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IPPS Assembly Presentations

November 14, 2025

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The Trillion-Dollar Cut: Impact of Medicaid Cuts on Health Care

Joint Session IPPS, OMSS, PPPS

What's on the Horizon for Medicaid Programs

American Medical Association
November 14, 2025

Jack Rollins, Director of Federal Policy
National Association of Medicaid Directors

Brief Overview of NAMD

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NAMD is a professional community of leaders who provide health insurance to almost 80 million people through Medicaid and the Children's Health Insurance Program in the states, D.C. and the U.S.

NAMD's mission is to help millions served by Medicaid by representing, elevating, and supporting state and territorial Medicaid and CHIP leaders in connecting eligible individuals to coverage, promoting access to care, delivering high-value services, and controlling program costs for sustainability.

NAMD supports the coalition of all 56 state and territory Medicaid programs and is led by a mission-focused 14-person Board of Directors representing the states of Georgia, Iowa, Kentucky, Maine, New Hampshire, New Mexico, New York, North Dakota, Oregon, Texas, Virginia, Wisconsin, the District of Columbia, and the U.S. Virgin Islands.

https://medicaiddirectors.org/resource/how-namd-does-our-work/

How NAMD Does Our Work

Strengthening Medicaid through a partnership approach

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We focus on supporting Medicaid partnerships.

Medicaid is a complex public program that operates in a constantly evolving federal and state policy landscape and health care ecosystem. It requires effective internal and external partnerships to deliver high value for the nearly 80 million people served by the Medicaid and CHIP programs and to ensure efficient use of the taxpayer dollars that fund it.

PARTNERSHIP IN MEDICAID OCCURS:

Partnership underpins all that we do at NAMD.
It is how we provide critical support that helps states and territories run effective and efficient Medicaid programs that are locally tailored to their own policy priorities and interpretation of the program.

Partnership Across Medicaid Programs and Between Core Functions

We facilitate connections between Medicaid Directors and members of their senior leadership teams from across the country to share locally relevant solutions, build community and operationalize federal policy. We also help leaders in functional areas work better together, delivering more effective results for the millions of Americans they serve and ensuring that federal and state/territory resources are used efficiently and accountably. We support these partnerships by:

Facilitating connections among all 56 Medicaid Directors through intensive support for new Directors, weekly Director calls, monthly regional gatherings, and conferences

Convening senior Medicaid agency leaders monthly through our affinity groups for CFOs, CIOs Eligibility Leaders, and Communications Leaders

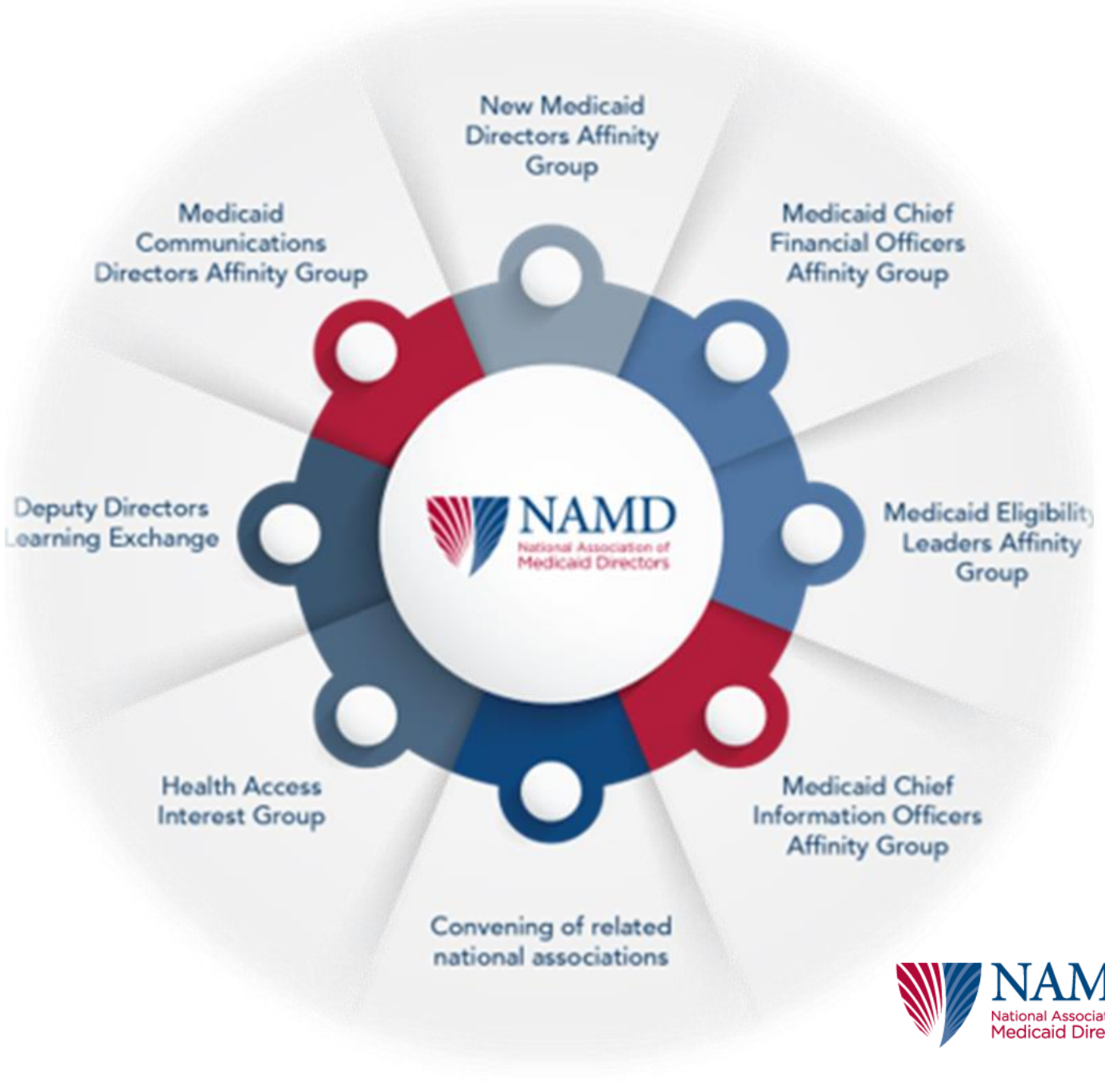
Gathering over 300 Medicaid leaders each week to **share information about federal policy** and budgetary developments

Supporting **timely sharing of insights** across the country through our member-initiated Rapid Response process

Creating other closely held spaces for all Medicaid leaders to **talk openly** about emerging priorities and operational needs

CONTACT: **Lindsey Browning**, *Deputy Executive Director of Programs*, lindsey.browning@medicaiddirectors.org

Our capacity to support and connect Medicaid leaders, as well as elevate their work, centers on our framework of collaborative and closely held convenings.



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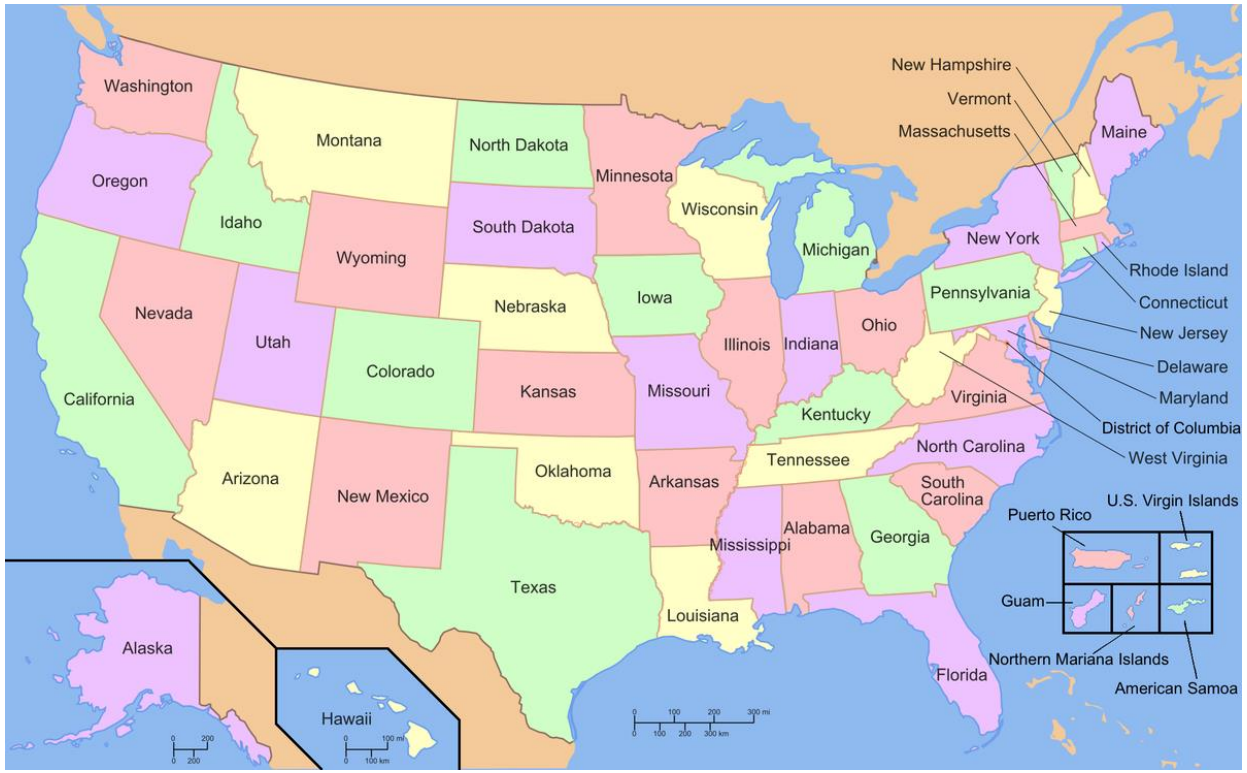
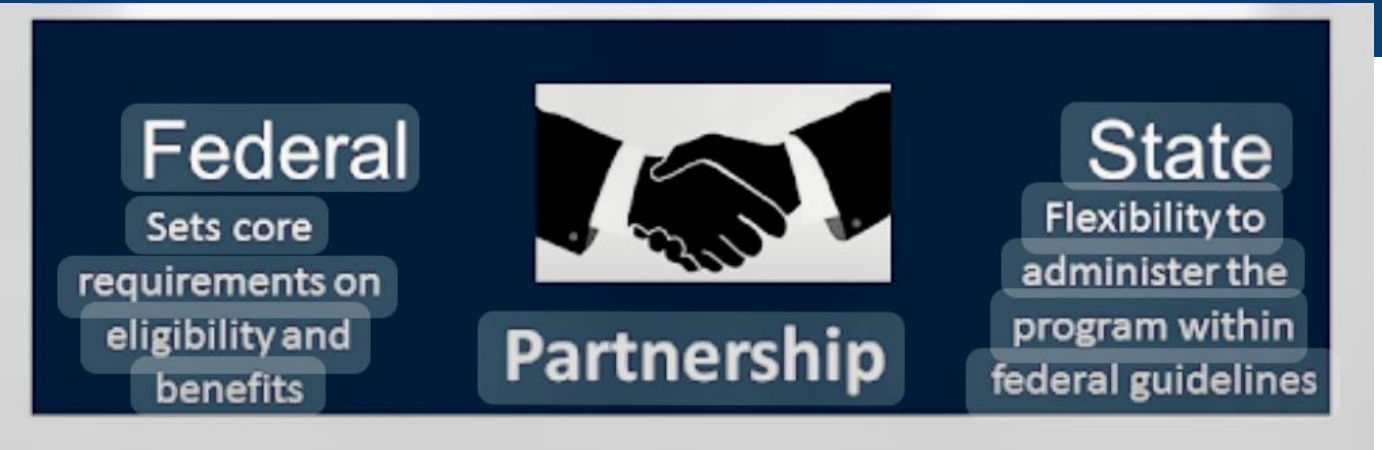
NAMD also holds a cooperative agreement with the Health Resources and Services Administration (HRSA)

The agreement focuses on enhancing Medicaid-public health partnerships through:

- **Building literacy among state Medicaid directors and other health care payment officials** about HRSA priorities and initiatives.
- **Establishing routine connections among Medicaid officials, other health care payment officials and state public health leaders** that transcend projects and endure over transitions of federal and state administrations.
- **Identifying opportunities to align strategies and interventions**, as well as to braid and optimize use of HRSA and Medicaid funding, **to ensure sustainable impact.**



A successful federal-state/territory partnership



- NAMD has had a longstanding, highly collaborative working relationship with the Center for Medicaid and CHIP Services (CMCS)

- We regularly partner through state/territory workgroups, affinity groups and CMCS participation in our in-person meetings

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Context on the program

Medicaid has experienced an intense few years

COVID-19 Public Health Emergency: rapid cycle uptake of newly eligible people/emergency authorities/telehealth, large infusion of federal pandemic funding

Post PHE: "Unwinding" the PHE continuous coverage requirement, post-unwinding managed care rate experience, spending down federal pandemic funds

Post unwinding: Navigating the change in federal administrations and identifying new opportunities, experiencing new state budget constraints, Congressional budget reconciliation

OBBBA Implementation: planning for and executing federal policy change (differential impact among states), navigating budget constraints, program sustainability

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Medicaid continues to serve more than one in five Americans.

- **An essential program**: the primary source of health insurance coverage for low-income Americans, serving 4 in 10 births, 30.1 million children, and 2/3 of older adults and people with disabilities
- **Impactful and well regarded:** The Kaiser Family Foundation Health Tracking Poll found in its February, 2025 Health Tracking Poll that more than half (53%) of adults say they (18%) or a family member (35%) have received help from Medicaid at some point and an additional 13% say a close friend has been covered by the program.

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Programs are operating in an evolving policy landscape

Over and above implementing OBBBA, programs are interested in:

- Understanding implications of recent guidance: HRSN CIB, DSHP/DSIP, 1115 workforce initiatives and continuous eligibility, managed care directed payment quality, operationalizing emergency Medicaid, and duplicate state enrollment

- Getting clarity on further Medicaid policy priorities of the administration (e.g. Make America Healthy Again, permissible uses of 1115 waivers, status of Biden administration rules package) and leading up on complementary state and territory priorities

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Programs are facing budget pressures

- Medicaid costs accounted for nearly 30 percent of state budgets in FY2024, which is the single largest budget item for states
- Health care cost growth continues to pressure Medicaid spending and crowd out investment in other state priorities
  - National healthcare costs continue to trend upward and grow more rapidly than the rest of the economy
  - Medicare and commercial have higher cost growth trends than Medicaid (8.1% and 11.5% in 2023 respectively), but growth in Medicaid is still significant (7.9% in 2023)
- Other than for states that have dedicated reserve accounts (e.g. Alabama, South Carolina, Tennessee, Utah), states and territories are facing new budget pressures, including slowing state revenue growth and sunset of federal pandemic-era funding
- For many states, OBBBA has significant federal revenue implications

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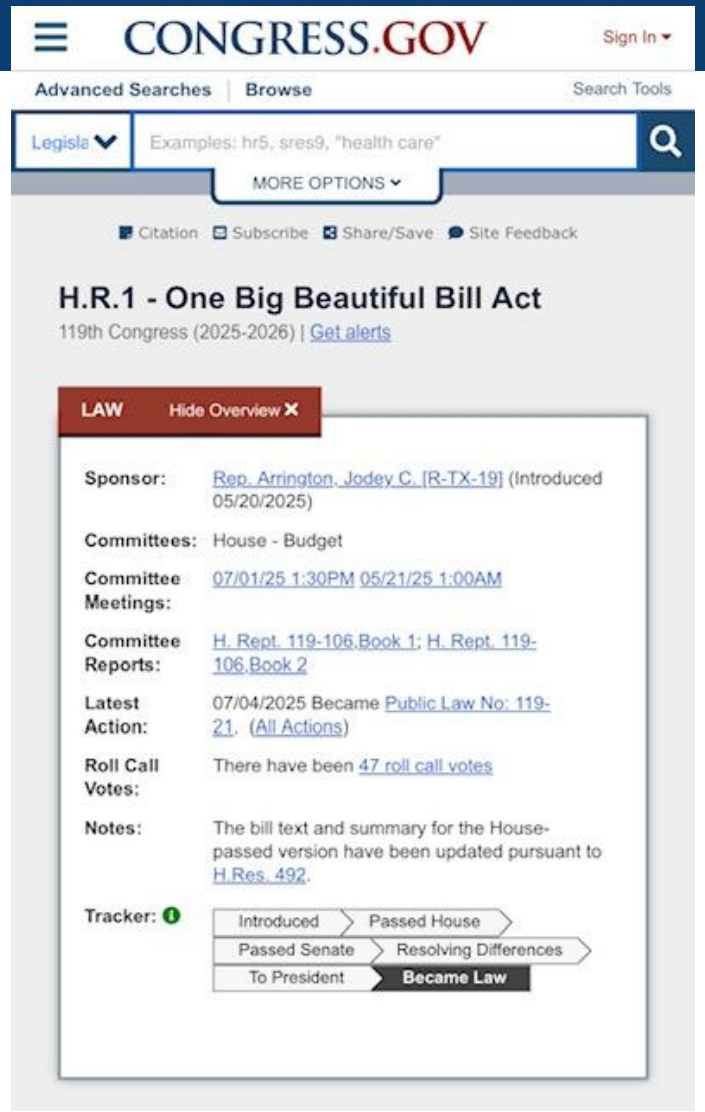
OBBBA Implementation



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What should everyone be conscious of?

- **Differential obligations as well as operational/financial impact across Medicaid programs** (expansion v. non-expansion states; US territories)

- **Implementation deadlines** (see this helpful annotated timeline by KFF) and **sequence and order of priority of OBBBA provisions for CMS**

- **States' need to engage in preparatory work** including 1) Rural Health Transformation program plans; 2) interpretation and application of other major OBBBA requirements; 3) budget forecasting; 4) mapping and procurement of needed changes to IT systems; 5) examining need for legislative action; and 5) plans for engagement with partners

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Differential obligations and impact across Medicaid programs

- **Requirements that affect all or most states:**
  - Processes for duplicate enrollment and deceased members/providers
  - Narrowed definition of “qualified alien” for purposes of eligibility
  - New limits on retroactive eligibility*

- **Requirements that affect only expansion states:**
  - Community engagement requirements**
  - More frequent redeterminations (at six-month intervals)
  - Cost sharing requirements**

* Note that there are different standards as between expansion and non-expansion states
** Non-expansion states that provide waiver coverage that is equivalent to minimum essential coverage (MEC) have to review the applicability of these requirements

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OBBBA Medicaid Policy Timeline

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July 4, 2025

Restriction on Funding to Certain Family Planning Providers (Sec. 71113)

- Temporarily restricts federal funding for one year to certain 501(c)(3) providers that offer abortions, primarily deliver reproductive health services, and received at least $800,000 in Medicaid payments in FY 2023, among other characteristics.
- Effective: July 4, 2025 (for 1 year)

Provider Tax Provisions (Sec. 71115)

- Prohibits new provider taxes on previously untaxed provider classes, caps overall tax rates at levels in place on date of enactment, and phases down hold harmless thresholds in expansion states, excluding Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDDs).
- Effective: Taxes will be capped as they were structured on July 4, 2025. Cap goes into effect on October 1, 2026. Expansion state phase down begins in FY 2028.

State Directed Payment Limits (Sec. 71116)

- Caps state directed payments in managed care programs at 100% of Medicare rates in expansion states and 110% of Medicare rates in non-expansion states. Grandfathered payments must be reduced by 10 percentage points per year starting in 2028.
- Effective: For rating periods beginning on or after July 4, 2025

Dec. 31, 2025

Rural Health Fund (Sec. 71401)

- Establishes a $50 billion grant program (FY2026–2030) for states to improve rural health care delivery. States must implement at least three eligible activities; CMS must make award decisions by December 31, 2025.
- Award Decision Deadline: Dec 31, 2025
- Funding Period: FY 2026–2030

Oct. 1, 2026

Eligibility Changes for Immigrants (Sec. 71109)

- Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.
- Effective: Oct 1, 2026

Dec. 31, 2026

Work/Community Engagement Requirements (Sec. 71119)

- States must require certain expansion adults to complete 80 hours per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19–64, with limited exemptions and must be verified through ex parte processes.
- Effective: Dec 31, 2026; HHS must issue rule by June 1, 2026; States may request a good faith effort extension through Dec 31, 2028.

6-Month Redeterminations (Sec. 77107)

- Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver. Current 12-month requirement remains for all other populations.
- Effective: Dec 31, 2026; CMS guidance due by Dec 31, 2025

Jan. 1, 2027

Retroactive Coverage Limits (Sec. 71112)

- Reduces retroactive coverage in Medicaid from up to three months to one month for expansion adults and two months for all other groups.
- Effective: for applications submitted on or after Jan 1, 2027

July 1, 2028

HCBS Waiver Option (Sec. 71121)

- Creates a new 1915(c) waiver that allows states to offer Home and Community-Based Services (HCBS) without requiring institutional level of care. States must meet cost neutrality and reporting standards.
- Effective: July 1, 2028

Oct. 1, 2028

Cost Sharing for Expansion Adults (Sec. 71120)

- Requires states to implement cost-sharing on expansion adults with income above 100% Federal Poverty Level. Caps charges at $35 per service and 5% of income; excludes key services like primary care, behavioral health, and those provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certified Community Behavioral Health Clinics (CCBHCs).
- Effective: Oct 1, 2028

This timeline does not include all Medicaid-related provisions from OBBBA.

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Preparatory work: Rural Health Transformation Program

- While a number of Medicaid programs played the lead role in development of their state's application, in others, governors' offices or other state agencies coordinated the work
- With the application window closing last week, each state will now await CMS funding decisions and potentially adjust scale of planned activities based on those decisions
- Both CMS and states are focused on sustainable, shovel-ready projects
- The territories are concerned that OBBBA excluded them from these funds and are advocating for Congressional action

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Preparatory Work: Interpretation and application of OBBBA requirements

- **Medicaid programs need guidance from CMS in areas in which the federal government has interpretive discretion on how to implement OBBBA –** non-exclusive examples of these policy questions center on medical frailty exemptions, look-back periods and use of self-attestation

- **CMS has signaled that it plans to issue guidance later this calendar year and has mapped out plans for partnership activities with NAMD membership**, including engagement through affinity groups and also resumption of the all-state call model that was used during unwinding

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Preparatory work: State budget forecasts

- Medicaid agencies are **developing budget requests for FY2027 now** that will be considered by legislatures in their 2026 sessions
- Budgets must project funding needed to deliver Medicaid benefits and implement OBBBA provisions, **especially those that are effective in CY'26 (work/community engagement, 6-month redeterminations)**
- **Providers should be aware that states are being asked for cost reduction options and are also beginning to factor in changes to provider tax revenue and state directed payments**

Budget considerations

- How will policies change the number of people covered by the program ongoing (caseloads) and the health care needs of those enrolled (acuity)?
- What will it cost to make IT systems changes and/or procure new solutions?
- Will new staff and contractors be needed (e.g., eligibility workers, call center staff)?
- How will changes in provider taxes impact resources available to fund the state share of program costs?
- Will CMS grant any good faith deadline extensions? (early signals indicate that extensions are unlikely)

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Preparatory work: Changes to IT systems

- Medicaid programs, especially those in expansion states, will **need to make significant IT systems changes or procure new IT solutions** to implement OBBBA
- Medicaid leaders are eager to partner with CMS and the IT vendor community to **leverage new models of investment that maximize value and avoid "first dollar" spending** (e.g. the CMS income verification tool that is being piloted)
- **In areas in which OBBBA provides clear guidelines, states are already moving ahead with systems changes** – non-exclusive examples of this include connecting MMIS and EMS systems, developing means of accessing wage data, creating interfaces with partners (e.g. SNAP) and developing notices

What is "first dollar" spending?
It's where each state pays a vendor to individually design, build, and launch their IT system changes, even when multiple states are making the same set of changes with the same vendor.

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Preparatory work: Identifying needed state legislative authority

- **State legislatures will play a key role in OBBBA implementation** by making appropriations of state funding and as needed, enacting enabling legislation

- **The timing of state legislative sessions is key.** Legislatures meet annually or biannually for a short window, often in the winter/spring. Special sessions may be needed, depending on timing.

- **Medicaid agencies must identify where changes in state law are needed to enable implementation of or align with new federal requirements.** This work is particularly challenging when states are waiting for clarity and guidance from CMS on questions of interpretation.

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Preparatory work: Plans for engagement with partners

- **Medicaid programs are starting to develop their member and partner engagement strategies now, keying to important analogous work during the unwinding**

- **Member engagement** will include working with Medicaid Advisory Councils and Beneficiary Advisory Councils, as well as developing member-facing explanatory materials around new obligations (e.g. work and community engagement, cost sharing)

- **As it was during the unwinding, it will be crucial, within the guardrails established by the OBBBA that prohibit plans from determining a member's compliance with work and community engagement requirements, for plans to partner on such activities as cueing members to their redetermination dates and identification of members whose exemption status (e.g. due to age or health condition) and/or health profile necessitates careful tracking and continuity of coverage**

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Advice for partnering

- ✓ **Recognize the differential impact and timing of OBBBA policies.** Non-expansion states are not as impacted by the policy changes.
- ✓ **Be aware of the fiscal context**. States must balance their budgets, and in leaner fiscal environments, Medicaid will necessarily face pressure to find savings.
- ✓ **Acknowledge operational realities for Medicaid**, such as the need for further guidance from CMS, budget forecasting, IT systems issues, and the role of state legislatures.
- ✓ **Partner in offering solutions and expertise**, such as helping Medicaid communicate policy changes to members, providers, and other stakeholders, as well as in other areas (behavioral health, pharmacy, long-term care, and value-based payment) that may be instrumental to saving program funds and achieving better outcomes for members.

Welcome your comments and questions

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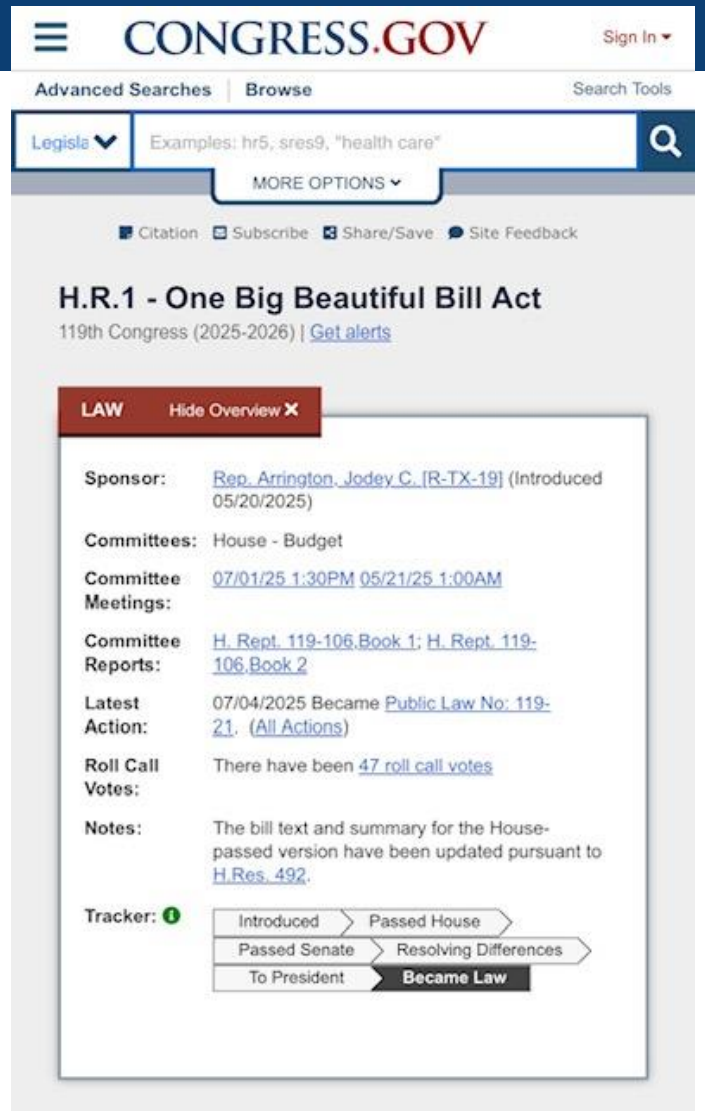
Appendix: Key Provisions of OBBBA



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OBBBA Rural Health Transformation Funding

- OBBBA creates a rural health transformation fund in the amount of $10 billion in each of FYs 26-30
- To receive these funds, states must submit applications to HHS during an application period that ends not later than December 31, 2025, that includes a detailed rural health transformation plan, a certification that none of the funds finance state share of Medicaid, and other information
- Only the 50 states (not DC or territories) are eligible
- The funds must be allocated using the following formula:
  - 50 percent of funds for each fiscal year are distributed equally among states with approved applications
  - 50 percent of funds are allotted based on the percentage of the population that is rural, the proportion of rural health facilities in the state relative to the number of rural health facilities nationwide, and the situation of hospitals

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OBBBA Medicaid Policy: Eligibility

The law establishes new conditions on Medicaid eligibility, particularly to qualify for coverage as a childless adult under the Affordable Care Act's Medicaid expansion

- ✓ Work/community engagement requirements
- ✓ Eligibility redeterminations every six months, rather than every 12 months
- ✓ Maximum home equity limit for eligibility for long-term services and supports
- ✓ Changes in non-citizen eligibility
- ✓ New retroactive coverage periods
- ✓ New pathway to qualify for HCBS waiver services

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OBBBA Medicaid Policy: Financing

The law aims to contain the growth of federal Medicaid spending through changes in how states finance their share of program costs

- ✓ Prohibits the use of new or increased provider taxes for most provider types. All states, except Alaska, use provider taxes to fund a portion of the state share of Medicaid programs.
- ✓ Phases down the "hold harmless" threshold for provider taxes in expansion states
- ✓ Limits state directed payments to a percentage of Medicare rates, instead of average commercial rates.
- ✓ Modifies technical aspects of existing Medicaid provider taxes
- ✓ Requires the CMS actuary certify that an 1115 waiver is budget neutral to the federal government

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OBBBA Medicaid Policy: Program Integrity

Creates new requirements around Medicaid program integrity, with a focus on eligibility policy and audit findings

- ✓ Authorizes a new system to prevent enrollees from being simultaneously enrolled in two state Medicaid programs
- ✓ Requires states to check the Death Master File quarterly to determine if enrollees or enrolled providers are deceased
- ✓ Limits HHS' authority to waive payment reductions for state Medicaid programs when HHS audits find an error rate over 3%

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OBBBA Medicaid Policy: Prohibited Providers

For the one-year period following date of enactment, OBBBA Section 71113 prohibits federal match for services provided by entities that:

- are 501(c)(3) entities
- are essential community providers that are primarily engaged in family planning services, reproductive health, and related medical care
- provide abortions (other than those provided in the case of rape, incest, or to save the life of the mother)
- received directly or through its affiliates over $800,000 in total federal and state Medicaid payments

The latest action in related litigation is that on 9/11/25, the First Circuit stayed a previous preliminary injunction pending appeal, leaving Section 71113 in effect

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H.R. 1 - California Case Study

Dustin Corcoran, CEO

November 14, 2025
AMA IPPS and OMMS

CMA

Estimated H.R. 1 Health Care Cuts/Coverage Losses In CA

10 YEAR COVERAGE AND FISCAL IMPACT ESTIMATES

- Cuts Medicaid by up to $187 billion (17% cut)
- Up to 3.4 million Medi-Cal & 400,000 ACA enrollees will lose health care coverage
- 3 million Medi-Cal enrollees to lose coverage due to work requirement red tape ($22.3 billion loss in federal funds to CA)
- 313,000 CA documented immigrants lose Medi-Cal and ACA coverage in 2026
- $66-$128 billion in provider tax cuts (average 20% cut)
- Uncompensated Care Costs Increase by $9.5 billion
- 217,000 health care jobs lost; $37 billon in reduced economic output

Sources: Manatt, CA Department of Health Care Services, California Hospital Association, UC Berkeley, KFF, Covered California

Medi-Cal Rates Before CA’S Current MCO Tax:

- Last broad Medi-Cal Rate increase in 2000-01.
- 10% rate reduction in 2011. That cut had been restored piecemeal over the years.

Low Reimbursement Rates Reduce Access

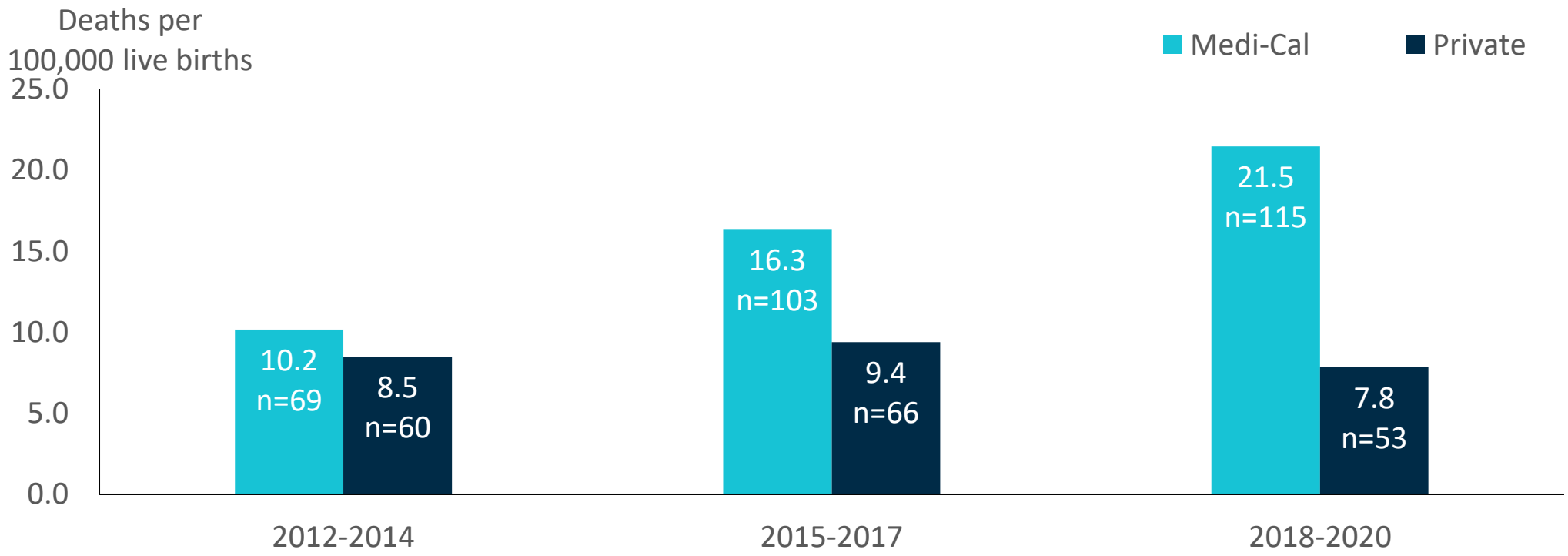
In 2022, California ranked 40th in Medicaid reimbursement rates nationally.

Data from the Commonwealth Fund

What does this mean for disparities?

Pregnancy-Related Mortality Ratio by Payer Type

California 2012-2020 (N=564)



Source: California Department of Public Health, CA-PMSS, 2012-2020

2024 Medi-Cal Rate Increases

- After reestablishing MCO tax, increased Medi-Cal base rates to at least 87.5% of Medicare for **primary care**, **maternity care** and **non-specialty mental health services.**
- Other rate increases slated to start Jan. 1, 2025, were swept in 2024-25 budget process.

California’s Prop. 35:

+ Guides use of California's MCO tax.

+ Protects the investment in Medi-Cal using MCO tax funds.

+ Ensures that the Prop. 35 funds were additive to existing Medi-Cal expenditures.

+ Gave health plans reassurance that the tax would not be inflated.

+ Established a high vote threshold for changes.

Proposition 35: 2025/26 Medi-Cal and Workforce Investment

Spending Category	Total Funds
Primary Care	$1.38 B
Specialty Care	$1.15 B
Outpatient Procedures (Facilities)	$490 M
Family Planning & Abortion	$500 - $600 M
Clinics	$100 M
Emergency Departments (Hospitals)	$560 M
Emergency Physicians	$200 M
Designated Public Hospitals	$150 M
Ground Emergency Transport	$100 M
Behavioral Health Throughput	$450 - $500 M
Workforce	$150 M
GME	$75 M
Total Expenditures	**$6 - $6.5 Billion**

Proposition 35: Implementation Status

Spending Category	Total Funds
Primary Care	$1.38 B
Specialty Care	$1.15 B
Outpatient Procedures (Facilities)	$490 M
Family Planning & **Abortion**	~~**$500 - $600 M**~~ **$90 M**
Clinics	$100 M
Emergency Departments (Hospitals)	$560 M
Emergency Physicians	$200 M
Designated Public Hospitals	$150 M
Ground Emergency Transport	$100 M
Behavioral Health Throughput	$450 - $500 M
Workforce	$150 M
GME	**$75 M**
Total Expenditures	**$6 Billion**

Proposition 35: 2025 and 2026 Medi-Cal and Workforce Investments

Spending Category	Total Funds
Primary Care	$1.38 B
Specialty Care	$1.15 B
Outpatient Procedures (Facilities)	$490 M
Family Planning & **Abortion**	~~**$500 - $600 M**~~ **$90 M**
Clinics	$100 M
Emergency Departments (Hospitals)	$560 M
Emergency Physicians	**$200 M**
Designated Public Hospitals	$150 M
Ground Emergency Transport	**$100 M**
Behavioral Health Throughput	$450 - $500 M
Workforce	$150 M
GME	**$75 M**
Total Expenditures	**$6 Billion**

Proposition 35: 2025 and 2026 Medi-Cal and Workforce Investments

Spending Category	Total Funds
Primary Care	**$1.38 B**
Specialty Care	**$1.15 B**
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Ground Emergency Transport	**$100 M**
Behavioral Health Throughput	$450 - $500 M
Workforce	$150 M
GME	**$75 M**
Total Expenditures	**$6 Billion**

Anticipated Prop. 35 2025 Primary and Specialty Care Increases - % of Medicare

- Procedure Code Target Evaluation & Management (E/M) Codes for Office Visits, Preventive Services, and Care Management - 90%
- Obstetric Services - 90%
- Evaluation & Management Codes for ED Physician Services - 90%
- Other Procedure Codes commonly utilized by Primary Care, Specialist, and ED Providers - 80%
- Non-Specialty Mental Health Services - 87.5%
- Vaccine Administration - 87.5%

Threats and Challenges for CA's MCO Tax

- H.R. 1 uniformity requirement for Medi-Cal & Non-Medi-Cal Plans.
  - Difficult to meet.
  - CA's MCO tax has waiver approved through December 31, 2026.
- CMS proposed rule requiring immediate tax uniformity
- H.R. 1 reduction of provider tax rates from 6% to 3.5% in Medicaid expansion states

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Thank You

2025 AMA Interim Meeting
OB3 Medicaid Impacts

Scott Keefer, VP, Public Affairs

November 14, 2025

Discussion Outline

1. The One Big Beautiful Bill (OB3) and Medicaid Financing Historical Context
2. Medicaid Disruption: The Political and Policy Implications
3. Implementation and Next Steps

Medicaid in the One Big Beautiful Bill (OB3)

Touted as reducing Waste, Fraud, and Abuse, Medicaid cuts exceed $900 billion and are projected to result in 10 million additional uninsured over 10 years

What's In?

Medicaid

- Work requirements for able-bodied adults beginning in 2027
- Twice annual eligibility checks for adults without children
- Phase-in of limits on provider taxes and state-directed payments beginning in 2028
- $50 billion in state grant funding to support rural health

ACA/Marketplace

- Requirements for pre-enrollment verification for Exchange coverage, effectively ending auto-reenrollment in 2028
- Removal of the current cap on recapture of excess tax credits

What's Out?

Medicaid

- Proposals fundamentally altering federal-state financing:
  - Per capita cap financing
  - Block granting of state funding
  - Removal of the 50% "floor" for federal matching funds

ACA/Marketplace

- Extension of the enhanced ACA subsidies set to expire in 2025
- Authorization of funding for cost-sharing reduction (CSR) payments under the ACA and related proposals

The Long History to Limit Supplemental Payments

Medicaid Financing and Budget Hawks

"Medicaid's open-ended financing structure encourages efforts to draw down federal matching funds in any way possible, some of which are not appropriate. These financing practices undermine the federal-state partnership and jeopardize the financial stability of the Medicaid program."

- ✓ The Senate Budget Committee directed a $3.4 billion reduction in federal Medicaid spending over 5 years in its FY 2005 budget resolution, attributing these savings to unspecified "waste and abuse in the system."
- ✓ See also GAO, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed," (February 2004), GAO-04-228.

How's It Playing? Public Angst and the Path Forward

A bipartisan Wall Street Journal poll found that 42% supported while 52% opposed OB3. 94% of Democrats, 12% of Republicans and 54% of independents oppose the law. Some polling (KFF) has support for the bill even lower.

Work requirements are more popular but a conundrum. While supported by a 62% to 34% margin, the WSJ noted "that backing vanishes when they are asked if they favor removing benefits from people who don't comply."

Economic anxiety across the Medicaid population is rising. According to Morning Consult polling, the gap in economic confidence between high- and low-earners is now the widest it has been in seven years

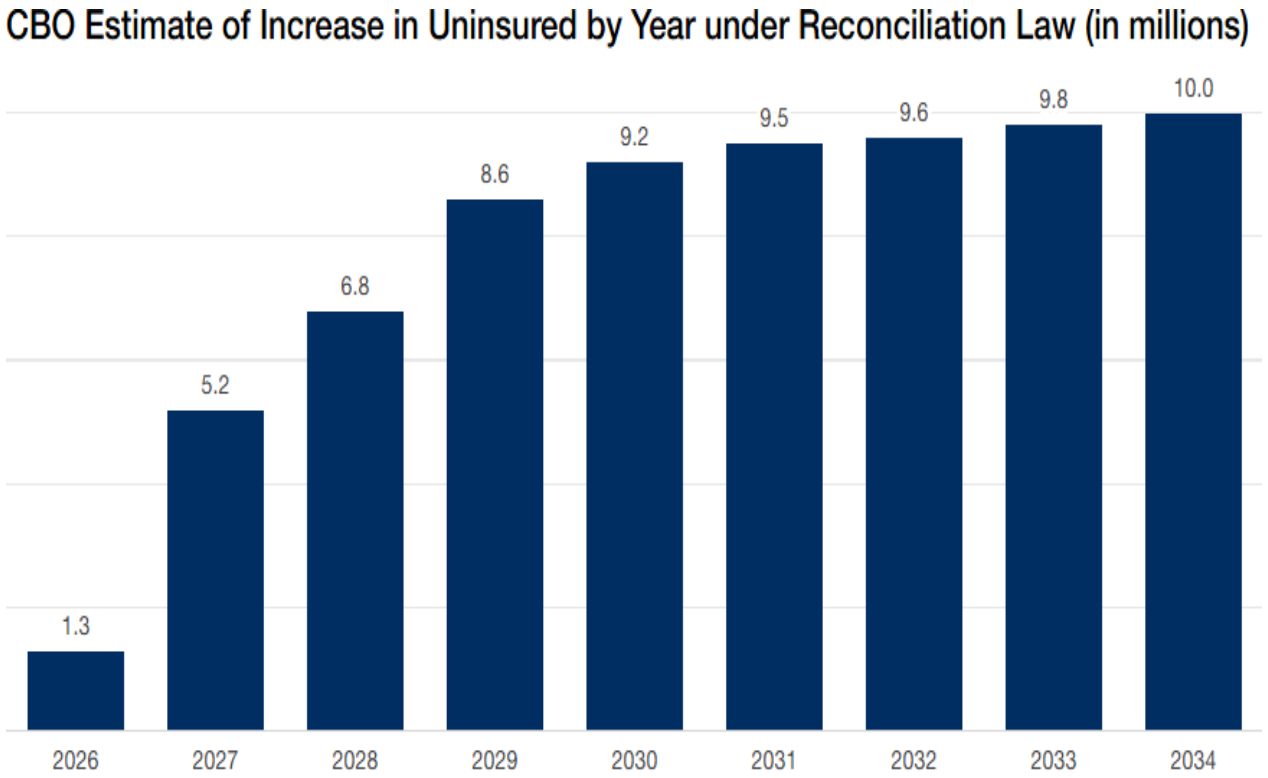
Political rhetoric regarding the impact of OB3's Medicaid changes will sharpen in the runup to the mid-terms whether viewed as curtailing fraud or the end of health care as we know it

Managing Medicaid Disruption

Implementation requires detailed federal guidance and will create very tight timelines, particularly for work requirements

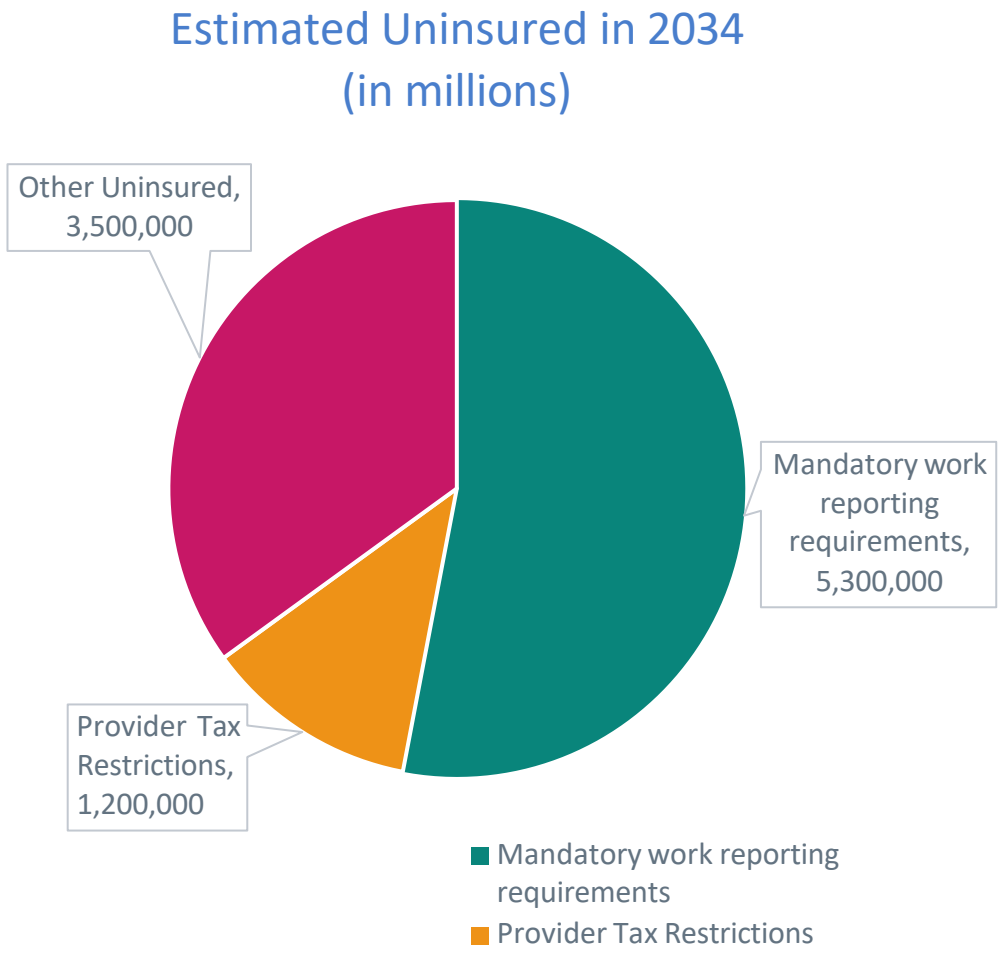
Impacted Area	What's Next?
Member	• Eligibility and paperwork requirements are predicted to cause coverage losses for millions • States are actively discussing lessons learned from COVID redeteriminations but ACA instability may further contribute to confusion and disenrollment
Operations	• The Trump Administration is working with vendors to automate new processes and develop applications to administer work requirements but burden will be high, particularly for state/local gov't • According to NACO, The state and county administrative cost share will increase from 50 to 75 percent beginning in FY 2027. Counties may face up to $850 million in added administrative costs
Financing	• Limits on state directed payments and provider taxes will strain budgets and the health care system • Physician/provider impact will be most pronounced in rural communities and county-owned facilities • Increases in the uninsured and reduced reimbursement will exert pressure on commercial payment

Medicaid Uninsured Breakdown as Estimated by CBO

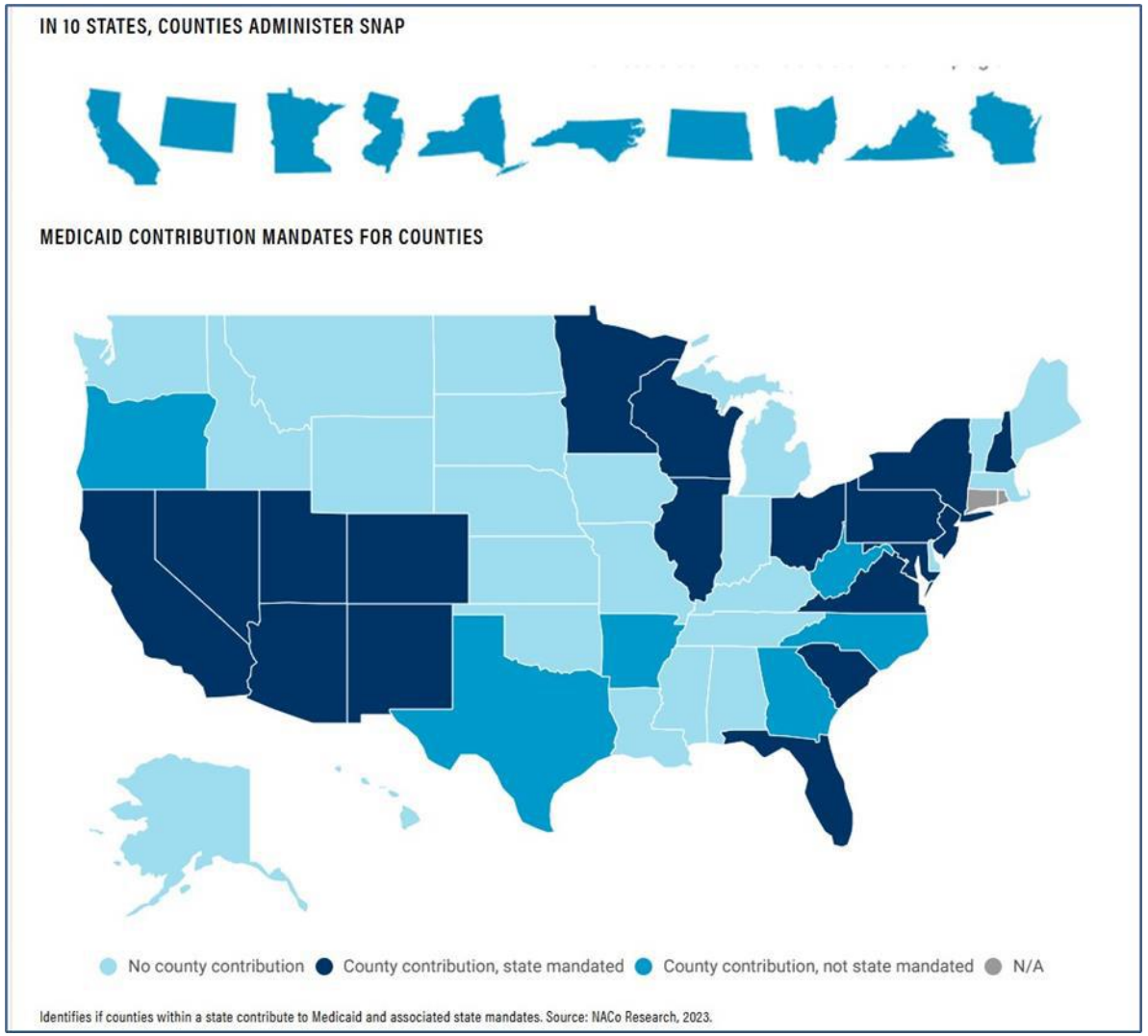


Source: Georgetown University Center for Children and Families analysis of the Congressional Budget Office's "Distributional Effects of Public Law 119-21" (August 2025).

Georgetown University McCourt School of Public Policy CENTER FOR CHILDREN AND FAMILIES



OB3 Impact is Significant on County and Local Gov't



- A significant portion of the state Medicaid match is financed by counties and even mandated in many states
- *County-owned hospitals and nursing institutions (approx. 1500)* make up a disproportionate share of rural and critical-access facilities
- Burden will be most pronounced in those counties that have a prominent role in both Medicaid and SNAP
- For example, NACO is highlighting St. Louis County in Northern MN as incurring new recurring costs of $16.5m equal to a 9.5% property tax increase

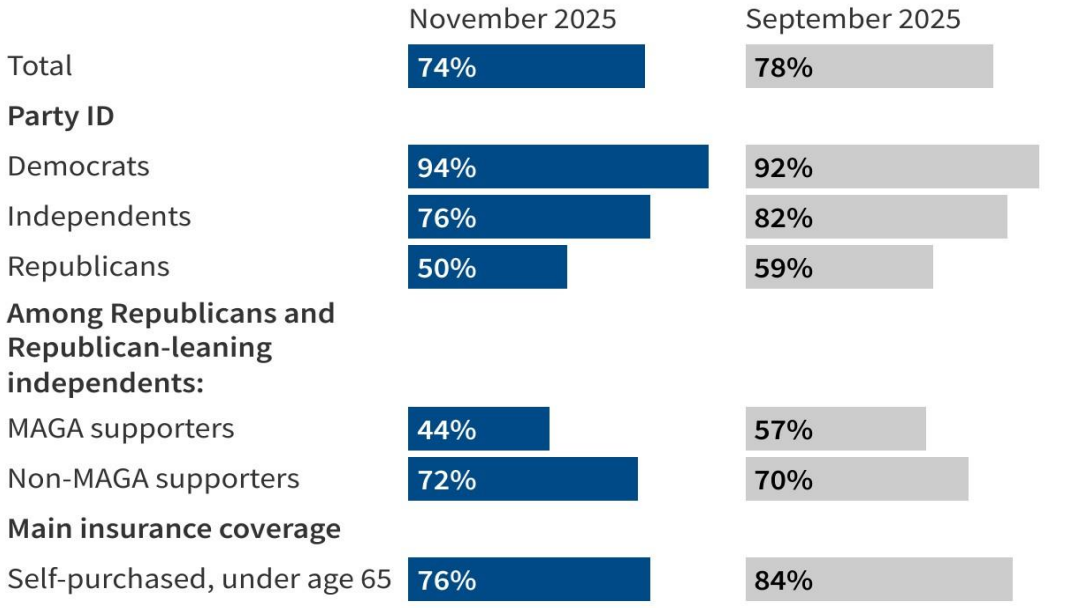
Source: National Association of Counties (NACo)
https://www.naco.org/resource/big-shift-analysis-local-cost-federal-cuts

Extending Enhanced Tax Credits (EPTCs) has Strong Support

Figure 1

A Majority of the Public Says Congress Should Extend ACA Tax Credits, Though Republican and MAGA Support Has Declined from Last Month

Percent who say Congress should **extend the enhanced premium tax credits**, rather than let them expire:



Note: See topline for full question wording.
Source: KFF Health Tracking Polls (October 27-November 2, 2025 and September 23-29, 2025) KFF

Source: KFF.org https://www.kff.org/public-opinion/kff-health-tracking-poll-public-weighs-in-on-health-care-debate-and-government-shutdown/

ACA Policy Implications and Timing

- Insurance commissioners and stakeholders agree that the consequence of letting the EPTCs expire is fewer young people and a less healthy risk pool
- The premium impact would create “cliffs” by income and impact most significantly larger middle -income households and the 55-64 population
- Timing is a critical challenge with open enrollment already occurring and an unrealistic timeframe to make policy changes/reforms for 2026
- Regulators and stakeholders are assessing timing concerns and exploring contingency planning such as a special enrollment period to address changes

What's Next? Shutdown Clouds Further Health care Action

Tension is strong between the bipartisan desire for a health bill and budget turmoil

The government shutdown has limited the effort to "sell" OB3 while the expiring ACA enhanced tax credits (EPTCs) have further clouded access to health insurance, including potential overlap for some populations. While bipartisan health care discussions are ongoing (including ACA) budget rancor looms over everything.

ACA reform demands run into operational headwinds due to technology and timing challenges. Suggestions that the ACA is too expensive miss the bigger point that all health care and by extension health insurance is expensive. The real issue is "net cost" of insurance in comparison to employer coverage, Medicare or other types of insurance.

Any health legislative package will likely include PBM reforms and measures resulting in budget savings, potentially including reforms of the 340b program or Medicare Advantage coding practices. Longer term a grown-up policy conversation is critical about the sufficiency of government payment.

AMA
AMERICAN MEDICAL ASSOCIATION

Medicaid Cuts and the Role of Physician & Health System Executives

Introductions

Suzanna Fox, M.D.

EVP Chief Physician Executive, Advocate Health

- 34-year career with Atrium Health
- Clinical background as an OB/GYN
- Graduate of University of Georgia and the Medical College of Georgia

ADVOCATE HEALTH

1st in Community Benefit ($6.05B)

2nd Largest Health System with Integrated Medical School

3rd Largest Nonprofit System

167K Teammates

5.6M Unique Patients

1K+ Sites of Care

69 Hospital Locations

11.7K Employed Physicians

42K Nurses

6.9K Advanced Practice Professionals

$35B Revenue

AA Bond Rating from all Agencies

Overview

- Revenue Risks
- Medicaid/Medicare Funding Changes
- Organizational and Physician Impact
- Mitigation Strategies

Revenue Risks

340B Rebate Model Impact

The 340B Rebate Model Pilot requires upfront drug payments and delayed rebates, straining safety-net providers financially. Manufacturer determines qualification.

Provider Tax Caps Effect

Gradual tax cap reductions through 2032 threaten billions in Medicaid funding, impacting state-directed payment programs. State by state variation. Begin 2028-2032.

Site-Neutral Payment Policy

Site-neutral payments could reduce outpatient reimbursements by 60%, shifting care site decisions and competition.

Medicaid and Medicare Funding Changes

Expansion versus Non-Expansion States

- Limits benefits of expansion.
- Penalizes expansion states (100 vs 110%-1/1/2028)
- Greater decreases in funding over time

Work Requirements on Eligibility

- Standard across states but difficult to monitor
- Georgia enrollment issue as a non-expansion state
- Significant administrative burden on healthcare systems to implement.
- Will reduce enrollment increasing under/uninsured.

Safety net hospitals/Rural communities at risk

Medicare - One 2.5% increase to Medicare Physician Fee Schedule conversion for 2026 only. Will not offset cuts

ADVOCATE HEALTH

Organizational and Physician Impact

Physician compensation

- Decreasing reimbursement
- Recruitment and retention concerns
- Sustainable compensation

Independent/aligned physicians may reduce number of Medicaid/uninsured patients

- Anticipate increase ask for subsidies
- Locums increases
- Pressure on safety net hospitals

ADVOCATE HEALTH

AMA
AMERICAN MEDICAL ASSOCIATION

Innovation Lightening Round

Jefferson Health

Leveraging Technology

David Burmeister, DO, MBA FACEP

AMA IPPS Interim Meeting

November 14th, 2025

Thomas Jefferson University

200+ Graduate and undergraduate programs

77,000+ Alumni

17 NCAA Division II teams

8,300+ Students (full/part time)

Over **$200 million** In applied, basic, clinical and scholarly research

1,000+ Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025

Jefferson Health

4,350 Employed physicians

13,600+ Nurses (full/part time)

4 Magnet® designated locations

4 Pathway to Excellence® designations

32 Hospital campuses

700+ Sites of care

2,500+ Advanced Practice Clinicians

8.8+ million Outpatient visits (hospital and physician)

Data is FY24 - updated April 2025

Jefferson Health Plans

362,000+ Total members

40+ Years of service

316,000+ Medicaid members

750 Employees

13,000+ Medicare members

20,000+ CHIP members

13,000+ Individual and family plans

Data is 12/24 - updated January 2025

Celebrating 30+ years of nationally ranked care

By U.S. News & World Report

Thomas Jefferson University Hospitals

- 2nd in the Philadelphia metro area
- 3rd in Pennsylvania (tied)
- 2nd in the nation for Ophthalmology (Wills Eye Hospital)

Lehigh Valley Hospital—Cedar Crest

- 1st in the Allentown metro area
- 3rd in Pennsylvania (tied)

Jefferson Abington Hospital

- 8th in the Philadelphia metro area
- 17th in Pennsylvania

Jefferson Moss-Magee Rehabilitation

- MossRehab 10th in the nation for Rehabilitation

THOMAS JEFFERSON UNIVERSITY HOSPITALS

Nationally Ranked in 6 Specialties

- #2 Ophthalmology — WILLS EYE HOSPITAL
- #19 Orthopedics — ROTHMAN ORTHOPAEDICS AT JEFFERSON HEALTH; THE PHILADELPHIA HAND TO SHOULDER CENTER AT JEFFERSON HEALTH
- #22 Ear, Nose & Throat
- #25 Neurology & Neurosurgery
- #35 Pulmonology & Lung Surgery
- #39 Gastroenterology & GI Surgery

HIGH PERFORMING

- Cancer — JEFFERSON HEALTH – SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER
- Geriatrics
- Urology

LEHIGH VALLEY HOSPITAL—CEDAR CREST

Nationally Ranked in 2 Specialties

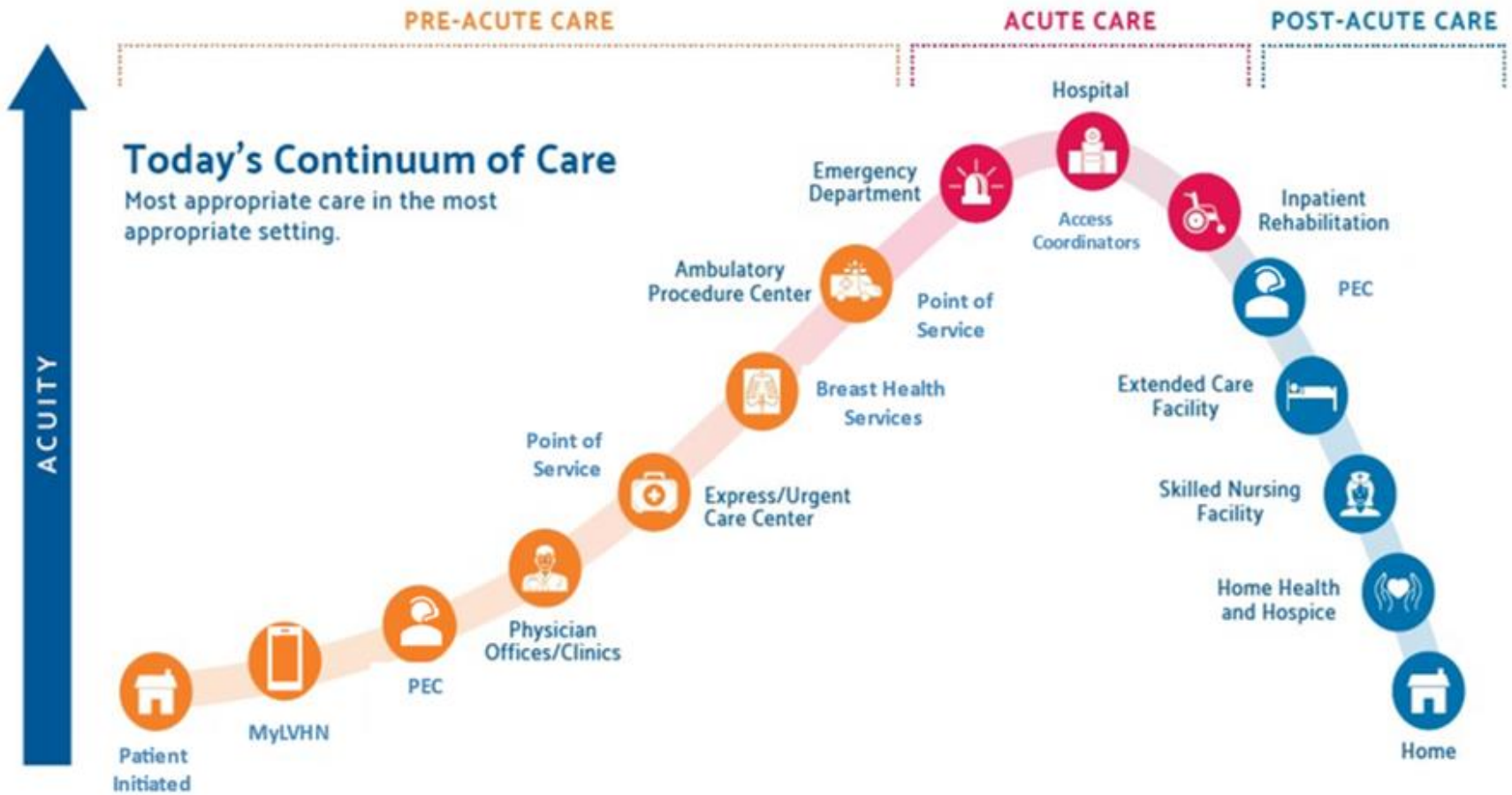
- #25 Orthopedics
- #42 Pulmonology

HIGH PERFORMING

- Cardiology, Heart & Vascular Surgery
- Diabetes & Endocrinology
- Gastroenterology & GI Surgery
- Geriatrics
- Neurology & Neurosurgery
- Urology

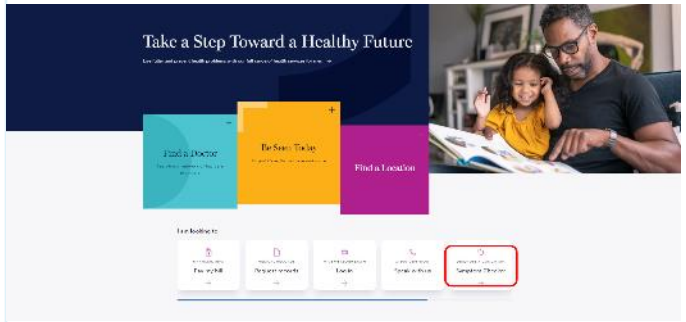
Patient Engagement at all access points

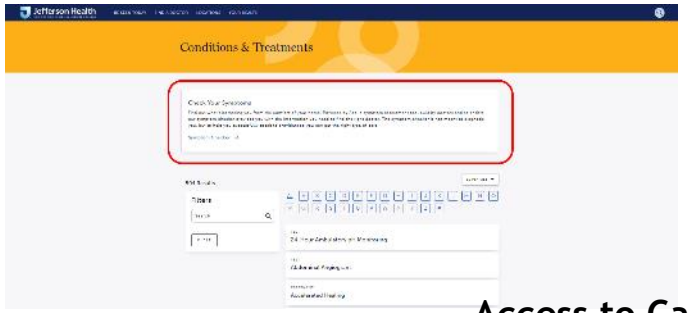
Comprehensive scheduling at every touchpoint



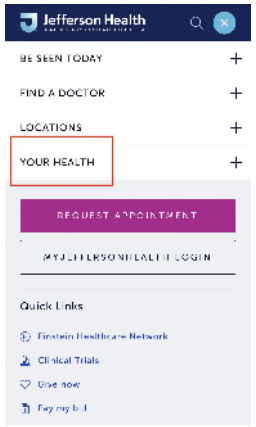
ADA Symptom Checker

Website





Mobile or MyChart



Access to Care

- **18,188** completed assessments (70% MyChart users)
- **42%** assessment conversion rate (After completing assessment, selected 'Next Steps' and is presented with Jefferson care options)
- **17%** of users over the age of 60, >**50%** under 40

Clinical

- Common symptoms – abdominal pain, fatigue, headache, nausea, cough, loss appetite, nasal discharge, sore throat
- Common conditions diagnosed - common cold, Covid, viral sinusitis, UTI, influenza, acute pyelonephritis, acute bronchitis, viral gastroenteritis
- Launched the BPA for primary care, urgent care and on demand telemedicine

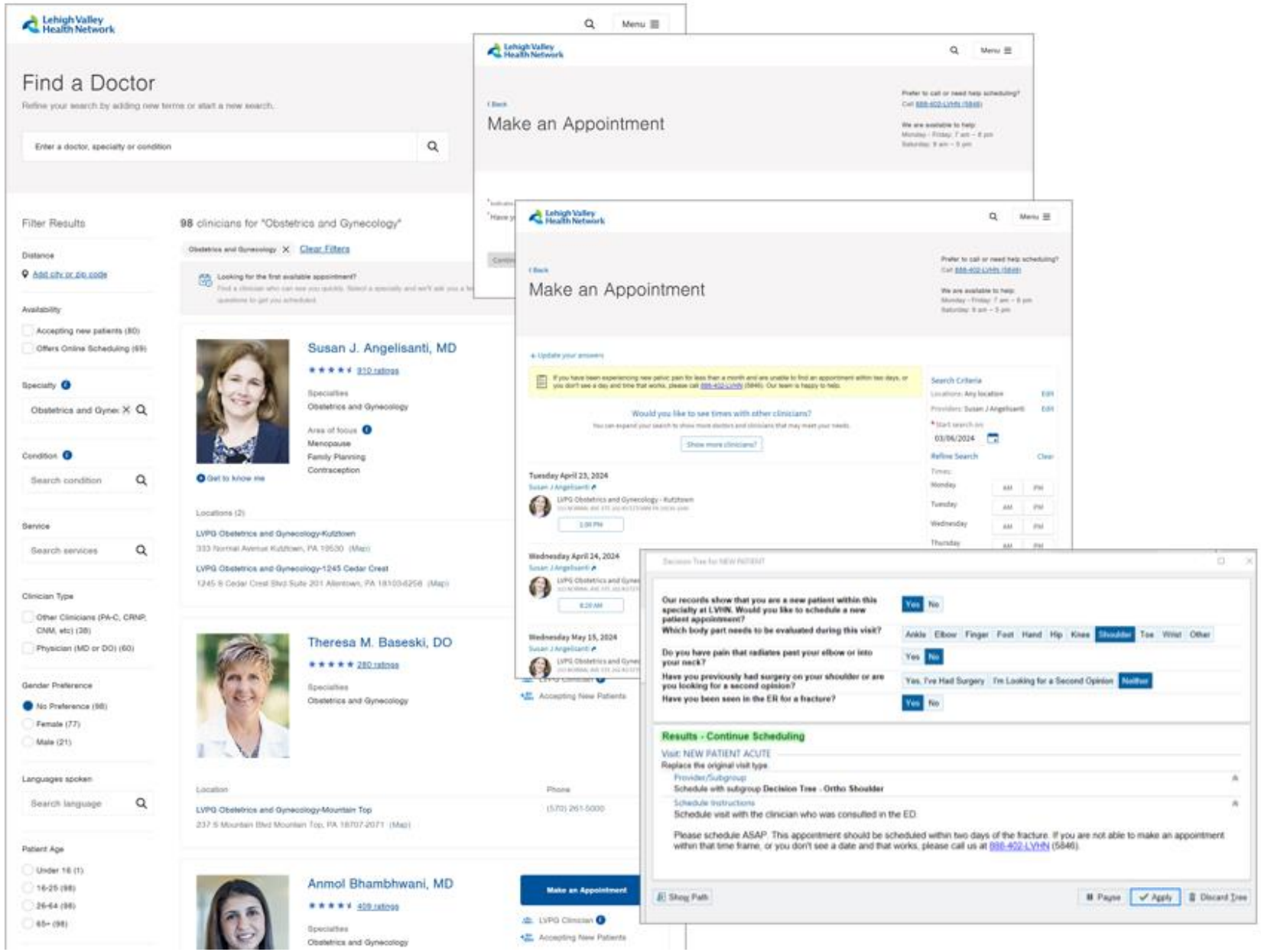
Effectiveness

- Recommendations for care needed
  - 49% connect with a provider now
  - 29% schedule an appointment with a provider
  - 18% find your nearest urgent care center
  - 3% find your nearest Jefferson emergency department
  - 0.34% call 911 (only 5 patients)

Guided Scheduling

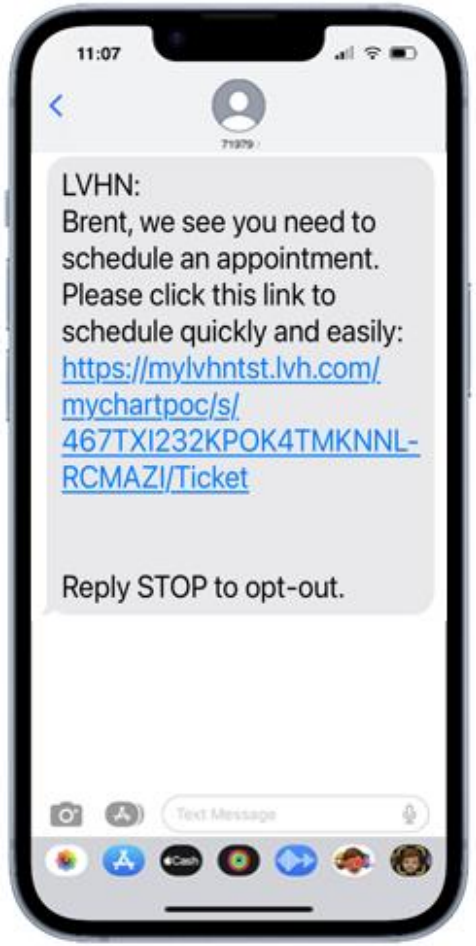
Thousands of appointments available on LVHN.org

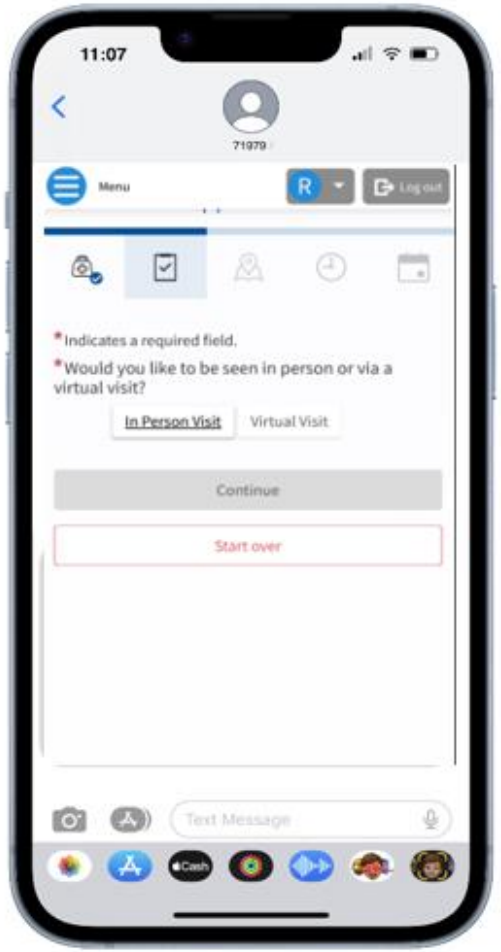
Schedule with the right clinician through Guided Scheduling.

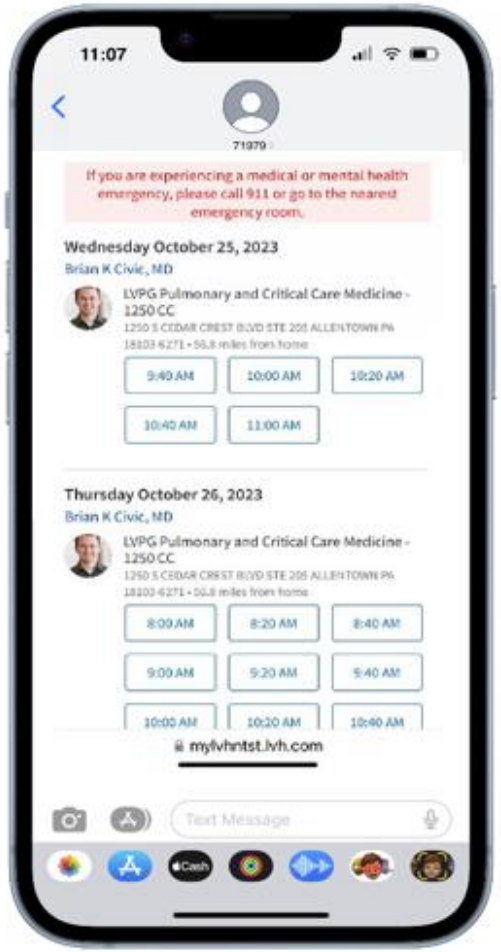


Hello World

Text functionality for patient appt scheduling







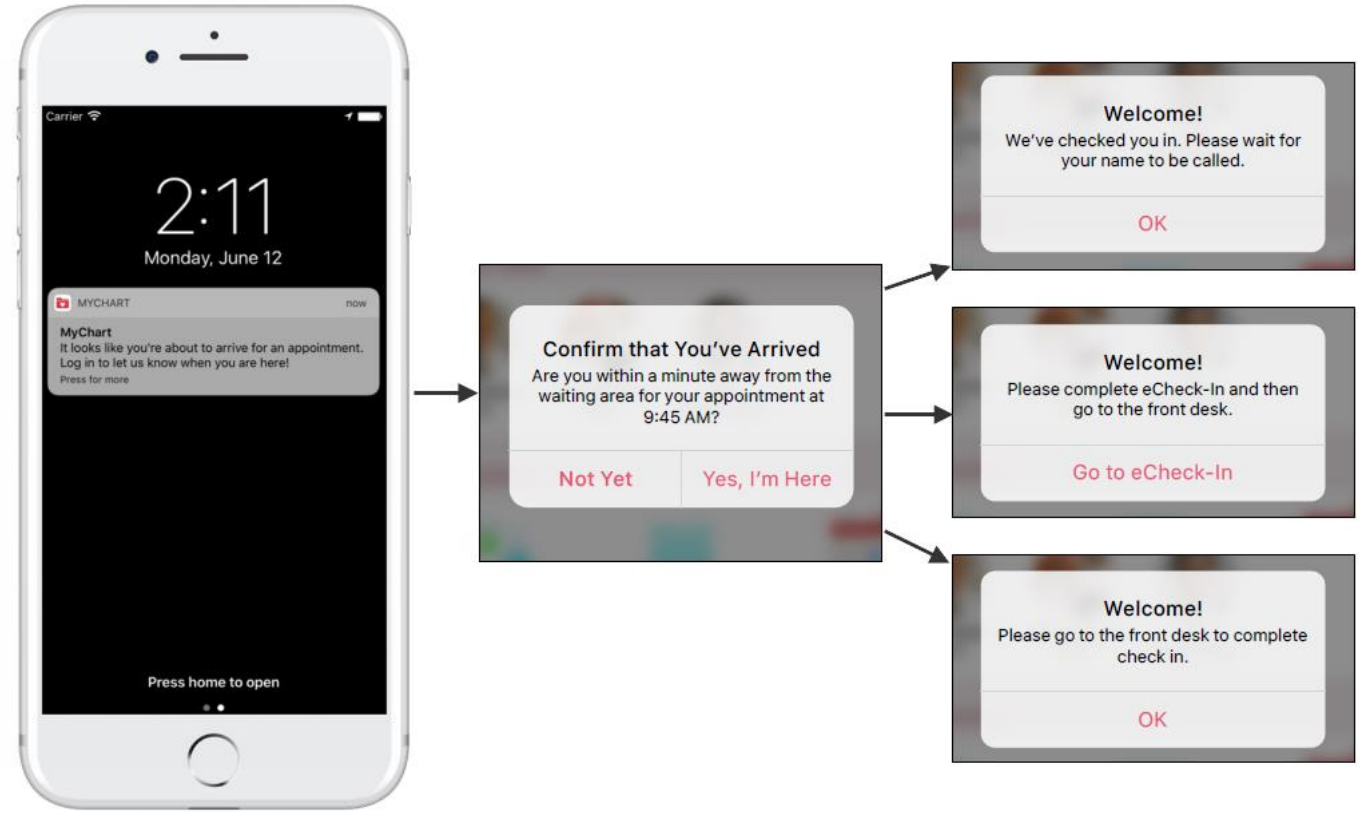
Scheduling Tickets

Clinician Orders a referral to a Specialty/Test
Patient is texted a link 30 min after order is placed, the patient is offered appointment options.

Hello Patient

Contactless Check-in

Hello Patient Contactless Arrival enables patients to arrive themselves for appointments directly from their mobile device.



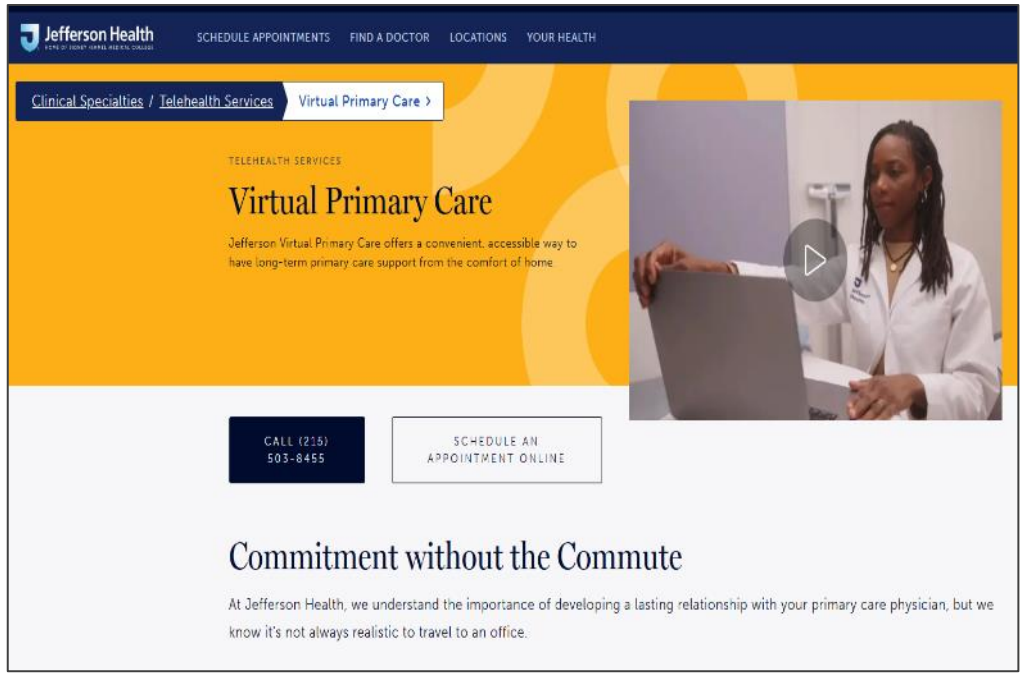
30 min prior to the scheduled appointment (arrival) time, Hello Patient sends a text message to the patient's cell phone.

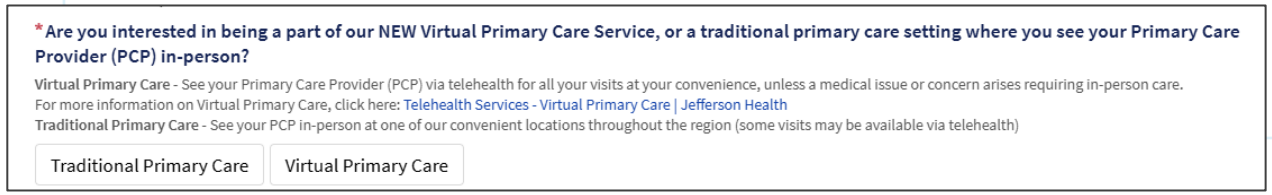
If the patient has outstanding check-in tasks, they will be prompted to complete eCheck-In or visit the front desk.

Virtual Primary Care

1. Public-facing website & Online Scheduling

https://www.jeffersonhealth.org/clinical-specialties/telehealth-services/virtual-primary-care





2. Call Center 1-800-JeffNOW

All patients requesting a new PCP appointment are offered the Virtual option

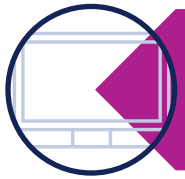
3. QR Code

Easily refer your patients using this QR code:

Patients 18 and older, located in PA and DE are eligible (NJ licensure pending)

Benefits of Virtual Primary Care

Improved and available access for patients



Convenient care to compete with patient/consumer demands

Comprehensive primary care, meeting patients where they are

Support expansion and growth in a virtual footprint

Provide supplemental access support to patients empaneled to other Jefferson PCPs or non-attributed patients needing care

Ambient Notes/In Basket Support

Expanded use of AI for Documentation Support

Abridge- real time ambient listening for notes

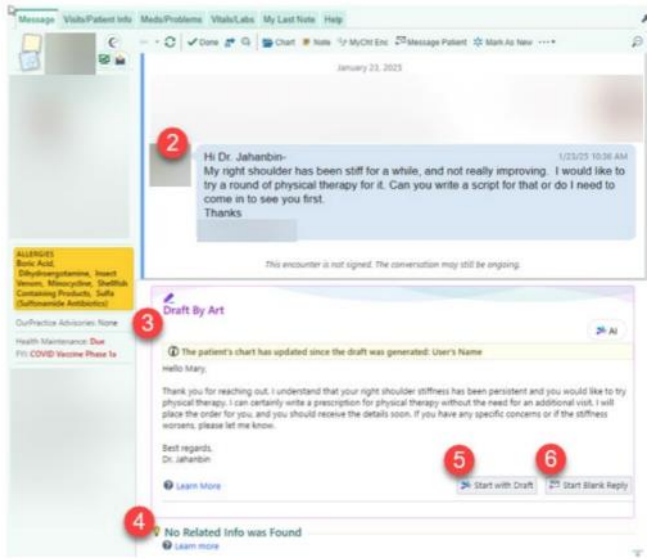
ART- AI-generated draft response to patient advice requests

ABRIDGE

A

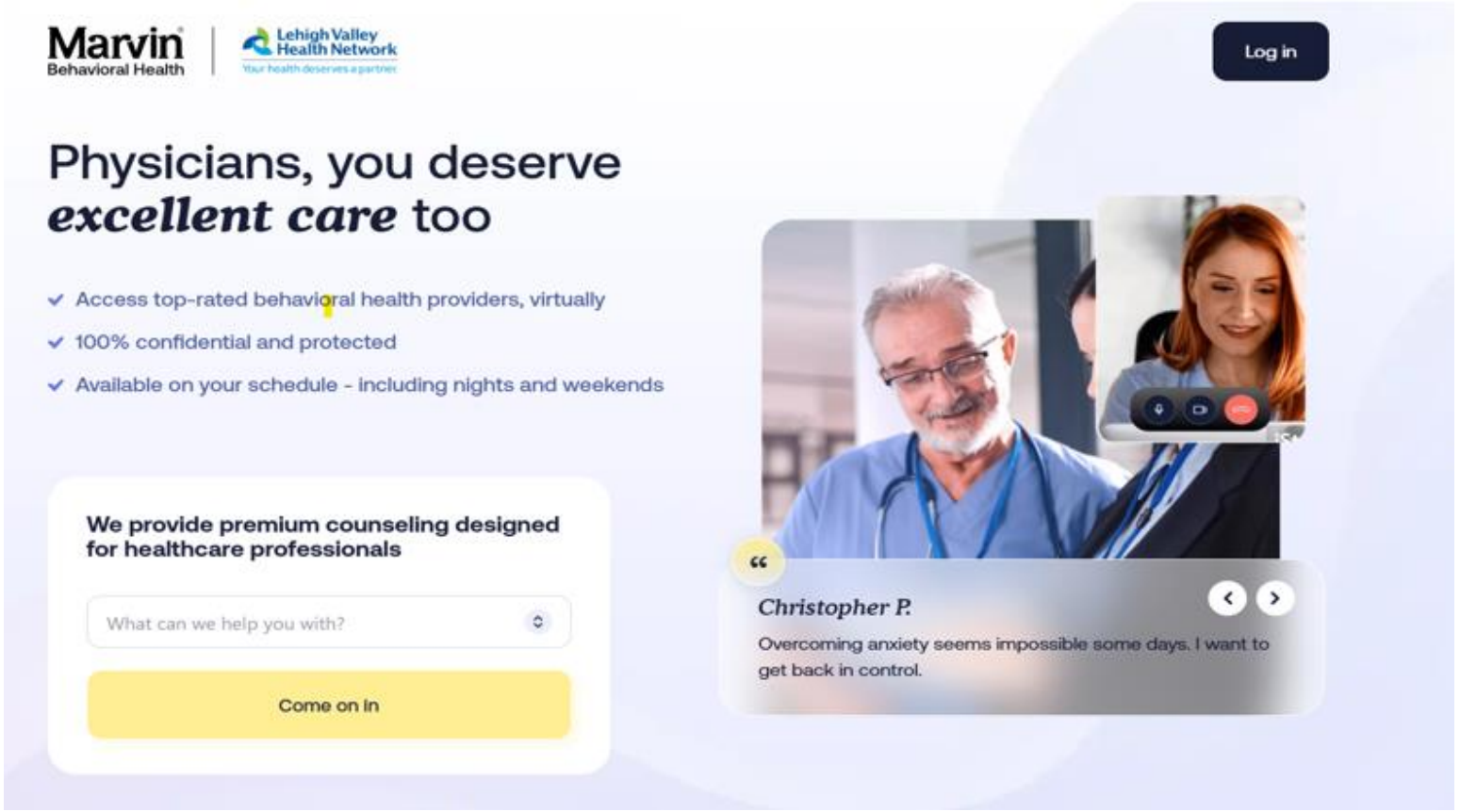
Try It Out.. Use a Generated Draft Reply to Respond to Messages

1. From **In Basket**, select the **Pt Advice Request folder**.
2. **Review** the message your patient sent.
3. Review the reply the model has drafted in the Generated **Draft By Art** section above the message.
4. Use the **Related Info** section to help you efficiently review the clinical context and the clinical accuracy of the reply. The Meds/Problems and Vitals/Labs message report tabs provide additional clinical information.
5. <u>If you want to use the provided text in your response</u>, click **Start with Draft**. This opens the **normal reply window** where you can **edit the drafted reply** to add more details or change the wording to make it sound a bit more like you before sending the message.
6. <u>If you don't like the provided text</u>, you can click **Start Blank Reply**, use a QuickAction, or use any other methods that you typically use to respond to the message.



Marvin

- The largest network of Mental Health providers focused on supporting healthcare workers.
  - Expert support from licensed, experienced therapists
  - Night and weekend sessions, all virtual
  - 100% confidentiality
  - 24/7 crisis support line
  - Available for all Jefferson/LVHN colleagues



Jefferson
Health

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

JeffersonHealth.org

Enterprise Clinical Partner Platforms

Christopher J. Ott, MD, FACEP

Chief Medical Officer

Physician Services

Clinical Services Group

HCA Healthcare | Physician Services Group

Our enterprise

HCA Healthcare is one of the nation's leading providers of healthcare services, comprised of approximately **2,300** ambulatory sites of care, including **186*** hospitals, in **20** states and the United Kingdom.

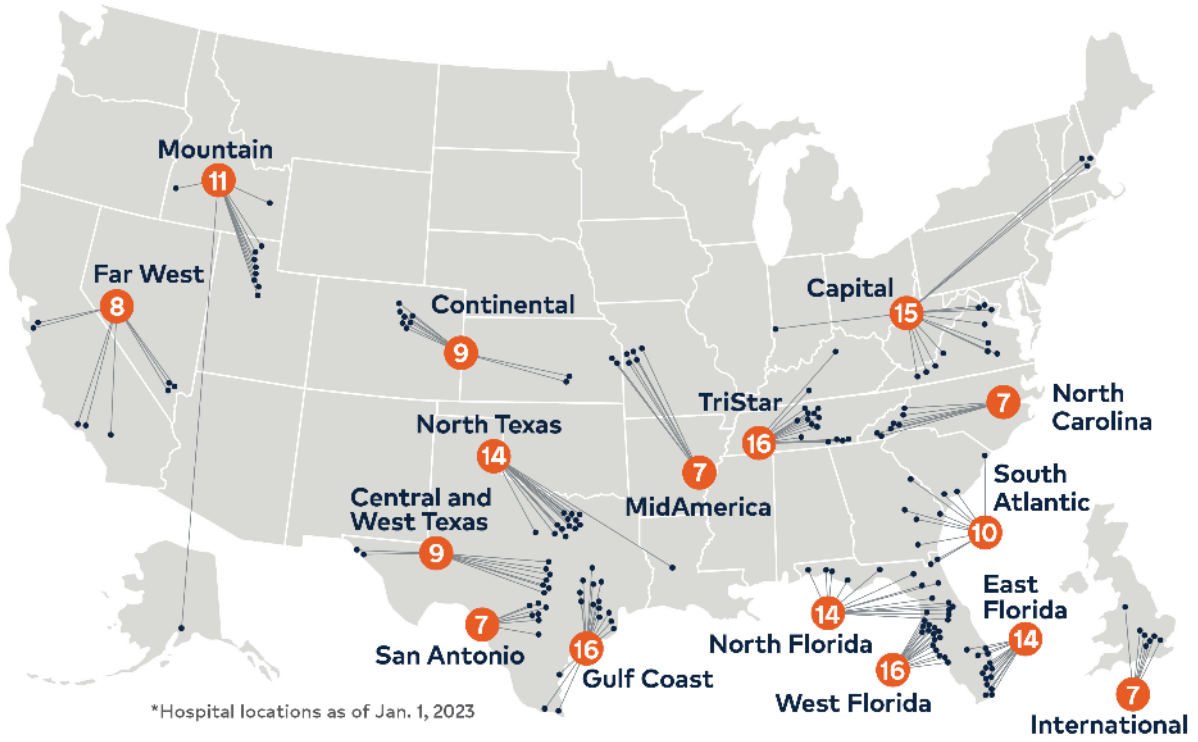
By the numbers

~300K
colleagues

110K+
registered nurses

44K+
active and affiliated physicians

Ranked 61
in Fortune 500**



Other sites of care:

HCA Healthcare® | Ambulatory Surgery Division

HCA Healthcare® | Physician Services Group

CareNow Urgent Care

Our affiliated businesses:

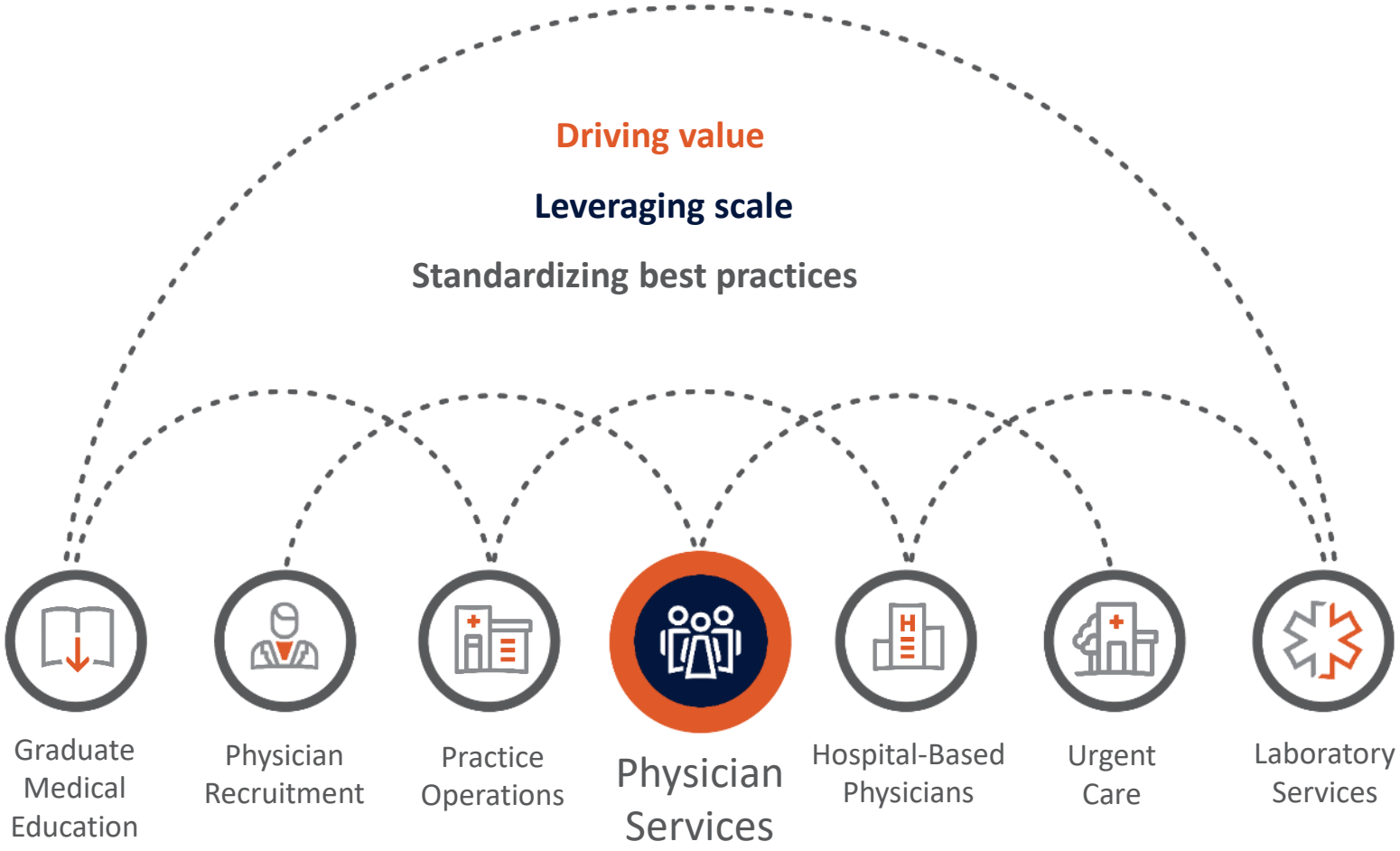
HEALTHTRUST

SARAH CANNON Fighting Cancer Together™

PARALLON HCA Healthcare®

GALEN COLLEGE OF NURSING

Physician Services
Clinical Service Group



Physician Services by the numbers

24M patient encounters**	**32,400** PS colleagues	**1,600+** practices	**16K+** employed and managed providers**
350 urgent care clinics	**5,834** residents and fellows	**325** GME programs	**450** SPS joint venture providers

Our Partners' Baseline Operational Requirements

- State Licensed Providers
- FDA Approved Technology
- In-network with mature revenue cycle for billing and collecting
- Acceptance of e-Referrals
- Post-treatment notes electronically sent to native EHR
- Will not bill and collect through our revenue cycle for payment and pay a vendor/referral source
- Physician, government, payer and professional society recognition of technology and care delivery platforms
- Patient engagement and acceptance of technology and care delivery platforms

Our Baseline Operational Requirements

- **Talkiatry Tele-Behavioral Health**
- **Fay & Nourish'd Tele-Dietician Consults**
- **Cardio-Rom in-home cardiac rehabilitation**
- **Rippl GUIDE Model Tele-delivery**
- **Digital Therapeutics in-office retina scanning for diabetics**

Physicians' powerful ally in patient care