be Asking

Are we modeling member loss and reinstatement risk using our own data?
How accurately can we forecast coverage disruption by member type or geography? ☐ Yes/ ☐ No

Do we have the capability to support or capacity to handle a doubling of redetermination outreach workload?
If not, what priorities and metrics of success need to shift? ☐ Yes/ ☐ No

Do we know where our eligibility data and the state system(s) data are misaligned?
What can we do now to reduce preventable disenrollment? ☐ Yes/ ☐ No

Are we quantifying financial losses from disenrollment, especially in rural areas?
Are we tracking and reporting this impact with enough precision to act? ☐ Yes/ ☐ No

Actionable Strategy for Policy Change Readiness

It's time for Medicaid MCOs to move from analysis to action. The changes ahead are operational, clinical, and urgent.

MCOs should prepare for a sharp increase in documentation demands from both members and providers. These requirements won't just add paperwork and reduce access; they will overwhelm Medicaid and MCO call centers, eligibility teams, and appeals units.

To respond with speed and discipline, Agilian advises MCOs to take the following actions:

- **Launch a Plan-Level Risk Model.** Forecast where and how coverage loss is most likely to occur by geography, eligibility type and member vulnerability. Use this to prioritize retention strategies.
- **Form a Policy-to-Ops Bridge Team.** Create a cross-functional working group that brings together policy, operations, IT, and compliance. Their job: track the changes, translate them into workflow, and execute rapid adjustments.
- **Prioritize Reinstatement ROI.** Shift outreach, IT, and compliance resources from growth to retention. Reinstating current members protects care continuity, improves outcomes, and stabilizes revenue.
- **Pressure Test State Data Interfaces.** Review how your plan exchanges data with the state. Identify where MCO updates (like address changes) are getting overwritten or ignored. Every mismatch raises churn risk.
- **Engage Early with High-Risk Providers.** Work now with rural hospitals, community health centers, and key maternal/behavioral health partners. Their capacity will be critical to absorbing system shocks.

You Can't Wait for Reconciliation

The Senate's revised version of H.R.1 may shift again, but the infrastructure to implement these policies is already forming. Legislation, regulation, and policy shielding are working together to ensure that at least part of this future becomes reality. For MCOs, waiting for final clarity is no longer a viable strategy. The timeline for disruption has started. It's time to retrain teams, rethink processes, and reallocate resources.

Readiness is the new compliance. And execution is the only viable defense.

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