The great Medicaid reshuffling: which business models will survive Trump's healthcare overall?

DEC 04, 2025 • PAID

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Abstract

On July 4, 2025, President Trump signed the "Working Families Tax Cut" legisl into law, introducing the most significant Medicaid and CHIP reforms since the Affordable Care Act. This legislation fundamentally alters the economics of serv Medicaid populations through community engagement requirements, financing reforms that restrict state funding mechanisms, immigration-related eligibility restrictions, and operational changes around enrollment and payment systems. F healthcare technology companies, these changes create clear winners and losers. analysis examines how different business models will perform under the new regulatory environment, focusing on which companies will benefit from increase state administrative burdens, which will suffer from reduced coverage and reimbursement, and which existing models face existential threats from financin restrictions. The core thesis is straightforward: companies that reduce state

administrative costs or serve commercially insured populations will thrive, while those dependent on Medicaid expansion populations, state directed payments, o provider tax financing face significant headwinds. Understanding these dynamic critical for angel investors evaluating early-stage healthcare companies over the 24 to 36 months.

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The Medicaid Reduction Reality

Let me be direct about what just happened. This legislation is designed to reduc Medicaid enrollment and federal spending, full stop. The framing around "safeguarding Medicaid and CHIP for the most vulnerable Americans" is politic rhetoric that obscures the actual intent and impact. When you require communi engagement for adult expansion populations, restrict immigration-based eligibil reduce retroactive coverage periods, implement six-month renewals instead of a renewals, and systematically eliminate state financing mechanisms, you are engineering a reduction in both enrollment and per-beneficiary revenue.

The numbers tell the story. Medicaid expansion states must implement commun engagement requirements starting January 1, 2027, requiring 80 hours monthly work, community service, or education for adults in the expansion population. S will conduct renewals every six months instead of annually for this group. Retro

eligibility drops from three months to one month for expansion adults and two months for everyone else. The immigration provisions eliminate federal funding most qualified noncitizens except lawful permanent residents, Cuban and Haitia entrants, and COFA migrants starting October 1, 2026.

On the financing side, provider tax revenue is frozen at July 4, 2025 levels, with expansion states facing a gradual reduction from current levels to 3.5 percent of patient revenue by fiscal year 2032. State directed payments get capped at 100 pe of Medicare rates for expansion states and 110 percent for non-expansion states. statistical test loophole for health care related taxes that let states preferentially high-Medicaid providers gets closed. Budget neutrality for 1115 demonstrations requires Chief Actuary certification.

What does this add up to? Probably 3 to 5 million people losing Medicaid covera over the next 24 months, with the heaviest losses in expansion states. States will see their effective match rates worsen as provider tax and state directed payment restrictions reduce their ability to generate federal dollars without increasing st general fund commitments. This creates a doom loop: reduced enrollment mean reduced revenue means reduced provider payments means reduced access means sicker remaining populations means higher costs per beneficiary means more pr to cut rates or benefits.

For investors, this is not a “wait and see” situation. The policy direction is clear, implementation timeline is aggressive, and the impact on business models is predictable. Some companies will benefit enormously from these changes. Many not.

Business Models That Will Flourish Unc New Rules

The obvious winners are companies that help states manage increased administr complexity while reducing costs. Think about what states now need to do that th did not need to do before. They need to verify community engagement for poten millions of beneficiaries every month. They need to process renewals twice as

frequently for expansion populations. They need to implement new systems to c
the Social Security Death Master File quarterly for both beneficiaries and provic
They need to prevent duplicate enrollment across states through a new federal s
They need to verify addresses through multiple data sources including USPS,
managed care plans, and other reliable sources.

This is a massive operational lift happening simultaneously with budget pressur
States cannot hire their way out of this problem. They need technology that autc
verification, reduces manual work, and prevents improper payments. Companies
providing these capabilities will see explosive growth.

Eligibility verification platforms are the most obvious beneficiaries. Any compar
can automate the monthly verification of work hours, education enrollment, or
community service participation will find eager state buyers. The regulatory
requirement is clear: states must verify compliance without requiring individual
submit additional information wherever possible, using reliable information ava
to the state. This means integrating with state workforce data systems, unemplo
insurance systems, education enrollment databases, and potentially third-party
verification services. The company that builds a comprehensive community
engagement verification platform with pre-built state data integrations will capt
enormous value. This is not a nice-to-have system. This is a mandatory system th
every Medicaid expansion state must implement by January 1, 2027, or face fede
penalties.

The market size is significant. There are currently about 23 million people enrol
Medicaid through the adult expansion population nationally. Not all of them are
subject to community engagement due to the various exceptions and exclusions
parents, caretakers, medically frail individuals, and others. But let's conservative
estimate that 15 million people need monthly verification. If states pay $2 to $5 p
verification per month, that is $360 million to $900 million in annual recurring
revenue across a market that did not exist 18 months ago. The companies that w
market will be those that move fastest to build state partnerships and demonstra
they can handle the technical complexity of integrating dozens of disparate data
sources while maintaining HIPAA compliance and state security requirements.

Program integrity and fraud prevention tools represent another massive opportu
The legislation adds specific requirements around deceased beneficiary removal,
deceased provider removal, duplicate enrollment prevention, and payment error
reduction. States face financial penalties if their eligibility error rates exceed 3
percent starting in fiscal year 2030, with new restrictions on the Secretary's abili
waive these penalties. This creates urgent demand for technology that catches er
before claims are paid. Companies providing predictive analytics for improper
payments, real-time eligibility verification, and automated beneficiary data matc
will see increased state procurement. The key differentiator will be demonstrati
proven error rate reduction with documented ROI. States will pay significant mo
for solutions that help them avoid federal disallowances.

Address verification and data management platforms have a clear new market. T
requirement for states to obtain address information from USPS forwarding
addresses, the National Change of Address database, managed care entities, and
data sources creates demand for companies that specialize in address hygiene an
enrichment. The managed care reporting requirement where MCOs, PIHPs, PAI
and PCCMs must transmit address information directly to states creates an
integration challenge that third-party platforms can solve. If you are a company
already does address verification for commercial purposes and can pivot to Medi
compliance, you have a new revenue stream.

The duplicate enrollment prevention system that CMS must establish by Octobe
2029 represents another infrastructure opportunity. While CMS will build the c
federal system, states need technology to submit data monthly and respond to
duplicate enrollment alerts. Companies that build state-side integration layers,
manage data quality for federal submissions, and automate the residency verifica
workflows when duplicates are identified will find buyers. This is not sexy techn
but it is necessary technology with a captive market.

The renewal technology market gets a substantial boost from the six-month rene
requirement for expansion adults. States that were just getting comfortable with
annual renewals now need to handle double the volume for their largest eligibili
group. Companies providing automated renewal processing, beneficiary

communication platforms, and renewal workflow management will see increased demand. The companies that win will be those that can demonstrably reduce the time required per renewal while maintaining or improving renewal completion r States care about two metrics: cost per renewal and inappropriate termination ra Hit both targets and you will win contracts.

Beyond the administrative technology plays, there is a significant opportunity in commercial insurance enrollment platforms. As millions of people lose Medicaid coverage, they need to transition to Marketplace coverage, employer coverage, or other insurance options. Companies that facilitate this transition, particularly th that can automate the enrollment process and integrate with both Medicaid syst and Marketplace systems, will see volume growth. The legislation specifically re combined notices and account transfers to the Marketplace when beneficiaries a procedurally disenrolled. Companies that make this transition seamless reduce coverage gaps and improve continuity of care while reducing state administrativ burden.

The HCBS technology market gets a boost from the new section 1915c waiver op that allows states to cover home and community-based services without requirin institutional level of care determination, beginning July 1, 2028. This expands th addressable market for HCBS management platforms, electronic visit verificatio systems, caregiver matching platforms, and remote patient monitoring tools. Sta get $100 million in fiscal year 2027 to support HCBS systems, which will drive technology procurement. The companies that position themselves as the infrastructure layer for this new waiver option will capture significant value. Th is building for the needs-based eligibility criteria that states will establish rathe the traditional ILOC requirements.

Rural health technology represents another winner category. The Rural Health Transformation Program appropriates $10 billion annually from fiscal years 202 through 2030, distributed to states with approved applications. Half gets distrib equally across approved states, half goes to at least 25 percent of states based on population and provider concentration. States must use these funds for improvi rural health care access, strengthening rural hospital partnerships, implementin

and technology-driven solutions, and ensuring long-term financial solvency of ru hospitals. Companies providing telehealth platforms, remote patient monitoring hospital-at-home technology, rural care coordination tools, and financial manage systems for rural hospitals will find new buyers with federal dollars to spend. Th procurement timeline is aggressive since states must have approved applications December 31, 2025, with funds available immediately thereafter.

Business Models Facing Existential Threats

Now let us talk about who gets destroyed. The most obvious losers are companie whose primary revenue comes from Medicaid expansion populations, particularl those in states that expanded Medicaid and have high immigrant populations. If customer base is low-income adults aged 19 to 64 without dependent children ar generate revenue through Medicaid claims, you are about to see your addressabl market shrink significantly.

Community engagement requirements will reduce enrollment through both acti disenrollment of non-compliant beneficiaries and passive disenrollment through increased friction in the renewal process. The research on Medicaid work requirements from Arkansas, which implemented work requirements before the were blocked by courts, showed coverage losses of approximately 25 percent in t affected population within 12 months. Not all of those people were ineligible. M lost coverage due to reporting requirements, confusion about exemptions, or ina to document their activities. The same pattern will play out nationally, though potentially worse since states will be implementing simultaneously with limited guidance and aggressive timelines.

The immigration restrictions compound the enrollment losses. The restriction o federal funding to only US citizens, nationals, lawful permanent residents, Cuba Haitian entrants, and COFA migrants starting October 1, 2026 eliminates covera refugees, asylees, trafficking victims, Afghan parolees, Ukrainian parolees, and c currently eligible under federal law. The legislation does not change PRWORA,

means these populations remain eligible under federal law, but states cannot cla federal matching funds for their coverage. Some states will cover these populatic with state-only funds. Most will not, particularly given the other fiscal pressures provider tax and state directed payment restrictions. This creates coverage losse concentrated in states with large refugee and asylee populations.

Medicaid MCOs face a perfect storm of bad news. Enrollment declines reduce premium revenue. The elimination of state directed payments or their reduction Medicare rate caps reduces the ability to overpay certain providers and maintain network adequacy. The provider tax restrictions reduce state fiscal capacity, whi will lead to rate cuts. The six-month renewal requirement increases churn, whic increases administrative costs and reduces the time to recoup care management investments. Medical loss ratios will compress as states cut rates while medical c remain sticky. The MCOs that survive will be those with diversified books of bu across Medicare Advantage, commercial, and Medicaid. The Medicaid-only MC in serious trouble, particularly those concentrated in expansion states.

The financing reforms are particularly brutal for Medicaid MCOs because they eliminate the hidden subsidy many plans relied on. State directed payments allo states to effectively pay providers above the published Medicaid rates by directi MCO spending to specific providers or provider types. The MCO would pay the provider at a higher rate, the state would reimburse the MCO through a directe payment arrangement, and everyone was happy except the federal government w was matching the inflated costs. The new caps at 100 percent of Medicare rates f expansion states and 110 percent for non-expansion states eliminate this subsidy Providers will see revenue decline. Networks will narrow. Access will worsen. M caught in the middle will see margins compress or turn negative.

Safety net providers dependent on provider tax financing and state directed payı face existential challenges. The provider tax freeze at July 4, 2025 levels with gra reductions for expansion states eliminates the ability to generate additional state matching dollars through increased taxes on high-Medicaid-volume providers. T state directed payment caps at Medicare rates reduce payments to safety net hos academic medical centers, and FQHCs that previously received significantly abo

Medicare rates through these arrangements. The combination means less revenu with more uncompensated care as newly uninsured patients seek care without coverage.

The math is brutal. Let us say you are a safety net hospital in an expansion state currently receives 70 percent of revenue from Medicaid, with 40 percent of that Medicaid revenue coming through state directed payments that pay you 150 per of Medicare rates. Your effective Medicaid reimbursement is maybe 120 percent Medicare on average across all service lines. Under the new rules, your state dire payments drop to 100 percent of Medicare. Your overall Medicaid reimburseme falls to maybe 95 percent of Medicare on average. Meanwhile, you lose 10 percer your Medicaid patient volume to coverage losses from community engagement a immigration restrictions. Those patients still show up, but now they are uninsur Your uncompensated care doubles. Your revenue drops 8 to 10 percent while yo costs remain flat or increase. You are now losing money on operations. How do y survive?

The answer for many safety net providers will be they do not survive, at least not their current form. We will see consolidation, closures, and conversion to other service lines. Companies providing services to these safety net providers or depe on these providers for patient access will face significant headwinds. If your bus model assumes continued existence of a robust safety net provider network, you to revisit that assumption.

Behavioral health companies serving Medicaid populations face particularly acu challenges because behavioral health conditions frequently qualify individuals f medical frailty exemptions from community engagement, but the exemption req documentation and determination by the state. In practice, many individuals wit substance use disorders or serious mental illness will lose coverage due to inabil navigate the exemption process rather than actual ineligibility. These are the pat least able to manage administrative complexity. The result is reduced covered liv behavioral health platforms, increased no-show rates as patients lose coverage, a reduced revenue. Companies that pivoted to Medicaid behavioral health during pandemic expansion are going to see their unit economics deteriorate rapidly.

Maternal health companies face a mixed picture that trends negative. The legisla maintains postpartum medical assistance protections and pregnant women are excluded from community engagement requirements. However, the immigration restrictions eliminate coverage for pregnant women who are qualified noncitizen not lawful permanent residents starting October 1, 2026, except for emergency Medicaid. The retroactive eligibility reduction from three months to one or two months affects women who discover pregnancy and apply for Medicaid to cover prenatal care already received. The net effect is probably a modest reduction in covered prenatal care visits and a more significant reduction in postpartum cove visits for immigrant populations. Companies generating revenue from Medicaid prenatal and postpartum visits will see volume pressure.

Chronic care management companies dependent on Medicaid revenue face chall from both enrollment reductions and the six-month renewal churn. Chronic car management programs require longitudinal engagement over many months to generate ROI. When beneficiaries lose coverage every six months and need to reestablish eligibility, the continuity necessary for effective chronic disease management breaks down. Companies will spend more money reengaging patien who churn off coverage and return, while seeing reduced revenue from successfu management due to shorter coverage duration. The economics get tough quickly

The Gray Zone: Models That Might Survive With Adaptation

Some business models fall into a gray zone where survival depends on execution adaptation. Medicaid-focused primary care platforms that capitated risk can potentially survive if they move upstream into helping states manage community engagement verification and address validation as part of their care coordinatior activities. The value proposition shifts from “we reduce ED utilization” to “we k your beneficiaries engaged and compliant with eligibility requirements while als managing their health.” This is a harder sell but potentially viable for plans with strong state relationships and demonstrated operational capabilities.

Care coordination platforms serving dual eligibles should be relatively insulated the Medicare coverage remains regardless of Medicaid status and the community engagement requirements do not apply to Medicare beneficiaries. However, the elimination of the enhanced FMAP for emergency Medicaid services for expansi populations starting October 1, 2026 means states will see increased costs for emergency care for undocumented patients who lose coverage. This fiscal pressu will create renewed interest in care coordination and diversion strategies for the populations, but the willingness to pay will be lower since states cannot claim enhanced federal match.

Social determinants of health platforms that focus on connecting beneficiaries t community resources could potentially position themselves as community engag verification partners, documenting volunteer service, community service participation, or education enrollment. The challenge is that most existing SDO platforms were not built with the verification rigor and data security requireme necessary for eligibility determination. Building to those standards requires significant investment and may not be worthwhile for the market opportunity.

Pharmacy benefit management and specialty pharmacy companies serving Medi should see some offsetting factors. Yes, covered lives will decrease. However, the members who remain will be sicker on average since healthier low-income adult be more likely to lose coverage due to community engagement noncompliance o administrative churn. This means higher utilization per covered life, though potentially lower absolute revenue depending on the magnitude of coverage loss The elimination of the 90 percent FMAP for expansion population emergency se also puts pressure on state budgets, which typically leads to pharmacy carve-out rate cuts in Medicaid MCO contracts, creating opportunities for PBMs to captu margin.

Investment Implications for Early Stag Health Tech

If you are an angel investor or early stage VC evaluating healthcare companies ir and 2026, this legislation should fundamentally alter your diligence process and investment thesis. The core question you need to ask about any Medicaid-expose business is simple: will this company have more or fewer potential customers in months than it has today? For most companies serving Medicaid expansion populations, the answer is fewer, and potentially far fewer.

The second question is about state fiscal capacity. Will states have more or fewe dollars available to pay for services in 24 months? Again, for expansion states de with provider tax restrictions, state directed payment caps, and enrollment reductions, the answer is fewer. This means pricing pressure, slower sales cycles reduced contract values even for companies providing valuable services.

The third question is about regulatory risk. Does this company's business model depend on regulatory interpretations or financing mechanisms that are now rest or prohibited? Many digital health companies serving Medicaid have business m that depend on permissive state plan amendments, creative interpretations of reimbursable services, or 1115 demonstration authority that allowed non-traditi benefit coverage. The requirement for Chief Actuary budget neutrality certificat for 1115 demonstrations starting January 1, 2027 makes approval of innovative demonstrations much more difficult. The elimination of state directed payments financing mechanism removes a major tool states used to fund value-based care arrangements and alternative payment models. If your company depends on regu flexibility that is being restricted, your path to scale just got much harder.

For companies building administrative tools for states, the opportunity is enorm but the competition will be intense. The companies that win will be those that m fastest to build partnerships, demonstrate ROI, and achieve scale economies. Th probably room for three to five winners in each major category like community engagement verification, duplicate enrollment prevention, and fraud detection. ' rest will struggle to gain traction. As an investor, you want to fund the category leaders or companies with truly differentiated technology or distribution. Me-to solutions will not succeed in this market.

The rural health opportunity is real but requires understanding that rural provi are financially fragile and technology adoption is slow. Companies need to build the reality of rural health systems: limited IT staff, constrained budgets, older technology infrastructure, and resistance to change. The winners will be compar that make implementation simple, provide exceptional support, and demonstrat financial ROI. Selling on clinical outcomes or patient experience will not work. S on "this will save you money or help you access federal rural health transformati funding" will work.

For companies with commercial insurance books of business, this is a massive acquisition opportunity. Millions of people losing Medicaid coverage creates an unprecedented opportunity to convert them to commercial members if you can s the enrollment friction and affordability challenges. Companies building in this need to understand that most people losing Medicaid will be eligible for subsidi Marketplace coverage, but many will not successfully enroll due to complexity o of awareness. The company that builds the smoothest off-ramp from Medicaid t Marketplace coverage will capture enormous value.

What This Means for Your Portfolio

If you have existing portfolio companies exposed to Medicaid, you need to have t uncomfortable conversation about how this legislation affects their business nov in six months when the problems are obvious. Companies need to model the fina impact of 20 to 30 percent enrollment reductions in their target populations, pri pressure from state rate cuts, and increased customer acquisition costs as their addressable market shrinks. Some companies will need to pivot to commercial populations, Medicare populations, or state administrative services. Some will n raise additional capital to survive the transition. Some will not survive at all.

For companies that provide services to Medicaid MCOs, you need to understand your customers are under severe financial pressure and will be cutting costs aggressively. If your product is not directly tied to regulatory compliance or clea reduces their operating costs, you will face churn. Position your value propositic

around helping MCOs manage the new regulatory requirements or reduce costs, around improving member experience or health outcomes. Those are nice to hav benefits. Cost reduction and compliance are must-have benefits.

For companies serving safety net providers, the financial viability of your custon at risk. You need to evaluate which health systems in your customer base are lik survive the next 24 months and which are at risk of closure or significant service reductions. Focus your customer success efforts on helping your strongest custo succeed and be prepared to write off revenue from customers that fail. Do not in heavily in customer acquisition from safety net providers unless you have very hi confidence in their financial sustainability.

For companies building new products, the opportunity is in administrative techn for states, commercial insurance enrollment platforms, and rural health technol funded by the Rural Health Transformation Program. These are the tailwinds. Everything else in Medicaid is a headwind. That does not mean you cannot build successful companies serving Medicaid populations, but you need to be clear-ey about the challenging market dynamics and build accordingly.

The investors who will do well in this environment are those who recognize that massive market shift is underway and position accordingly. The Medicaid expan of the last decade created opportunities for companies serving low-income adult previously had no coverage. That era is ending. The next era is about administra efficiency, cost reduction, and serving the populations that remain covered. Inve accordingly.

The bottom line for angel investors is this: Medicaid just got a lot smaller, a lot r administratively complex, and a lot more focused on cost containment rather tha coverage expansion. Companies that help states manage that complexity while reducing costs will do well. Companies that depend on the expansion populatior revenue will struggle. Companies serving safety net providers dependent on stat directed payments and provider taxes will face existential challenges. And the w to adapt is measured in quarters, not years.

You need to evaluate every Medicaid-exposed investment through this lens. The playbook of “Medicaid is a growing market with increasing coverage” no longer applies. The new playbook is “Medicaid is contracting in enrollment but expand administrative requirements, creating opportunities for the right kinds of techn companies while destroying business models dependent on expansion coverage.” on the right side of that divide and you will do very well. Get on the wrong side you will watch your portfolio companies struggle and fail despite good executio market shift is not something companies can overcome through better tactics. Y need the right strategy for the new market reality.

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