



## **After the Big Beautiful Bill: Evolving Health System Strategies Amid Medicaid Cuts**

### ***AMGA 2026 Annual Conference Deep Dive***

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### **Session Summary**

This two-hour deep dive session focused on the financial and operational implications of the One Big Beautiful Bill Act (OB3) for medical groups and health systems serving Medicaid populations. The session moved from policy framing to financial modeling to peer learning, featuring Darryl Drevna (AMGA Regulatory Affairs), Matthew Wells (AMGA Consulting), Dr. Suzanna Fox (Advocate Health), and Dr. Scott Rathgaber (Emplify Health), with a fireside discussion led by Dr. Mark LePage (Trinity Health).

Drevna laid out the structural architecture of OB3's Medicaid cuts: three interlocking mechanisms spanning eligibility restrictions (work requirements, semi-annual redeterminations), provider tax enforcement (safe harbor reduced from 6% to 3.5% by 2032 in expansion states), and state-directed payment caps (capped at 100% of Medicare in expansion states). The Congressional Budget Office (CBO) projects 7.8-10.5 million Medicaid and CHIP enrollees losing coverage by 2034, with total coverage losses including Affordable Care Act (ACA) changes potentially affecting 16 million Americans.

Wells translated the policy into operational math, using a 300-provider Oregon medical group with \$144 million in professional revenue and 16% Medicaid dependency as a case

study. Even a 5% Medicaid revenue impact would cost that group \$1.18 million annually, and a 10% impact would cost \$2.36 million. He outlined 10 operational mitigation levers: financial modeling, staff education, referral optimization, community resource navigation, expense management, productivity improvement, on-call restructuring, care model redesign, emergency department (ED) streamlining, and revenue cycle reinforcement.

Fox and Rathgaber offered contrasting but complementary perspectives. Advocate Health operates a \$36 billion enterprise across six states, including both expansion and non-expansion markets, with 200,000 patients receiving charity care annually and 50,000 already enrolled in Medicaid with staff assistance. Emplify Health is a \$3 billion rural-dominant system in Wisconsin (non-expansion), where 340B Drug Pricing Program eligibility risk represents an outsized threat far exceeding the direct Medicaid revenue exposure. Both leaders emphasized that the administrative burden of the new eligibility requirements will fall substantially on health systems rather than states, and that the real cost of compliance and outreach work is not yet quantifiable but unavoidable.

The fireside discussion surfaced candid reflections on segmented care delivery, direct employer contracting, the limits of virtual care resistance from physicians, and a broader call to use this moment not just to recover lost ground, but to fundamentally redesign a system already broken before OB3 was passed.

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## **Five Key Takeaways**

1. The financial exposure is real but highly variable, and organizations that haven't modeled it yet are behind. The \$1 trillion in federal Medicaid cuts over 10 years translates to very different local impacts depending on payer mix, expansion status, provider tax history, and 340B eligibility. For Emplify Health, the existential risk isn't even the direct Medicaid revenue loss, it's the potential loss of 340B qualification, which alone exceeds the system's entire annual operating margin. That's the kind of asymmetric risk that demands board-level attention, not just operational modeling. Organizations still treating this as a budgeting exercise, rather than a strategic planning trigger, are underestimating the exposure.

2. The administrative burden of reverification is a cost center that will scale faster than anyone anticipates. Both Fox and Rathgaber were explicit that states lack the infrastructure to enforce new eligibility requirements, which means health systems will absorb that function. Semi-annual redeterminations, quarterly cross-checks, and immigration-related eligibility restrictions will require dedicated staff, workflow redesign, and likely technology investment. Neither organization had yet quantified the cost of this work, which is itself a

warning signal. The systems that invest early in Medicaid navigation infrastructure, including community health workers, eligibility tracking tools, and multilingual outreach, will retain more covered patients than those treating compliance as a passive process.

3. Productivity improvement among underperforming providers is the most immediate lever for addressing the financial implications, but it requires nuance. Advocate Health has already built internal lists of physicians operating below the median and is actively addressing capacity gaps in markets where patients face 30- to 50-day wait times. The ROI here is straightforward: Moving a provider from the 25th to the 50th percentile in a capacity-constrained market generates meaningful access and revenue without adding headcount. But both Fox and Rathgaber were careful to note that low production isn't always inefficiency. Mission-critical roles and specific community coverage needs justify below-median volumes. The discipline is in separating those cases from genuine underperformance.

4. Care model segmentation is the most strategically uncomfortable but operationally necessary shift. Rathgaber described what may be the most honest moment of the session: His organization has always prided itself on being insurance-agnostic, treating every patient identically. That model is no longer financially sustainable. The emerging approach is to differentiate not on care quality, but on care wraparound, concentrating social workers, community health workers, and population health infrastructure in sites that predominantly serve Medicaid patients, rather than distributing those resources thinly across all sites. The resistance inside organizations is significant because the framing sounds like tiered care, but the actual logic is the opposite: ensuring Medicaid patients get the resources they actually need, rather than a generic experience designed for commercially insured patients.

5. The systems that will come through this shift most successfully are the ones treating it as a catalyst for the overdue redesign, not just a revenue recovery problem. Rathgaber put it plainly: Before OB3, the system was already broken. Reimbursement trends and cost inflation had already crossed into an unsustainable trajectory. The bill accelerated a crisis that was already forming. The organizations that survive and lead will be those willing to ask harder questions about payment models, care delivery structure, employer partnerships, and how they communicate financial reality to their communities without inducing panic. That's a harder strategic posture to hold than pure mitigation, but both Fox and Rathgaber modeled it clearly.

*This summary was prepared with AI assistance and reviewed by AMGA staff.*