The 14-Month Implementation Checklist: What MCOs Must Do Now

The Timeline Problem

Medicaid managed care organizations have 14 months until OB3's work requirements take effect in December 2026. That's not adequate preparation time.

Building infrastructure to manage enrollment volatility, integrate with state verification systems, extend SDOH platforms, train care coordination teams, and establish community partnerships requires 12-18 months under ideal conditions. You're already behind.

The urgency compounds because much depends on external parties moving on their own timelines. State Medicaid agencies are building verification portals and exemption processes. If you're not at the table influencing design now, you'll inherit systems that don't integrate with your care coordination platforms. Community-based organizations are determining whether to expand navigation capacity. If you're not negotiating partnership terms now, you'll find the best organizations already contracted with competitors.

This isn't about whether work requirements are good policy. That debate is over politically. This is about what operationally competent managed care organizations must do in the next 14 months to avoid operational chaos in December 2026.

Internal Actions: Build the Foundation (Months 1-6)

Start with actuarial and financial analysis. Model the fiscal impact of work requirements on your expansion population under multiple churn scenarios: 15%, 25%, 35% annual turnover. Calculate increased care coordination costs, technology investments, and utilization pattern changes.

Sequence: Complete by Month 3. This analysis informs every subsequent decision.

Deliverable: Financial model showing breakeven points, rate increase needs, and margin projections.

Build risk stratification and predictive models. Develop algorithms identifying which members are at high, medium, and low risk of losing coverage due to work requirement non-compliance. Risk factors include employment type, digital literacy, housing stability, language barriers, chronic conditions affecting work capacity, and historical coverage patterns. You can't afford intensive navigation for all expansion members. Identify the 10-15% who need intensive support and the 60-70% who can navigate with minimal help.

Sequence: Pilot models by Month 4, refine by Month 6.

Deliverable: Member-level risk scores updated monthly, integrated into care coordinator workflows.

Redesign care coordination workflows. Integrate work requirement support into existing care coordination processes. Care coordinators need to know each member's verification status, upcoming deadlines, and exemption eligibility just like they know medication lists and chronic conditions. Work requirements are now a social determinant of health that directly impacts health outcomes. They can't be handled by separate teams.

Sequence: Workflow redesign by Month 4, staff training by Month 6.

Deliverable: Updated care coordinator protocols, integrated dashboards showing verification status alongside clinical information, documentation templates for exemptions.

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Train care coordination and member services teams. Every staff member who touches expansion population members needs training on work requirements: eligibility rules, exemption categories, documentation requirements, state verification processes, how to escalate complex cases. December 2026 will bring an avalanche of member questions. Your staff needs to answer these questions accurately while maintaining focus on health management.

Sequence: Curriculum development by Month 3, training rollout Months 4-6, ongoing refreshers.

Deliverable: Trained staff with certification, knowledge base for reference, escalation protocols for complex cases.

Extend SDOH and health-related social needs platform capabilities. If you have SDOH platforms for screening, referrals, and resource coordination, extend them to include work requirement support. Add functionality for tracking verification deadlines, documenting qualifying activities like employment, education, and volunteering, connecting to job training and employment services, and managing exemption documentation. You've already invested in SDOH infrastructure. **Work requirements are another social need.** Build on existing platforms rather than creating parallel systems.

Sequence: Requirements definition by Month 2, development or configuration Months 3-5, pilot testing Month 6.

Deliverable: Integrated platform where care coordinators manage health needs and work requirement support in one workflow.

Develop technology for gap engagement. Build systems to maintain light-touch connection with members during coverage gaps. Automated text messaging campaigns, condition-specific self-management resources, community resource directories, re-enrollment navigation tools. Some coverage loss is inevitable. Members who receive support during gaps return healthier and re-enroll faster. The technology investment is minimal while the ROI is significant.

Sequence: Design by Month 3, development Months 4-5, testing Month 6.

Deliverable: Automated engagement system for disenrolled members, opt-in text campaigns, self-service re-enrollment portal.

Build data infrastructure for impact tracking. Create systems to comprehensively track work requirement impacts: coverage loss rates, churn patterns, health outcomes during and after gaps, utilization changes, care coordination effectiveness, administrative costs, disparities by demographic group. You need this data for three purposes: internal operations improvement, contract negotiations with states demonstrating actual costs, and policy advocacy showing what works and what doesn't.

Sequence: Data model design by Month 2, infrastructure build Months 3-5, dashboards by Month 6.

Deliverable: Real-time dashboards tracking key metrics, quarterly reports for leadership, exportable data for state reporting and advocacy.

Establish internal coordination mechanisms. Create formal coordination between departments that traditionally operate in silos: care management, eligibility and enrollment, member services, provider relations, community engagement, finance, legal. Work requirements touch all these functions. Without coordination, you'll have conflicting member communications, duplicated efforts, dropped handoffs, and missed escalations.

Sequence: Governance structure by Month 2, regular meetings starting Month 3.

Deliverable: Cross-functional work requirements task force, clear escalation pathways, shared accountability for outcomes.

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Prepare provider network. Train network providers on medical exemption processes, create simple documentation templates, integrate exemption attestation into EHR workflows, establish rapid response processes for urgent exemption needs. Providers will be asked to document medical exemptions. If the process is burdensome, they won't do it consistently. If it's streamlined, they become partners in preventing inappropriate coverage loss.

Sequence: Provider engagement starts Month 3, training and tools rollout Months 4-6.

Deliverable: Provider portal for exemption documentation, EHR templates, training materials, dedicated support line for provider questions.

Design deep member engagement strategy. Go beyond passive communication to active, personalized engagement. Member advisory councils composed of expansion population members to co-design support systems. Peer navigator programs where members who successfully maintain coverage help others. Regular member feedback loops through surveys, focus groups, and listening sessions. Member-facing technology designed with and tested by actual users, not assumed to work based on vendor promises. Member confusion drives coverage loss, but traditional top-down communication often fails. Members know what obstacles they face better than any consultant.

Sequence: Member advisory recruitment Month 2, first meetings Month 3, ongoing engagement throughout. Peer navigator pilot Month 4, scale Month 6-8.

Deliverable: Active member advisory council meeting monthly, peer navigator program with 20-30 navigators serving 200-300 members, regular member feedback incorporated into system design, member-tested communications and technology.

External Actions: Build the Ecosystem (Months 1-8)

Engage immediately with state Medicaid agencies. Establish direct, regular communication with state officials designing work requirement implementation. Offer MCO perspective on what will work and what will fail. Advocate for integration points between state verification systems and MCO care coordination platforms. States are designing systems now. If you wait until systems are built, you'll be stuck with whatever they created.

Sequence: Initial contact Month 1, ongoing engagement throughout.

Key asks: API access to state verification systems, real-time eligibility updates, care coordinator ability to initiate exemption processes, simplified medical exemption pathways, data sharing agreements, joint problem-solving for complex cases.

Deliverable: Formal partnership agreements, technical integration specifications, regular coordination meetings.

Negotiate contract terms and rate adequacy. Present actuarial analysis showing increased costs from work requirement administration, enrollment volatility, and changed utilization patterns. Negotiate rate increases, risk corridors, or outcome-based adjustments. Current capitation rates weren't set with work requirement volatility in mind. If you don't secure adequate rates now, you'll be managing unsustainable populations or exiting markets.

Sequence: Analysis complete by Month 3, negotiations Months 4-8, rate adjustments effective by contract renewal.

Deliverable: Contract amendments reflecting work requirement costs, documented methodology for future rate adjustments as experience emerges.

Formalize community-based organization partnerships. Identify CBOs currently providing or capable of providing work requirement navigation support. Negotiate formal partnership agreements: scope of services, funding, data sharing, quality expectations, coordination protocols. CBOs are trusted community presence with existing relationships in neighborhoods where your members live. They're more cost-effective than building internal navigation infrastructure and more culturally competent for diverse populations.

Sequence: CBO landscape assessment Month 2, partnership negotiations Months 3-6, contracts finalized by Month 7.

Deliverable: Executed contracts with 3-5 CBOs per service area, clear referral pathways, shared data systems, regular coordination meetings.

Establish employer engagement program. Identify major employers in your service area whose employees are Medicaid expansion eligible. Develop relationships offering to help with work verification processes, provide health plan liaisons for questions, coordinate efficient documentation. Employer cooperation makes verification dramatically easier. Employers who understand the stakes are often willing to help but need simple, standardized processes. Employer identification Month 2, outreach Months 3-6, partnerships operational by Month 8. Deliverable: Memoranda of understanding with major employers, standardized verification letter templates, employer portal for verification submission.

Partner with educational institutions. Establish relationships with community colleges, vocational programs, adult education providers. Negotiate automated reporting of enrollment and attendance that counts toward work requirements. Education is a qualifying activity. If the reporting is automated, students maintain coverage without administrative burden. This supports both health coverage and educational attainment.

Sequence: Institution identification Month 2, partnership development Months 3-6, technical integration by Month 8.

Deliverable: Data sharing agreements, automated enrollment and attendance reporting, student support services coordination.

Expand or develop SDOH vendor partnerships. If you use SDOH platform vendors like Unite Us, FindHelp, or GroundGame.Health, negotiate work requirements module additions. If you don't use vendors, evaluate whether build versus buy makes sense given timeline. These platforms already coordinate community resources. Adding work requirement functionality leverages existing infrastructure. The timeline is too tight to build sophisticated platforms from scratch.

Sequence: Vendor assessment Month 1-2, negotiations Months 2-4, implementation Months 5-8.

Deliverable: Enhanced platform capabilities, integration with state systems, training for care coordinators and community partners.

Coordinate with other MCOs in your markets. Establish communication with competitor health plans serving the same geographies. Share non-proprietary information about what's working, what's failing, best practices, joint advocacy needs. All MCOs face the same state systems and many of the same community partners. Coordination prevents duplication, reduces fragmentation for providers and CBOs, and creates unified voice for advocacy.

Sequence: Initial meetings Month 3, ongoing coordination throughout.

Deliverable: Regular MCO coordination meetings, shared advocacy positions on state policy, coordination on community partnerships to avoid conflicts.

Build provider education and engagement infrastructure. Partner with major provider groups and safety-net systems to ensure understanding of work requirements, exemption processes, and how they impact patient care. Create joint protocols for identifying and documenting exemptions. Providers are frontline for identifying medical exemptions. If they don't understand the system or find it too burdensome, valid exemptions won't get documented and members will lose coverage inappropriately.

Sequence: Provider organization outreach Month 3, protocol development Months 4-6, training rollout Months 6-8.

Deliverable: Provider education program, clinical protocols, EHR integration, support infrastructure.

Engage with advocacy and community organizations. Meet with organizations advocating for Medicaid beneficiaries and organizations serving immigrant, disability, and vulnerable communities. Understand their concerns, share your operational constraints, identify opportunities for partnership. These organizations will document failures and advocate for policy changes. Being in dialogue means you can problem-solve together, understand early warning signs of system failures, and potentially partner on solutions.

Sequence: Outreach Months 2-3, ongoing dialogue throughout.

Deliverable: Regular stakeholder meetings, shared problem identification, joint advocacy where appropriate, feedback loops for system improvement.

Participate in industry advocacy and verification innovation. Through industry associations like AHIP and Medicaid Health Plans of America, participate in collective advocacy for sensible implementation, adequate rate adjustments, and policy improvements based on emerging evidence. Simultaneously, work collectively to solve the verification submission burden through industry-wide solutions like standardized payroll processor integrations or shared verification platforms that multiple MCOs can use. Individual MCOs have limited leverage with states and CMS. Collective industry voice is more influential. Shared evidence across plans is more credible than individual plan complaints.

Sequence: Engagement starts Month 1, ongoing throughout. Verification innovation working groups Month 2-6, pilot implementations Month 7-10.

Deliverable: Industry white papers, joint advocacy positions, shared evidence briefs, unified recommendations to states and CMS, potentially shared verification infrastructure reducing per-plan costs.

Build payer-facilitated verification infrastructure. Rather than leaving members to navigate state verification systems alone, create MCO-operated submission pathways that reduce administrative burden. Member-facing mobile app where members photograph paystubs or volunteer logs and MCO submits verified information to state systems on their behalf. Partnerships with major payroll processors like ADP, Paychex, and Gusto where MCO facilitates automated data feeds to state verification systems. Community health worker home visits where CHWs help gather documentation, upload to systems, and confirm submission. MCO verification concierge service where members can call and have someone walk them through submission process or handle it for them.

State verification systems will inevitably be complex and difficult for some members to navigate. If MCOs can serve as trusted intermediaries, gathering information from members through easier channels and handling state submission, you reduce member burden while ensuring verification happens.

Sequence: Requirements definition Month 2, partnerships with payroll processors Months 3-6, member app development Months 4-7, CHW training Month 5, verification concierge pilot Month 6.

Key requirement: Must have state agreement that MCO-facilitated submissions are acceptable and data sharing agreements enabling MCO to submit on member's behalf with appropriate consent and privacy protections.

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Deliverable: Operational verification facilitation pathways reducing member burden, documented processes for each submission type, trained staff, technology platforms integrated with state systems, partnership agreements with payroll processors.

Months 7-10: Pilot and Refine

With foundation built and partnerships established, use this period for pilots in select counties or with select populations.

Test everything: risk stratification accuracy, care coordinator workflows, technology integrations, community partnership protocols, provider engagement, member communications.

Identify failures early when you can fix them. The member who loses coverage during your pilot in August 2026 is unfortunate. The 10,000 members who lose coverage during full implementation in January 2027 because you didn't pilot is catastrophic.

Key pilots include high-risk member intensive navigation with 100-200 members, SDOH platform integration and CBO coordination in 2-3 counties, provider exemption documentation with 3-5 major provider groups, gap engagement technology tested with members who lost coverage during unwinding, state system integration in one service area with willing state partnership, payer-facilitated verification submission with 500-1000 members testing app, CHW support, and concierge service, and deep member engagement incorporating peer navigators and member advisory council feedback on system design.

Success metrics include coverage retention rates versus control groups, care coordinator time allocation and satisfaction, member feedback and confusion points, technology system reliability and adoption, partner effectiveness and coordination quality, cost per member for interventions, verification submission success rates through different channels, member satisfaction with verification process comparing MCO-facilitated versus self-navigation, and peer navigator effectiveness measured by coverage retention of members they support.

Iterate rapidly. Weekly pilot reviews. Immediate fixes for identified problems. Don't wait for perfect. Get to good enough and refine based on real experience.

Months 11-14: Scale and Launch

Final months before December 2026 implementation are about scaling what worked in pilots, training all staff, finalizing all partnerships, stress-testing all systems, and preparing for the onslaught.

November 2026: All staff trained and certified on work requirements. All technology systems operational statewide. All community partnerships active with service capacity confirmed. All provider network engaged with exemption processes established. All member communications deployed in all languages across all channels. Governance and escalation protocols operationalized. Data collection and reporting systems fully functional.

December 2026: Launch with full support infrastructure operational. Daily monitoring of key metrics. Rapid response to emerging problems. Weekly cross-functional review meetings. Member hotline capacity doubled for expected question volume. Executive leadership engaged and visible.

Early 2027: Intensive first 90 days monitoring and iteration. Document everything that's failing for rapid fixes. Maintain high-touch with states for real-time problem-solving. Begin collecting evidence for rate negotiations and policy advocacy. Celebrate staff managing impossible complexity with grace.

The Resource Reality

This level of implementation isn't cheap. For an MCO serving 100,000 expansion members, reasonable budget allocation breaks down as follows.

Internal investments as one-time costs: Technology development and configuration $2-4M, staff training and development $500K-1M, data infrastructure $500K-1M, provider network engagement $250-500K, member education materials $250-500K. Total one-time: $3.5-7M.

External partnerships as annual costs: CBO contracting $1-3M, SDOH vendor enhancements $500K-1M, employer and education partnerships $200-400K, advocacy and coordination $100-200K, verification facilitation infrastructure including payroll integrations, member app, and concierge service $800K-1.5M, peer navigator program $300-600K. Total annual: $2.9-6.7M.

Ongoing operations as annual costs: Additional care coordination capacity $1-2M, gap engagement technology $200-400K, enhanced member services $500K-1M, data analysis and reporting $300-500K, member advisory councils and engagement $100-200K. Total annual: $2.1-4.1M.

Total first year: $8.5-17.8M. Ongoing annual: $5-10.8M. Per member per month: $4.25-9 PMPM for expansion population.

This is substantial. But compare it to the alternative: chaotic implementation, mass coverage loss, spiking utilization when members return sicker, quality metric failure, and potential market exit. The investment is operational necessity, not optional enhancement.

The Urgency Message

Executives reading this may think: we'll start next quarter or we'll see how other plans handle it first. That's a mistake. The timeline is unforgiving.

Month 3: Plans that started Month 1 are completing actuarial analysis and beginning state engagement. You're starting from zero.

Month 6: Plans that started Month 1 are piloting systems. You're still building foundations.

Month 9: Plans that started Month 1 are refining based on pilots. You're just beginning partnerships.

Month 12: Plans that started Month 1 are scaling for launch. You're scrambling.

Month 14, December 2026: Plans that started Month 1 launch imperfectly but operationally. You launch in chaos.

The plans that execute well aren't those with the most resources. They're those that started earliest and iterated fastest. Start now. The operational crisis is 14 months away. That's a planning luxury that expires quickly.

Begin with the actuarial analysis and state engagement. Everything else flows from those two foundations. But begin this month.

The Disclaimer

Each Healthcare Insurer in the US is unique, with varying degrees of expertise in Medicaid, different organization structures, internal cultures, partner and vendor relationships, and ultimately very different business objectives. I do not pretend to know your organization, your business priorities, or your strategies. Direct as this article is, it is centered in a desire to spur action, to frame the priorities so nothing gets missed, and last but not least, to help people (the business we are all in...). This is not perfect, neither am I. Please

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point out what I missed, blame me and flame me by all means, but please act. No disrespect intended, no false pride, and no presumptions of knowing everything.

References

1. Sommers BD, et al. "Consequences of Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." *Health Affairs*. 2020;39(9):1524-1532.
2. Congressional Budget Office. "Budgetary Effects of H.R. 5376, the Build Back Better Act." December 2021.
3. Hinton E, et al. "5 Key Facts About Medicaid Work Requirements." Kaiser Family Foundation. February 2025.
4. Musumeci M, et al. "Medicaid Enrollees with Complex Care Needs: Characteristics, Costs, and Coverage." Kaiser Family Foundation. May 2019.
5. Kangovi S, et al. "Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial." *JAMA Internal Medicine*. 2018;178(12):1635-1643.
6. Berkowitz SA, et al. "Addressing Basic Resource Needs to Improve Primary Care Quality: A Community Collaboration Programme." *BMJ Quality & Safety*. 2016;25(3):164-172.
7. Gottlieb LM, et al. "Effects of In-Person Assistance vs Personalized Written Resources About Social Services on Household Social Risks and Child and Caregiver Health: A Randomized Clinical Trial." *JAMA Network Open*. 2020;3(3):e200701.
8. Onie RD, et al. "Integrating Social Needs into Health Care: A Twenty-Year Case Study of Adaptation and Diffusion." *Health Affairs*. 2018;37(2):240-247.
9. Government Accountability Office. "Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements." GAO-20-149. October 2019.

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