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Medicaid and the Road Ahead: Spending Cuts, Work Requirements and What's Next for States, Providers and Families

A KFF and States Newsroom Event

Speaker 1: Hello, and welcome to today's event, Medicaid and the Road Ahead: Spending Cuts, Work Requirements, and What's Next for States, Providers and Families. Presented in partnership by KFF and States Newsroom. And now, it's my pleasure to introduce Dave DeWitt, editor-in-chief at the Ohio Capital Journal.

David DeWitt: Hi. Thank you all so much for being with us today. Good afternoon to you all. We are here to examine how states are dealing with new federal funding cuts and changes to Medicaid, the publicly-funded health insurance program for people with low incomes. These changes are expected to put new financial pressures on state governments, healthcare providers, and those who depend on the coverage. Families and individuals are already feeling caught up in unpredictable and confusing changes at times when they're dealing with significant health crises.

We have a panel here, a great panel of experts, policy experts and reporters to discuss what's happening. I'd like to introduce them all to you now. We have Robin Rudowitz is senior vice president at KFF and director of the program on Medicaid and the Uninsured. Jennifer Tolbert is deputy director of KFF's Program on Medicaid and the Uninsured and the director of State Health Policy and Data. Kyle Pfannenstiel is a reporter for States Newsroom's Idaho Capital Sun. And Anna Claire Vollers is a staff writer for Stateline.

I want to start off with Medicaid was established 61 years ago next week, July 30th, as part of President Lyndon Johnson's Great Society program. As a state and federal partnership program, first, I'd like to lay the groundwork for what exactly has been changed at the federal level and what that means for states. Robin, would you please walk us through the changes made by Congressional Republicans and President Trump to the Medicaid program and broadly what impact that is having in the states?

Robin Rudowitz: Sure. Thanks so much. And I'm happy to kick things off. Before I jump into the specifics, I wanted to put the changes in a bit of context. When the 2025 tax and spending legislation was passed last year, estimates showed that the changes

would reduce federal spending by over $900 billion over the next decade and increase the uninsured. Since Medicaid was enacted, Congress has acted over time to incrementally expand coverage to children, pregnant women, people with disabilities, and then more low-income adults with the passage of the Affordable Care Act. The recent changes are really the biggest rollback in federal support for the Medicaid program in the history of the program. The new law has a lot of different provisions, but the biggest changes are related to eligibility. And that includes a new work requirement for certain adults to meet work or community engagement requirements as well as financing, including new limits on both how states pay, their state share of the Medicaid program, and how states can pay providers.

You asked about the implications for states and noted that state Medicaid programs vary, so the impact of the changes is also likely to vary, but generally the law creates significant new financial and administrative challenges for states. Often federal Medicaid funding is the largest source of federal funds that come to states, so reductions in federal support for Medicaid can have a big impact on state budgets and leave states with really tough choices when they're faced with balancing their budgets. They can raise revenues, cut other areas of their state budget, or make cuts to Medicaid. And there are really not many easy ways to reduce Medicaid spending. States can reduce provider rates, they can cut benefits or limit coverage. And these options can have direct implications for providers and people on the program.

I think the second big area of impact for states is related to capacity to implement the numerous and complex changes within really tight timeframes, often with limited staff. Implementing work requirements alone is a huge lift for states to be ready to go into effect by January 2027. And I would also just note that these challenges for states for Medicaid are not happening in isolation. States are managing broader fiscal and implementation challenges beyond the Medicaid program, so all of these things are happening at the same time.

David DeWitt: Wow. There's a lot to unpack here. Okay, thank you, Robin. I want to start by focusing on people. The Nonpartisan Congressional Budget Office estimates that Medicaid changes in the new law will result in 7.5 million more uninsured by 2034. Combined with changes to the ACA, the uninsured could increase by 10 million by 2034 and by even more with the expiration of enhanced ACA subsidies.

Jennifer, you recently published research on the high cost of private insurance and limited availability of public coverage, particularly in states that have not expanded Medicaid under the Affordable Care Act. Would you tell us more

about what's happening with uninsured Americans and what impacts these Medicaid changes will have?

Jennifer Tolbert: Sure. As you noted, the Congressional Budget Office has estimated that the provisions in the law will increase quite substantially the number of people who are uninsured. And the changes to Medicaid account for 3/4s of that increase, and over half or about 5.3 million people will become newly uninsured because of Medicaid work requirements.

Now, because the Medicaid eligibility changes in the law really do target states that have expanded Medicaid, the increases in the uninsured will be larger in those 40 states and the District of Columbia. And as you noted that when you combine the changes in the law with the expiration of the enhanced premiums tax credits in the marketplace, the number of people without coverage will increase to about 14 million. And as we know, these anticipated coverage losses will have implications for access to care and financial stability among those people who are losing coverage and will create financial strain among providers.

But even before the changes in the law take full effect, coverage losses are already occurring. Medicaid enrollment has fallen by five million in the past year, and marketplace enrollment has dropped by about three million in the first couple months of this year as people faced higher premiums because of the expiration of those enhanced premium tax credits. These early coverage losses could exacerbate the impact of the changes in the law and could lead to even larger increases in the share of people who are uninsured in the coming years.

David DeWitt: How interesting. Okay. A lot has to do with what state policymakers have done and what they might do here, and so this puts a lot onto state policymakers. Thank you, Jennifer.

Anna Claire, you've reported that state Medicaid budgets will be reduced by a total of $665 billion over the next decade, with some states seeing a much larger impact than others. You've also reported that they're facing some tight timelines for the implementation of these new rules that are going to be required. Could you tell us a little bit more about what's going on in the states with regard to their budgets and the implementation of these rules?

Anna Claire Vollers: Yeah. Some even newer research is suggesting that state Medicaid funds are expected to lose $679 billion between now and 2034 thanks to the provisions in the One Big Beautiful Bill Act. That's the combined hit from reduced federal funding and reduced state dollars. And as you heard a minute ago, the federal government meanwhile could save us more than $900 billion over that time.

The state general funds, which are the pots of money that states use for everything, not just Medicaid, are projected to lose around $82 billion. And that number is smaller because not every dollar that's cut from Medicaid actually costs the state's general fund. And so what all of that means is that these losses are going to hit states differently. For example, work requirements, other provisions that will lead to fewer enrollees for a state program will also shrink how much the state has to chip in. And in some cases that's going to shrink the amount the state has to pay by more than the amount it's losing in federal matching funds. The state could end up with a little bit of a budget cushion in some situations. States like Tennessee, Mississippi, Oklahoma, Kentucky could actually see savings in their general funds north of 2% relative to their Medicaid funds because of this.

And then on the other hand, states that expanded Medicaid and that have leaned really heavily on being able to pull down extra federal matching dollars are going to see some of the biggest losses. The new law clamps down hard on things like provider taxes, which cut federal funding without actually shrinking the size of their Medicaid program. That means that the states will have to pull money from their general funds or scale back what they're offering. For example, California could lose more than $100 billion from just provider tax changes alone, and its state general fund could drop by more than 6%. Zooming out, 26 states are projected to see Medicaid budget losses of at least 5%. A few of them, Arizona, Iowa, Nevada are looking at declines of more than 15%, which is pretty steep.

It all comes down to geography and how a state built its program. The steepest hits are going to be on states that expanded Medicaid and are leaning hard on things like state-directed payments and provider taxes. And meanwhile, non-expansion states like, say, Florida, they may barely feel it.

David DeWitt: Wow. Okay. Yeah, there's a wide differentiation between which states might experience, but they all have the same requirements as far as the timelines that they're facing for implementing new rules; is that right? What kind of timelines are they facing?

Anna Claire Vollers: Yeah, they're all staring down that January 1st deadline for the expansion states to put their work requirements in place. A lot of state officials have said that's not enough time to get a really complex system in place. And they've said the federal government took too long to give them guidance around how to implement these work requirements. The law allows the feds to grant extensions through 2028, but we've seen the Centers for Medicaid, Medicare have been indicated that those extensions would only be in extraordinary cases.

David DeWitt: I see. Okay. I want to come back to that, the work requirements topic, because that's a big one. But you talked about how states who experienced expansion are going through some changes more drastically than other states. Kyle, the state of Idaho has had an interesting experience with that as voters passed Medicaid expansion in 2018. And as I understand it, even though it's been a long time goal, lawmakers in Idaho did not repeal expansion you reported, but they did make a lot of their own changes, including with regard to work requirements. Could you please give us a rundown of what's been happening in Idaho?

Kyle Pfannenstiel: Yeah, this is a fight that's been brewing for quite a few years. As you said, Idaho voters passed a ballot initiative in 2018 to expand Medicaid. Pretty much every year since then, there's been some talk in the legislature among Republicans about repealing expansion or adding side boards like Medicaid work requirements. And all that really came to a head this year. We had a tight budget year. After years of tax cuts, we were staring down a potential budget shortfall. And lawmakers have to balance the budget in Idaho, it's a constitutional requirement, so they cut spending across state government services, and Medicaid was no exception. They looked for $45 million in cuts to Medicaid.

And I think this goes back to something that Robin was talking about. There aren't a lot of easy options when you look at Medicaid cuts. We worked from this list that the governor's office published in his budget plan for the year about what options there are for Medicaid services to cut. And many of them were calling for wholesale removal of services like home and community-based services, dental care, and what they actually ended up was by cutting provider reimbursement rates. About half of the cuts they needed to make came from a general cut to provider reimbursement rates. All providers who take Medicaid are taking another 4% cut, or they're extending the 4% cut that they made last year to provider reimbursement rates. That was extending a cut that the governor made outside of legislative session because he saw this budget issue coming up.

And then the other big cut they made was targeted specifically at residential habilitation care providers. Those are people who care for people with disabilities. On top of the 4% cut, they took another 6% cut to the reimbursement rates. And as a lot of folks can expect, general Medicaid providers and residential habilitation providers said that these cuts would really affect their bottom line and their ability to stay in business. And I think we have yet to see how that shakes out.

But the other big thing they did this year was they adopted Medicaid work requirements. That's something that Idaho Republicans have been wanting to do for a really long time, and the One Big Beautiful Bill made it a lot easier. They don't have to go through this process to get permission from the federal government to enact these work requirements. And I guess the national rhetoric on work requirements really hit home here. A lot of advocates said that these are essentially administrative barriers to access the program. One expert here pointed back to Medicaid unwinding, the process to review everybody's eligibility after 2024. She said that was going to foreshadow what would happen with work requirements. And for folks who don't know, a lot of people who lost Medicaid in Idaho in that process didn't lose because the state proved they were ineligible, it's because they didn't fill out paperwork, which I think is advocates' main concern with how work requirements would go. That's that all summed up.

David DeWitt: Yeah, thank you for that. That's a lot going on in Idaho. And I want to get back to the impact on providers here in a little bit, but first I want to focus a little bit more on these work requirements. Thank you, Kyle. Robin, in an issue brief last year done with Jennifer and others, you noted data show the majority of Medicaid enrollees are working. Would you please tell us a little bit more about work status and barriers to work among Medicaid adults?

Robin Rudowitz: Sure. We've conducted a number of different analyses looking at the work status of adults enrolled in Medicaid, and they all really show similar results. Most adults with Medicaid coverage are, as you noted, already working or they report barriers to work. We know that those who are working are typically working in low-wage jobs, so they continue to meet the income standards to be on the Medicaid program. And they're also typically working in jobs without access to private insurance. We also know that the data show when we look by age those who are under 50 are more likely to be working while older adults who would be subject to the new work requirements, those between ages 50 and 64, are less likely to be working and more likely to have barriers to work. And we also know that adults who are not working typically report that they're not working because they are either attending school, engaged in caregiving responsibilities, or because they have an illness or disability.

Under the new law, and I think Kyle touched on this a bit, many people who are working or may qualify for an exemption may lose their coverage, not because they're not eligible but because they might have difficulty navigating their ways to document or report their current status. States can use some data matching, but in many cases that's going to be difficult to do the data match. Again, for individuals who are working, sometimes if they're working in multiple jobs, part-

time jobs, jobs with not stable work hours or working in the gig economy like people driving for Uber, these types of jobs will make it difficult to do the data match to document that they're meeting those requirements.

David DeWitt: I see. Okay. Interesting. And thank you, Robin. In a way, this isn't theoretical because Idaho isn't the only state to put in its own work requirements. Even before the One Big Beautiful Bill Act, Arkansas implemented work requirements, so this has been test run. Anna Claire, you reported that in Arkansas, 18,000 adults lost coverage before a judge halted the law. But what impact did the work requirements have on employment in the state?

Anna Claire Vollers: Yeah, this is one of those earlier experiments that gives us a little bit of insight into how work requirements could pan out. As you said 2018, Arkansas tried work requirements during President Trump's first term. By the time a federal judge halted the policy less than a year later, 18,000 adults had already lost coverage. And that was one in four of the people who were subject to the requirement, so that's a pretty big chunk. Studies have come out since then that found that the work requirements didn't actually increase employment in the state, and most of the people who lost coverage were actually working or they qualified for an exemption. Like what Kyle talked about in Idaho, they lost coverage because they couldn't navigate the complicated reporting system. In that case, they had to log their hours every month on an online portal that was just really complex. People who lost their coverage in Arkansas during that time reported having problems paying off their medical debt. They reported delaying healthcare or delaying for medications because of costs.

And there are some limits to what we can learn from this. The new work requirement system will run differently. It requires verification at least every six months rather than monthly. And Arkansas' program ran for less than a year, so the Medicaid beneficiaries didn't have a lot of time to learn the system. The state didn't take a lot of time to build it out at that time. But I think we're seeing similar situations like what Kyle's talking about in other states that are trying this, and Arkansas is just one more example that we've had of what could happen when we try Medicaid work requirements.

David DeWitt: Right. Okay. Thank you, Anna Claire. It sounds like that paperwork, the reporting how these hours are logged or the documentation will be a big issue for states as they implement this new law.

Jennifer, you recently wrote about a rule on work requirements from the Centers for Medicare and Medicaid Services. And one issue that has received

attention is the definition of medical frailty. What does this rule mean for those who now have to provide new documentation of their medical frailty?

Jennifer Tolbert: Right. The rule that you're referencing was released on June 1st of this year, and it basically tells states how they need to implement work requirements. It covers a lot of territory beyond just medical frailty, but this issue of how the rule approaches medical frailty is one that has raised a lot of attention.

And so just to provide a little bit of context, when we talk about the federal work requirements, what is required is that people enrolled in the Medicaid expansion and in certain waiver programs will newly be required to work 80 or more hours a month or engage or attend school halftime or engage in community service. Now, the law does provide for and exempt certain individuals from those requirements, and among those exemptions are for people who are medically frail. But as I noted that the rules approach to medical frailty is going to create new administrative barriers and could put coverage at risk for some vulnerable populations.

What the rule does is it adopts a much more restrictive approach to determining medical frailty for purposes of exempting or excluding people from the work requirements and introduces a two-part test that requires people to both have a qualifying condition and demonstrate that that condition limits their ability to work, attend school, or to volunteer. As an example, someone with HIV, which is a serious condition requiring ongoing access to medication to prevent immune system dysfunction, would not automatically qualify as medically frail simply because they have HIV, but that individual would have to show that their HIV condition is severe enough that it prevents them from working.

This approach to medical frailty will create challenges for states as they set up processes to verify whether individuals qualify. And while states are required to use data where possible to automate the process, in many cases, and I would say most even, data alone will not be sufficient to determine whether a condition impairs the ability to work. States will therefore have to rely more heavily on providers and obtaining documentation from providers to confirm medical frailty.

And while states can also accept self-attestation from individuals to verify medical frailty in the first year of implementation, their ability to rely on self-attestation will be limited starting in January of 2028. And so this restrictive approach will increase the administrative burden on both individuals in the clinical workforce and could lead to people falling through the cracks and losing coverage, and again, not because they don't qualify as medically frail, but

because they simply can't provide the required documentation within the specified timeframe. And I'll also note that requiring providers to determine whether an individual is able to work will likely require a subjective decision that could raise ethical concerns.

David DeWitt: Oh, wow. Interesting. Okay. Thank you. Thank you, Jennifer. And on that medical frailty, aside from just the work requirements specifically, Anna Claire, you reported that 25 Democratic attorneys general have sued over the Medicaid frailty rule. Would you please tell us about that lawsuit?

Anna Claire Vollers: Yeah, that came last month when all the states were Democrat-led. 25 of them sued the Trump administration specifically over that narrowed guidance of who qualifies as medically frail. States had been asking for more guidance around the medically frail designation while they were trying to get their systems in place ever since the law passed last year, but when the guidance came last month, a lot of them were not pleased.

The attorneys general and governors that are part of the lawsuit said that the feds surprised them with this new rule several months after they'd already been working with CMS on how to implement the work requirements. And they're saying the Trump administration is unlawfully reinterpreting the law that Congress passed. Like Jen said, the new guidance says not only that a Medicaid recipient has to have a significant health condition, but they also have to be significantly impaired in their ability to work. And that's the distinction that states say Congress did not make in the new law. Lawsuit is pending. We'll see where that goes.

David DeWitt: Okay, I see. It's an interesting argument. All right, thank you, Anna Claire. I wanted to return, like I said earlier, back to the issue of health providers, because these cuts will not just have a big impact on citizens and state budgets and states policymaking, but also on healthcare providers. Kyle, I know in Idaho lawmakers have tried a variety of methods to make cuts to Medicaid, including slashing funding for a mobile treatment program for people with severe mental illness. And you mentioned the impact on healthcare providers earlier. Would you tell us a little bit more about what's going on there?

Kyle Pfannenstiel: Yeah, this was actually a cut made outside of legislative session. The thread gets a little complicated to follow, but it starts with the governor's executive order for budget cuts, and then the state health agency made budget cuts, and then a managed care company cut this program for people with severe mental illness. It was a mobile treatment program that brought treatment directly to people with severe mental illness. And immediately, this sparked a lot of backlash.

Providers were very public saying that this was going to risk public safety and risk their patient safety. An influential sheriff spoke out about how this cut risked public safety, and providers and patients sued.

And even though the legislature didn't officially make this cut, they ultimately had to wrestle with this. The cut took effect December 1st, and it extended until April. All of this was happening during Idaho's part-time legislature, which typically meets the first few months of the year. And they had to wrestle with, about once a month, a patient who was previously being treated on this program had died, and lawmakers had to wrestle with whether they wanted to refund this program, especially in a tight budget year. And they found a relatively creative solution. Instead of using traditional state taxpayer funds, they tapped legal settlement funds from tobacco and opioid manufacturers to refund the program.

And I think the thing that really stuck with me along this is that several officials throughout the process, including the managed care company said, "We didn't have many options to make a cut." There are only so many things that you can cut without changing state or federal law in Medicaid, and this unfortunately was one of the optional services. And I think this is something that I'm paying very close attention to as my state continues in our budget troubles. And I hope folks will pay attention to as their state goes through budget troubles what are optional Medicaid services? How important are they to your community, to your patients, to providers? Stuff like that.

David DeWitt: Oh, yeah. Some big decisions from policymakers on this stuff. Thank you, Kyle. And just to continue on the thread of what providers are going through, I wanted to mention the Commonwealth Fund estimates that Medicaid cuts also mean 996,000 fewer jobs nationwide in 2029, half of which will be health related, including hospitals, clinics, pharmacies, nursing homes. This is significant to me because if you look at recent job reports, the healthcare field is the one place where job Labs seem to be growing right now, but there might be some trouble ahead.

A March report by Public Citizen shows that 446 safety net hospitals nationwide are at risk of closing due to the cuts, mostly in rural areas. Robin, you've done some analysis recently on new restrictions on Medicaid state-directed payments for hospital and other healthcare services. Would you please tell us a little bit more about what these caps mean for healthcare providers?

Robin Rudowitz: Sure. I'll try. These changes, I think, are some of the most complex changes that were included in the law. But most states use managed care to deliver services

to people on the Medicaid program. And under certain rules, states can direct the managed care plans to make certain payments to providers. And prior to the changes in the law, states could tie some of these directed payments to private insurance rates; and those were designed to help bolster provider rates and to expand access to services.

We did look at the current landscape of use of state-directed payments, and we found that 41 states were using these type of payments. And spending through these payments was about $93 billion annually. And most of the payments are directed to hospitals. The new law, as you said, places new limits on state-directed payments and will put a large share of the federal funding for these payments at risk.

We don't know right now exactly how states or providers will respond to the changes, but we know that these changes also combined, and I think Anna Claire mentioned these before, changes to how states pay for their Medicaid programs, so limits to their provider taxes, as well as increases in the uninsured that Jen mentioned. All of these things together can result in reduced reimbursement rates and less revenues to providers, so some may be forced to close or limit services or limit access to people on the Medicaid program. And I would just say some other KFF research from our hospital team shows that hospitals that do serve a large share of Medicaid enrollees already have more challenging finances relative to other hospitals. Again, the combination of all these things happening at the same time could really exacerbate a lot of these challenges and produce challenges for access.

David DeWitt: Thank you, Robin. Okay. I'd like to remind the audience here that if you have a question, you can submit questions via the Q&A button in the Zoom control panel at the bottom of your screen. And we'd like to begin to open this discussion up to questions. We've had a really great turnout, and we're really grateful for how many people have joined us today. We're going to try to get as many questions in as we can. And again, you can submit them with the Q&A button in the Zoom control panel at the bottom of your screen.

Just as I kick off the Q&A section, I wanted to mention this one last topic where we've done reporting on this in Ohio where emergency room doctors have warned about increased strain because of a giant jump in the number of uninsured Americans that will increase ER trips as those people lose access to primary care. And I remember reporting on this issue before the Affordable Care Act was ever passed. When people go uninsured, they don't receive preventative healthcare, and they end up in the ER, and then taxpayers have to pay for that. As we start this new section of the program here, I just wanted to

ask Jennifer, what are the implications of the increased uninsured to healthcare providers and just society at large?

Jennifer Tolbert: Yeah, the implications of people losing coverage and becoming uninsured are pretty significant, mostly to the individual, but as you note, also for providers and for the healthcare system more broadly. And what we know is that people without insurance coverage are more likely to forego care, or delay or forego care altogether because of cost. And that happens even among adults with chronic conditions who need ongoing management of their health conditions. Those without insurance coverage are, again, more likely to just not get the care that they needed because of costs than adults with the same condition who have health insurance.

And this inability to access care when it's needed and in the most appropriate setting can have serious health consequences leading to worse health outcomes and even preventable deaths in some cases. But there are also financial consequences for individuals who are uninsured. Healthcare is expensive, and uninsured adults are more likely than those with insurance to have difficulty paying their healthcare costs. And these unaffordable medical bills can quickly turn into medical debt because many uninsured individuals have low incomes and little, if any, savings. And again, those financial consequences will follow people as they use up their savings and are unable to get loans, car loans to buy a car or pay other necessary expenses.

And then as Robin and you noted, any increase in the share of people who are uninsured will also increase uncompensated care costs for providers as people continue to get care that they need but are less able to pay for that care. And as noted, this is going to put a financial strain on providers and the entire healthcare system at a time when the system is already facing pretty significant financial pressures from the reduced federal Medicaid spending and other changes in the reconciliation law. These consequences are going to have dramatic effects both for individuals as well as the broader healthcare system.

David DeWitt: Well, thank you, Jennifer. That relates to one question we've gotten from the audience here. Well, several questions. We'll try to cover as many as we can, but one of the questions is asking about the human cost and the downstream impact of uninsured individuals on the health system, which you mentioned there. They're referring to medical debt, bankruptcy, preventable deaths. And they make the point that states will lose human capital and charity costs will increase. Do you have anything to share on that, Jennifer?

Jennifer Tolbert: Well, I think that dovetails with what I just noted, that people who are uninsured are much more likely twice as likely to have medical debt as people with insurance. We know healthcare is expensive, so it is challenging for anyone to afford, but when you don't have health insurance coverage and you, as an individual, are on the hook for paying for the full cost, it can just be just simply unaffordable.

And while there are programs that have been put in place to help defray the cost of getting care for people who are uninsured, when we passed the Affordable Care Act and implemented the coverage expansions back in 2014, some of the funds that had previously supported those programs were instead redirected to supporting and paying for coverage. There's less money in the system to pay for those uncompensated care costs and to help defray the cost for uninsured individuals. Again, I think the consequences are going to be widely felt, especially by the individuals who are losing coverage and becoming uninsured, but again, for the system more broadly.

David DeWitt: Interesting. Okay. And I don't mean to be picking on you, Jennifer, here, but I've got one more for you. You mentioned that we've already seen Medicaid enrollment decline over the past year, even before most of the Big Beautiful Bill Act provisions have taken effect; why is that?

Jennifer Tolbert: Yeah, that is a really good question, and I don't think we actually know yet. Part of the problem is we can see data on overall enrollment numbers, but what we don't have yet is more detailed data to indicate who is losing coverage. Are there particular groups, people with certain incomes? Is it that immigrants, perhaps due to some of the immigration enforcement activities and the chilling effects of policies adopted by the Trump administration, are they disenrolling from the Medicaid program out of fear? We simply don't know that yet. And it will probably take a little bit of time for the data that we need to get underneath these numbers to be available. We're going to continue monitoring and collecting all of the data we can, and we'll hope to shed some light on that soon, but as of right now, we don't yet have a lot of insights.

David DeWitt: Okay, fair enough. Thank you, Jennifer. Robin, I'd like to turn to you here for this next audience question. They're asking what kind of pressures this puts on safety net hospitals and specifically how this will impact providers further downstream, such as the work requirements and medical frailty stuff, and then how providers can prepare without clear guidance yet from the states.

Robin Rudowitz: Yeah, I think I touched on some of these challenges, and I think it's really a combination of these financing changes, so the changes to state-directed

payments as well as the provider tax changes combined with the changes that are going to affect and increase the uninsured, so the work requirements as well as some of the ACA changes that are all really going to contribute to and exacerbate already challenging fiscal circumstances for hospitals. Again, hospitals that serve a disproportionate number of Medicaid enrollees already have more fiscal challenges.

Also note that there's been a lot of focus on rural hospitals. We know that rural hospitals already have experienced a number of closures. Our data show that from 2017 to 2024, 52 rural hospitals on net closed and many rural hospitals are curtailing service lines, so stopping their provision of certain services. We know from our polling that people in rural areas, 1/3rd of them say that there are not enough hospitals to serve their community. Half say that there are not enough primary care providers or mental health providers. And Medicaid is one in five discharges in rural hospitals, and Medicaid really finances nearly half of all the births in rural areas, so these changes in Medicaid financing, we're particularly watching safety net hospitals as well as implications for hospitals in rural areas.

David DeWitt: Okay. Yeah. Thank you, Robin. Just a quick follow-up. Which part of the law will most severely affect hospital reimbursement?

Robin Rudowitz: Yeah, I think what we're watching most carefully is how the response to some of the changes on state-directed payments. Again, this is large amount of money that's in the system now. And we know that a lot of those directed payments are for hospitals, so we don't know how states are going to respond to some of these new limits and then how the providers are going to respond. But I would say as those start to phase in and states look at what the ramifications are and what their potential responses can be, I think that's an area that we're really watching closely on the response to those changes.

David DeWitt: Okay. Yeah, thank you. I want to switch gears a little bit here and turn to the reporters, Anna Claire and Kyle. We have a question here about what kinds of things local reporters should be keeping an eye on in their community with regard to the future changes in Medicaid and local impact and fallout. The question asker says, "It's a huge issue, and our readers are likely overwhelmed. What stories should we be covering to best inform and serve our community?" Kyle, would you go ahead and start, and then we can turn to Anna Claire?

Kyle Pfannenstiel: Sure. I love this question. I think Medicaid is a massive program, and I learn something new just about every day about how the program works. But I think what I really focused on for covering our state budget cuts was, I guess, find whatever the local hook is for Medicaid in your state. My state is trying to shift

all of Medicaid to managed care companies, so I've tried to put a really big effort into understanding how one of the major primary managed care companies is doing its work. I got pretty familiar with some of the providers who work under the contract, some of the associations that are lobbying groups for providers and get networked with them. Whenever there was a cut about the program, I was often finding out directly from the providers very soon after the cut was founded. And I think those are some really powerful stories to be told.

I also think if you have a chance to cover the legislature, paying attention to the budget is, I think, especially important with Medicaid, some of the wonkiest details I've gotten and weird budget documents that end up changing my understanding of how a story will work. And also going to committee hearings and hearing providers testify and pulling them aside and asking for their number afterward and staying in touch with them over the years. I think there's a lot of ways that you can build on whatever's already happening in your community and just be well-sourced. I think, in my experience, Medicaid news rarely falls in your lap. It's very bureaucratic, and you have to do a little bit of work to make it make sense and make it be compelling, but I think there's some powerful stories in the program.

David DeWitt: Yeah, thank you, Kyle. Absolutely. And just speaking from my own reporting experience, I can tell any other reporters joining us today that being willing to dive into those documents, you will find stuff that other people aren't going to be able to find or won't find just because they're not doing that legwork; and it can really pay off sometimes. Anna Claire, do you have any advice for local reporters on what they should be looking at covering?

Anna Claire Vollers: Yeah, I would second everything Kyle said. I think those are great advice. I think also to look at how these changes to Medicaid will impact an entire system, that it is obviously a huge impact on the people who rely on Medicaid, but it will also impact everybody else, the providers, the people who use healthcare resources in the community who aren't on Medicaid, to keep that in mind as something as a way to make this issue have a broader impact.

And also I think you can take individuals. I talked with a pediatric dentist in Alabama here where I live a few months ago about provider reimbursement rates, which is not a fun or sexy topic. But what he was talking about was explaining that the low rates that Alabama Medicaid pays for dentists mean that very few, if any, accept Medicaid anymore and what this has meant to the children that rely on his care. And so finding, I think, those individuals that can help you tell one piece of the story rather than trying to tell the entire story about these impacts on Medicaid will really help readers understand.

David DeWitt: Thank you. Yeah, that's very helpful reporting advice. One question that caught my eye here that I wanted to make sure we got to is we've talked about Medicaid adults, but the question is how will the Medicaid cuts trickle down to CHIP and children? Jen, would you be able to give us any insights on that?

Jennifer Tolbert: Sure. Interestingly, we are not seeing a change in CHIP enrollment in particular. We are, however, seeing a pretty significant decline in child enrollment in Medicaid. Again, the changes that are happening are not necessarily affecting the CHIP program, which targets children with slightly higher family income. But again, we are seeing pretty steep declines in child enrollment in Medicaid.

And in fact, the child enrollment in Medicaid has now dropped below pre-pandemic levels. What we saw when going back to before the start of the pandemic in February 2020, when the pandemic hit, a requirement was put in place that states maintain coverage for people who were enrolled in the program. As a result, we saw a pretty significant increase in Medicaid enrollment. And then when that policy ended, we saw a decline in enrollment. But when it comes to adults, enrollment has remained above those pre-pandemic levels. We've held on to some of the increase that happened during the pandemic. But just recently, we saw a complete erosion in the enrollment of children in Medicaid. And their enrollment fell below those pre-pandemic levels, so wiped out all of the gains that happened during the pandemic.

David DeWitt: Okay. Yeah. Thank you, Jennifer. I see another question here about possible future policymaking that I wanted to get to. Robin, if Democrats win the 2028 election, the question says... I assume they mean perhaps the presidency and taking some control of Congress as well. The question is can they undo these changes or would it be up to Congress since it was a bill that was passed? I guess if the Democrats win the White House, could they undo any of this administratively, or would everything have to be done through Congress?

Robin Rudowitz: Yeah, that's a good question. But a lot of these changes were enacted in, so it's new law. Many of them would take additional legislation for Congress to overturn the broad parameters of work requirements, limits on provider taxes, state-directed payments.

I think what a new administration would have potentially more control over are some of the rules that they have put forth to implement these changes. Like on the work requirements, a new administration could issue new rules that might change the interpretation of how to implement some of these changes. And I would say it could be difficult to make legislative changes because many of these provisions did generate significant reductions in federal spending, so

reversing those would be challenging to reverse. I think we are all usually, or a lot of us that sit in Washington particularly are focused on national elections, but I'm sure our state reporters are also very well aware that 39 states have gubernatorial elections, so there's a lot that will be happening at the state level that can impact some of the policy decisions around Medicaid as well.

David DeWitt: Yeah, that's an important note and related to our discussion here about how much depends on state policymaking. This is for the whole panel, but the question is is the panel familiar with any efforts to broadly communicate these complexities, especially for work requirements to affected Medicaid enrollees? The quote is, "We've largely failed at this during redetermination. Any lessons learned or suggestions?" Does anyone want to jump in on that? Jennifer, Robin?

Jennifer Tolbert: Sure, I'll jump in and then others can follow. But I think the messaging and the outreach and communication around work requirements in particular will be uniquely challenging. And I think suggest that this is going to be very difficult to communicate to individuals, mostly because not everyone will be subject to these new work requirements. It only applies to people who are enrolled through the Medicaid expansion pathway. Someone who has Medicaid because they are receiving SSI or because they are pregnant or a child would not be subject to these new requirements. I think it's going to be challenging for states to communicate and target messaging just to the people who need to hear and understand what these new requirements will be without alarming or creating confusion among people who will not be subject to the requirements. And obviously states took on this challenge during the unwinding of the continuous enrollment provision following at the end of the pandemic. We know the messages didn't get through to a lot of people, so I think this is going to be even harder and will challenge states even more.

David DeWitt: Okay. A related question to that is for the journalists, Kyle and Anna Claire, have your sources in government, are they talking to you about how difficult implementing these rules will be? Is it difficult to get people to be candid about the problems that they're facing with this? Or how is that going talking to officials about the implementation itself? Kyle?

Kyle Pfannenstiel: Yes, yes, quite difficult. We have a Republican-controlled state with a super majority in the legislature. I think for our state officials to publicly take issue with any guidance or action by the Trump administration is a difficult task for me to get at. But I'm trying to get at how some of this guidance is affecting states. And I guess I reported on how some lawmakers seem frustrated by the One Big Beautiful Bill capping state-directed payments the way it did because Idaho was... The way that a senior lawmaker put it, Idaho is banking on having

high state-directed payments for our rollout of managed care. As we changed the structure of Medicaid, we wanted to change financial structures so hospitals were in a better position, and now that plan isn't going to work out. But I think there are times where folks are able to be candid, but I think it's a little limited.

David DeWitt: I see. And Anna Claire, how's your experience been getting officials to talk about what it's like to try to implement this?

Anna Claire Vollers: Yeah, I mean it kind of depends on the political party of the officials in question, but I think even in Republican states, it's been very difficult. But what I have found in some cases is you will see officials, lawmakers being a little more candid in some of these committee meetings, these budget meetings where they're talking about the nuts and bolts of how their state is going to implement this, the kinds of losses they might face. And so sometimes when they're talking about themselves and the stakeholders and these public hearings, you might get them to be a little more candid about the steep mountain they face.

David DeWitt: Well, maybe that's another good tip for any of the journalists joining us today here, to take the time to watch those committee meetings. And even if they're long and boring, there might be some really important stuff being shared in there. Unfortunately, we're at the last couple minutes of our program here, and we have some great questions here; I'm sorry that we couldn't get to all of them.

But I just want to take the time to thank all of our wonderful panelists for joining us and educating us today with your perspective. Robin and Jennifer and Kyle and Anna Claire, I really appreciate all that you've had to share with us today. And everybody else, I'd just like to say thank you on behalf of States Newsroom for joining us. I know that at States Newsroom, we're going to continue to do a lot of reporting on all of the developments in all of the states as they work through implementing these new requirements.

Thank you all for joining us. I really appreciate it, and I hope that you all have a wonderful day. I just want to mention that this recording will be sent out via email to all attendees who RSVPed. Thank you all again.