Managing the Multiply Burdened: Care Coordination When Medical Risk, Social Complexity, and Administrative Barriers Converge

The Actuarial Nightmare: When Three Bad Things Happen at Once

Here's what keeps MCO actuaries awake: a member with uncontrolled diabetes, unstable housing, and two part-time jobs at different small businesses. Medical complexity means expensive if care breaks down. Housing instability means documentation challenges. Multiple small employers means verification nightmare.

Traditional MCO stratification logic breaks here. You'd normally classify this member as high medical risk requiring intensive care coordination. But intensive coordination assumes stable enrollment, working phone number, and capacity to engage with healthcare. This member has none of that. They're churning off coverage every few months due to verification barriers. Your care coordinator can't reach them. When you finally connect, they're managing immediate survival needs – food, shelter, keeping multiple jobs – not managing diabetes.

So you scale back investment. Rational decision. Why spend resources on someone who won't stay enrolled? But then they return six months later in DKA with a $20,000 hospitalization. Your quality metrics tank. Your medical loss ratio spikes. The member loses vision, kidney function, or digits. Everyone loses.

This isn't an edge case. In some Medicaid expansion markets, members with this triple burden – high medical complexity, high social complexity, and high administrative vulnerability – represent 15-25% of your population. Work requirements make this population larger and more visible because administrative barriers now determine coverage stability for everyone.

Article 3 examined stratifying Medicaid expansion populations and building care coordination for different risk levels. Article 3B provided implementation checklists. This article addresses members who defy that stratification logic: the multiply-burdened who need intensive support precisely because traditional models suggest avoiding them.

Why Traditional Care Coordination Models Fail

Standard care coordination assumes five things that aren't true for multiply-burdened members.

First assumption: stable enrollment enables ROI. Traditional model says invest in care coordination month one through three, see utilization reductions month four onward, recover investment over 12-18 months. Reality for multiply-burdened: they churn off coverage every 3-6 months regardless of your investment. You never see the ROI period because enrollment isn't stable long enough. The member who finally gets stable diabetes management loses coverage next month due to verification failure, returns four months later starting from scratch.

Second assumption: intensive intervention prevents acute care. Traditional model says care coordinator helps member manage chronic conditions, connects to primary care, prevents ED visits and hospitalizations. Reality for multiply-burdened: social and administrative barriers prevent intervention effectiveness. The diabetic who understands their condition perfectly still ends up in DKA because they lost housing, couldn't refrigerate insulin, missed three doses, then lost coverage before they could get to the doctor. Your excellent care coordination couldn't overcome structural barriers.

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Third assumption: member engagement drives outcomes. Traditional model says engaged members follow care plans, attend appointments, take medications, improve health outcomes. Reality for multiply-burdened: engagement requires executive function, time, stability, and capacity these members lack. When you're managing homelessness, food insecurity, and work requirement documentation simultaneously, diabetes self-management drops down the priority list. It's not disengagement – it's triage of limited cognitive and practical resources.

Fourth assumption: quality metrics incentivize good care. Traditional model says MCOs optimize for quality metrics because contract performance and star ratings depend on them. Reality for multiply-burdened: quality metrics penalize serving unstable, complex populations. Every missed appointment, every gap in medication adherence, every ED visit during coverage lapses tanks your scores. The rational response is avoiding these members entirely or providing minimal care that doesn't expose you to metric penalties.

Fifth assumption: care coordination is separate from benefits navigation. Traditional model says care coordinators handle health needs, eligibility specialists handle enrollment, benefits specialists handle work requirement documentation. Reality for multiply-burdened: benefits navigation IS care coordination for these members. If they lose coverage, your care coordination becomes irrelevant. You can't separate health management from coverage stability because unstable coverage destroys health management.

The multiply-burdened break every assumption underlying standard care coordination. Traditional models optimize for a different population – people with medical complexity but social stability and administrative capacity. For the multiply-burdened, you need different models entirely.

The Business Case Despite the Paradox

Traditional actuarial logic says avoid multiply-burdened members. But there's a counterintuitive business case for intensive investment.

Start with catastrophic cost prevention. The diabetic with housing instability who loses coverage returns in DKA. That $15,000-20,000 hospitalization costs more than months of intensive support. Even if you only catch one catastrophic event, you've paid for significant intervention. Prevention costs less than crisis management.

Consider emergency utilization reduction. Even unstable members use emergency departments. Multiply-burdened members without care coordination use ED for primary care, for medication refills, for crisis management. Intensive support reduces ED visits even during enrollment because you're connecting them to alternatives and preventing crises before they reach emergency level.

Think about quality metric protection in stable subpopulations. Not every multiply-burdened member churns constantly. Some you successfully stabilize. Those members – the 30-40% who respond to intensive support and maintain coverage – drive quality performance improvements that offset losses from unstable members.

Look at contract negotiations leverage. Document actual costs of serving complex populations. When contract renewal comes, you have data showing that standard capitation rates don't cover multiply-burdened populations. States may not increase rates immediately, but you've established the case. Without documentation, you have no negotiating position.

Recognize competitive advantage. Plans that can manage complexity well differentiate in RFP responses. States increasingly recognize that rock-bottom bids often mean avoiding difficult populations. Demonstrating competence with multiply-burdened members – through data showing coverage retention, quality outcomes, and cost-effective interventions – positions you for contracts that reward capability over simply price.

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Finally, acknowledge mission alignment. For mission-driven plans – safety-net systems, community-focused plans, nonprofits – serving vulnerable populations is core identity. Walking away from multiply-burdened members because they're difficult contradicts organizational purpose. Sometimes business case aligns with mission.

The business case isn't overwhelming. You won't show traditional ROI on every member. But you can show that intensive support costs less than doing nothing, improves outcomes for significant subpopulations, and positions the organization strategically. That's sufficient justification for targeted intensive support models.

Five Intensive Support Models

Standard care coordination won't work. What will? Five models show promise for different segments of multiply-burdened populations.

Model 1: Dyad Care Coordination

The dyad model pairs a nurse care coordinator with a community health worker, creating a two-person care team assigned to 25-30 highest-complexity members. The nurse handles clinical oversight and medical management, coordinates with providers for specialty care, manages medication reconciliation and adherence support, documents medical exemptions, navigates insurance and benefits, and intervenes during health emergencies. The community health worker meets members where they are through home visits and field outreach, resolves practical barriers around transportation, food, and housing, supports work requirement documentation, mediates cultural differences and builds trust, coordinates social services, and checks in daily during high-risk periods.

Integration happens through weekly team huddles reviewing every assigned member, shared documentation systems, co-visits for complex situations, and warm handoffs between clinical and social support. This model targets members with serious mental illness plus unstable housing, members with multiple chronic conditions plus cognitive impairment, and members with recent hospitalizations plus social isolation. The dosage is 2-4 contacts per week during crises, weekly contact during stable periods, with immediate response within 24 hours to member-initiated contact.

Cost runs $120K annually for a nurse-CHW dyad serving 25 members, which equals $4,800 per member per year or $400 PMPM. The ROI pathway is preventing hospitalizations at $15K+ each, reducing ED visits at $1,200 each, maintaining medication adherence to prevent disease progression, and keeping members enrolled to avoid churn costs of $200-400 per disenrollment-reenrollment cycle. You break even preventing 6-8 hospitalizations annually across the 25-member panel.

Model 2: Community Health Worker-Intensive Model

This model uses CHWs carrying smaller caseloads of 15-20 members with intensive support focus rather than traditional care coordination. The CHW meets members in community settings rather than offices, accompanies them to all appointments including medical visits, social services, and work requirement verification, handles all documentation gathering and submission, texts or calls daily during unstable periods, builds relationships that enable honest disclosure of problems, navigates crises with immediate response, and connects members to every available community resource. One nurse care manager supervises 3-4 CHWs, providing clinical guidance and handling medical complexity beyond CHW scope.

This model targets members who need intensive support but whose medical complexity doesn't require nurse-level intervention – those facing work requirement documentation challenges, social service navigation needs, mental health support needs, or substance use recovery support. The dosage is daily contact during crises, 2-3 times weekly during maintenance periods, with the CHW available by phone or text throughout the week.

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Cost is $60K per CHW serving 20 members, which equals $3K per member per year or $250 PMPM. The ROI pathway involves lower cost than the dyad model, more cultural competence for diverse populations, and scalability to larger numbers. It prevents coverage loss and avoids churn costs, reduces emergency utilization, and maintains primary care engagement.

Model 3: Flexible Funds Plus Intensive Care Management

This model enhances traditional care coordination with flexible spending authority of $500-2,000 per member annually for barrier reduction. The care coordinator handles standard care coordination activities but has authority to deploy flexible funds without extensive approval processes, maintains weekly contact during high-risk periods and monthly contact during stability, responds rapidly to missed appointments or verification deadlines, coordinates with providers for exemptions, and integrates benefits navigation with health management.

Flexible funds cover transportation through Uber or Lyft credits, bus passes, or car repair, cell phone and data plans enabling communication and portal access, document services like obtaining birth certificates, medical records, and official IDs, work essentials including shoes for jobs, uniforms, and childcare during verification appointments, housing stabilization through security deposits or utility bills preventing shutoffs, and food to prevent medication non-adherence due to hunger.

This model targets members whose barriers are primarily financial rather than capacity-based – they understand what they need to do but lack resources to do it. Cost runs about $3,500 annually for enhanced care management plus $1,500 in flexible funds, totaling $5K per member per year or approximately $417 PMPM. The ROI pathway removes financial barriers that prevent self-management. Members with transportation can attend appointments. Members with cell phones can receive reminders and communicate with providers. Members with stable housing can store medication properly. The model prevents small barriers from becoming large crises.

Model 4: Peer Support With Professional Backup

This model uses peer navigators – people with lived experience who successfully maintained coverage despite challenges – serving 10-15 multiply-burdened members each. A professional care coordinator provides backup and clinical support, supervising 3-4 peer navigators. The peer navigator maintains frequent touchpoints 2-3 times weekly, assists with documentation based on their own experience, provides emotional support and encouragement, engages in shared problem-solving drawing on personal knowledge, models successful navigation, and handles crisis response with escalation to professionals when needed. The professional provides clinical oversight for medical complexity, handles complex case management beyond peer scope, coordinates with providers for specialty care, navigates systems requiring professional credentials, trains and supports peer navigators, and maintains quality oversight.

This model targets members who benefit from peer credibility and shared experience – people in recovery, people with mental illness, and people experiencing homelessness. Cost runs $30K per peer navigator plus $25K in allocated professional time, totaling $55K serving 12 members, which equals $4,583 per member per year or $382 PMPM. The ROI pathway leverages the credibility and trust of peer relationships to enable engagement that professional relationships can't achieve. It costs less than all-professional models. Peers understand barriers firsthand and offer solutions that actually work for the population.

Model 5: Integrated Behavioral Health Plus Care Coordination

This model embeds a licensed behavioral health clinician in the care coordination team, serving 30-50 members requiring behavioral health integration. The behavioral health clinician conducts mental health and substance use assessment and treatment, uses trauma-informed approaches to care, provides crisis

intervention and safety planning, coordinates medication management with psychiatry, supports cognitive and executive function through task breakdown, reminders, and external structure, documents medical exemptions for mental health conditions, and integrates with the medical care team.

Integration addresses mental health barriers to work capacity, supports exemption documentation with clinical expertise, reduces stigma through the integrated model, treats the whole person rather than siloed conditions, and ensures the behavioral health provider understands work requirement context affecting member stress. This model targets multiply-burdened members where mental health or substance use is a primary factor in both medical risk and administrative vulnerability.

Cost is $90K for a behavioral health clinician serving 40 members, which equals $2,250 per member per year or $188 PMPM. The ROI pathway addresses root causes of administrative vulnerability, prevents psychiatric hospitalization at $10K+ per admission, improves medication adherence for all conditions, and stabilizes social functioning enabling work and documentation capacity.

Solving the Exemption Documentation Problem

Multiply-burdened members are most likely to qualify for exemptions and least able to document them. Standard exemption processes fail predictably.

The invisible disability problem manifests when mental health conditions, chronic pain, episodic illnesses, and cognitive impairments don't present obviously. Provider documentation focuses on diagnosis rather than functional capacity. Forms ask whether someone can work, but the answer varies by day, by treatment status, by current stressors. The solution requires shifting from diagnosis-based to function-based exemption documentation through simplified attestation forms with checkboxes stating "This patient cannot consistently meet work requirements due to medical condition." Care coordinators should initiate exemption applications rather than waiting for members to navigate the process. Comprehensive functional assessment should document work barriers. Integration with disability determination processes means SSI or SSDI applications should trigger automatic medical exemptions.

The episodic condition challenge arises when someone with bipolar disorder, multiple sclerosis, rheumatoid arthritis, or migraines can work when stable but not during exacerbations. The solution involves variable hour accommodations averaging compliance over longer periods – 40 hours during bad months, 80 or more during good months, averaging 60 over six months. Rapid exemption processes should trigger automatically based on healthcare utilization patterns including hospitalization, ED visits, and increased pharmacy fills. Providers need authority to temporarily adjust requirements during acute episodes. Members need graduated return to full requirements after medical interventions stabilize their condition.

The caregiving documentation burden emerges because proving caregiving responsibilities requires documentation that invades privacy or doesn't exist. The solution uses self-attestation with limited verification – birth certificates for children, not hour-by-hour care logs. Medical providers can confirm care recipient's needs without detailed care plans. Presumptive eligibility should cover parents of children under certain ages. Recognition of kinship care must include grandparents, siblings, and extended family raising children. Domestic violence exemptions shouldn't require police reports or protective orders.

The language and literacy barrier exists because exemption processes assume English literacy and bureaucratic system familiarity. The solution provides in-language exemption applications using culturally adapted processes, not just translated documents. Verbal applications with interpreter support should be standard. Visual documentation through photos or videos can replace written statements. Community organizations can facilitate applications as trusted intermediaries. Simplified language at fifth-grade reading level maximum makes materials accessible. Mobile apps for photographing documents and secure storage accessible to members and care teams streamline the process.

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The Verification Facilitation Challenge

Multiply-burdened members face exceptional verification complexity. Traditional self-navigation fails. MCOs need verification facilitation infrastructure addressing multiple employment patterns.

For gig economy workers, platform partnerships enable automated reporting with the MCO as intermediary. Bank statement verification can show deposits from platforms. Self-attestation with sampling audit rather than universal documentation reduces burden. Aggregate monthly earnings work better than hourly tracking.

For members with multiple part-time jobs, MCO verification concierge services consolidate documentation from multiple employers. Payroll processor partnerships work when any job uses ADP, Paychex, or Gusto. Care coordinators can reach out directly to employers on the member's behalf with appropriate authorization. Simplified verification should accept total hours from any combination of sources.

For seasonal and irregular work patterns, annual averaging of 960 hours annually works better than 80 monthly. Carry-forward of excess hours from high months should cover low months. Automatic exemptions during known off-seasons for certain industries prevent unfair penalties. Recognition of seasonal work patterns in verification design ensures agricultural, tourism, and retail workers aren't penalized for employment patterns beyond their control.

For informal economy work including babysitting, yard work, house cleaning, and handyman work, self-attestation with client or employer confirmation letters provides reasonable verification. Community organization verification through trusted intermediaries offers alternatives. Lower verification standards with higher audit rates acknowledge reality. Recognition that documentation burden may be impossible for legitimate work is essential.

For self-employment, simplified documentation using calendar logs suffices. Tax return provisions accepting quarterly estimated tax payments provide proof. Invoice and receipt documentation works. Business license or registration should count as qualifying activity – starting a business counts as work.

Technology infrastructure supporting all these approaches includes mobile apps for photographing documents, secure document storage accessible to members and care teams, automated reminders for expiring exemptions or upcoming deadlines, templates and checklists for each verification type, and direct submission from app to state systems with member consent.

The key insight: MCO-facilitated verification treats the health plan as intermediary rather than observer. Members provide information to the MCO through easier channels, the MCO handles state submission and documentation formatting. This requires state agreement that MCO submissions are acceptable and data-sharing agreements enabling submission with appropriate consent.

The Ethical Tensions MCOs Must Navigate

Intensive support for multiply-burdened members raises profound ethical questions that don't have clean answers.

The first tension asks when support is enabling versus infantilizing. Helping people navigate systems can shade into doing everything for them. Where's the line between meeting people where they are and removing all responsibility? The balance requires meeting current capacity honestly – someone with cognitive impairment genuinely can't navigate bureaucracy alone. Build capacity over time through modeling and teaching. Recognize some barriers won't resolve and permanent accommodation is appropriate. Let members define their own goals rather than imposing your vision of independence.

The second tension involves allocating scarce resources fairly. You can't provide dyad care coordination to everyone who might benefit. How do you decide who gets intensive support? The framework requires triaging

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by immediacy of crisis – who loses coverage or health soonest without intervention? Time-limited intensive support with graduation goals expects members to need less over time as capacity builds. Graduated support levels start with highest-risk members for intensive models, then transition to moderate-risk models as they stabilize. Transparent criteria for resource allocation prevent arbitrary decisions.

The third tension questions when administrative support crosses into doing work that maintains dependency. If you handle all documentation, scheduling, and system navigation, do members ever develop capacity to manage independently? The approach involves teaching while doing – walk members through processes rather than just handling them. Use graduated responsibility transfer where you handle it the first time while explaining, do it together the second time, member handles with support the third time, and member handles independently the fourth time. Accept that some members won't ever manage independently and that's not failure.

The fourth tension asks how to serve members without reinforcing the administrative burden system you're trying to help them navigate. Does excellent MCO support for work requirement documentation make the system sustainable when it should be redesigned? Yes, effective support makes dysfunctional systems work better. But letting members suffer to prove the system is broken isn't ethical either. The solution requires simultaneous support and advocacy – help members navigate while documenting system failures and advocating for policy change.

What Success Actually Looks Like

Don't measure success by compliance rates alone. Success for multiply-burdened members looks different across multiple dimensions.

Coverage stability shows through fewer disenrollments, faster re-enrollment when gaps occur, and shorter gap duration when coverage is lost. Crisis reduction manifests as fewer hospitalizations, fewer ED visits for primary care-manageable conditions, and fewer psychiatric crises. Basic stability means stable housing, food security, and medication access maintained through coverage disruptions.

Capacity building appears when members gradually need less intensive support, develop skills to manage independently, and successfully navigate one system that previously overwhelmed them. Trust development emerges when members reach out before crises instead of disappearing, accept help instead of declining services, and advocate for themselves with confidence.

Exemption success means eligible members receive appropriate exemptions, exemptions process efficiently, and members maintain exemptions through renewal periods. Member experience matters when members report that support felt helpful rather than intrusive, feel respected and heard, and maintain dignity throughout interactions.

Track these outcomes in addition to traditional utilization and cost metrics. They better reflect whether you're actually helping the multiply-burdened rather than just managing them.

The 14-Month Implementation Reality

You have 14 months until December 2026. That's enough time to pilot intensive support models but not enough to perfect them.

During months one through three, identify the multiply-burdened population using risk stratification. Develop or acquire intensive support model infrastructure. Establish partnerships with behavioral health providers, CHW organizations, and peer support programs. Design workflows integrating work requirement support into care coordination.

During months four through six, pilot intensive support models with 100-200 members. Test verification facilitation infrastructure. Develop exemption documentation protocols with provider partners. Build flexible funding mechanisms. Train care coordination teams on new approaches.

During months seven through ten, scale successful pilot elements. Refine models based on member feedback and outcome data. Expand community partnerships. Increase flexible funding allocations based on actual needs. Integrate behavioral health support more deeply across all models.

During months eleven through fourteen, finalize all intensive support models. Train all relevant staff. Establish member identification and referral processes. Set up monitoring and quality assurance systems. Prepare for December 2026 launch with full infrastructure operational.

Accept that you won't serve every multiply-burdened member with intensive models immediately. Start with highest-risk members – those with recent hospitalizations, serious mental illness, unstable housing, or multiple chronic conditions. Expand as you demonstrate effectiveness and secure additional resources.

Conclusion: Beyond Stratification

Standard stratification logic says avoid multiply-burdened members. Too expensive, too unstable, too resource-intensive. But work requirements make avoidance impossible. These members are your population whether you invest or not. The question is whether they receive support that maintains health and coverage or whether they cycle through crisis and coverage loss repeatedly.

The business case for intensive support isn't overwhelming but it's real. Prevention costs less than repeated crisis management. Stability in even a subset of multiply-burdened members improves quality metrics. Documentation of actual costs supports contract negotiations. Capability with complex populations differentiates your organization.

More fundamentally, these are the members who need MCOs most. If Medicaid managed care can't figure out how to serve people facing medical risk, social complexity, and administrative barriers simultaneously, what's the point? This is the core competency challenge for the work requirements era.

Build intensive support models that actually work for multiply-burdened members. Document what works and what doesn't. Advocate for policy changes that reduce unnecessary administrative burden. Support members through the complexity while pushing to reduce that complexity. That's the path forward.

The multiply-burdened aren't edge cases. They're the stress test for whether MCOs can deliver on the Medicaid mission when that mission becomes conditional.

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Appendix: Common Profiles of Multiply-Burdened Populations

Understanding Intersectional Complexity

The multiply-burdened aren't a single population. They're people at intersections of medical complexity, social vulnerability, and administrative barriers. These profiles help MCOs recognize patterns, but remember: each individual has unique circumstances requiring personalized support.

Profile 1: The Gig Economy Worker with Chronic Condition

Medical: Type 2 diabetes requiring insulin, hypertension, early stage kidney disease **Employment**: Drives for Uber/DoorDash, income varies $800-2,200 monthly, no employer-sponsored benefits **Social**: Lives alone in one-bedroom apartment, limited family support, smartphone-dependent for everything **Administrative**: No traditional paystubs, income fluctuates week to week, platform doesn't provide standard verification

Why Traditional Systems Fail: Care coordination assumes stable income and employment documentation. Verification systems assume employer-issued paystubs. Disease management assumes ability to afford copays and medications during low-income weeks.

What This Person Needs: Flexible verification accepting platform earnings data or bank deposits. Pharmacy assistance bridging low-income periods. Diabetes supplies delivered rather than requiring pickup during work hours. Care coordinator who understands gig economy employment patterns.

Prevalence: 10-15% of expansion populations in urban/suburban areas, higher in cities with large gig economies.

Profile 2: The Single Mother with Mental Health Challenges

Medical: Major depressive disorder, episodic – functional for weeks then barely able to work. Medication helps but takes time to stabilize. **Employment**: Retail, 25-30 hours weekly, works when able but job instability due to mental health episodes **Social**: Single mother, two children (ages 4 and 7), limited childcare options, relies on family when available **Administrative**: Misses verification deadlines during depressive episodes. Can't navigate exemption documentation when struggling. Childcare conflicts with verification appointments.

Why Traditional Systems Fail: Monthly verification doesn't accommodate episodic capacity. Mental health exemptions require documentation during periods when seeking help is hardest. Childcare needs conflict with administrative requirements.

What This Person Needs: Caregiver exemption for parent of young children. Episodic disability recognition with flexible compliance during stable periods. Care coordinator proactive outreach during episodes. Integrated behavioral health support addressing mental health alongside work requirement navigation.

Prevalence: 15-20% of expansion populations, particularly single-parent households.

Profile 3: The Seasonal Agricultural Worker

Medical: Chronic back pain from physical labor, diabetes, no regular primary care – uses ED when crises happen **Employment**: Agricultural work during harvest (March-October), 60-80 hour weeks. Minimal work November-February. **Social**: Lives in rural area, limited English proficiency (Spanish primary), extended family network for mutual support **Administrative**: Works harvest season but can't meet monthly hour requirements year-round. Language barriers complicate verification. Rural location limits volunteer opportunities during off-season.

Why Traditional Systems Fail: Monthly requirements don't accommodate seasonal employment patterns. Verification systems assume consistent monthly hours. Rural areas lack alternative qualifying activities during off-season. Language barriers make navigation difficult.

What This Person Needs: Annual averaging recognizing seasonal work patterns. Spanish-language interfaces and support. Rural-appropriate exemption categories. Community health worker with agricultural worker experience understanding seasonal employment realities.

Prevalence: 5-10% in agricultural states (California Central Valley, Eastern Washington, Texas Rio Grande Valley, Florida, Georgia).

Profile 4: The Older Adult with Multiple Chronic Conditions

Medical: 58 years old, hypertension, diabetes, osteoarthritis limiting mobility, early stage COPD from smoking history **Employment**: Previously worked construction, now physically unable. Doing occasional handyman work for cash, 10-20 hours monthly when able. **Social**: Lives with adult daughter who works full-time. Providing childcare for grandchildren after school. Limited transportation – daughter's car. **Administrative**: Doesn't meet work hours through paid employment. Caregiving for grandchildren doesn't qualify. Medical conditions qualify for disability but SSI application pending (12+ month wait). Can't document cash handyman work with traditional paystubs.

Why Traditional Systems Fail: Too young for age exemption (some states). Disability exemption pending but not approved. Caregiving grandchildren may not qualify depending on custody arrangements. Cash economy work difficult to verify.

What This Person Needs: Immediate medical exemption based on functional assessment, not waiting for SSI approval. Recognition of grandparent caregiving. Cash economy work verification through client attestation or community validation. Transportation assistance to medical appointments for exemption documentation.

Prevalence: 8-12% of expansion populations approaching age 60 with chronic conditions and work limitations.

Profile 5: The Domestic Violence Survivor

Medical: PTSD, anxiety disorder, chronic pain from past injuries, avoids healthcare system due to trauma **Employment**: Recently left abusive relationship, living in shelter, actively job searching but no employment yet **Social**: No family support (family sided with abuser). In domestic violence shelter with three children. Seeking permanent housing and safety. **Administrative**: Can't provide stable address for correspondence. Afraid to document domestic violence (protective order would reveal location). Not working yet but actively searching. Children's school enrollment in flux.

Why Traditional Systems Fail: Verification requires stable contact information. Domestic violence exemption requires documentation that threatens safety. Housing instability prevents receiving mail notifications. Trauma makes system navigation overwhelming.

What This Person Needs: Domestic violence exemption without requiring protective order or police report – provider attestation sufficient. Alternative contact methods (shelter case manager, email). Trauma-informed care coordinator. Immediate connection to shelter-based healthcare rather than waiting for permanent housing.

Prevalence: 3-5% of expansion populations, underreported due to safety concerns.

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Profile 6: The Person in Substance Use Recovery

Medical: Opioid use disorder in recovery, currently in outpatient treatment program three times weekly. Hepatitis C from past injection drug use. Depression and anxiety. **Employment**: Recently completed residential treatment, now in sober living house, working part-time at coffee shop (20 hours weekly), attending treatment **Social**: Estranged from family, building new support network through recovery community, transportation via bus (1.5 hours each way to treatment) **Administrative**: Treatment hours count toward work requirements but documentation is complicated. Part-time job plus treatment hours might total 80 but coordinating verification from both is difficult. Housing in sober living is contingent on treatment compliance and employment.

Why Traditional Systems Fail: Verification from treatment programs isn't standardized. Combining hours from employment plus treatment requires coordinating two different verification sources. Recovery is fragile – administrative stress risks relapse.

What This Person Needs: Treatment hours automatically counting toward requirements with provider attestation. Substance use disorder treatment exemption during early recovery. Care coordinator understanding that administrative burden threatens recovery. Integrated behavioral health and medical care.

Prevalence: 8-10% of expansion populations, varies significantly by region and opioid epidemic impact.

Profile 7: The Recently Released from Incarceration

Medical: Untreated chronic conditions during incarceration (diabetes, hypertension), mental health challenges (depression, PTSD from incarceration) **Employment**: Seeking employment but criminal record creates barriers, enrolled in job training program through re-entry organization **Social**: Living in transitional housing, limited family support, no transportation, rebuilding life after 5-year sentence **Administrative**: Job training should count toward requirements but verification from re-entry program is unfamiliar to state systems. No employment history recent enough for verification. No stable address or phone yet.

Why Traditional Systems Fail: Criminal background checks by employers limit job options. Re-entry programs may not know how to provide acceptable verification. No recent work history for immediate employment verification. Transitional housing addresses change frequently.

What This Person Needs: Job training and re-entry program hours counted automatically toward requirements. Care coordinator connected to re-entry services. Healthcare re-establishment priority given untreated conditions during incarceration. Employment services understanding criminal justice involvement.

Prevalence: 2-4% of expansion populations, concentrated in states with high incarceration rates.

Profile 8: The Rural Resident with Limited Infrastructure

Medical: Rheumatoid arthritis with episodic flares limiting hand/joint function, requires specialty care 90 miles away **Employment**: Works 15 hours weekly at local gas station (only employer in 20-mile radius), wants more hours but none available locally **Social**: Lives 35 miles from nearest town, no public transportation, unreliable used car, limited broadband/cell service **Administrative**: Can't reach 80 hours monthly with only local employer. No volunteer opportunities within reasonable distance. Can't attend verification appointments in county seat (70 miles away). Spotty cell service prevents reliable app use.

Why Traditional Systems Fail: Rural job markets can't provide 80 monthly hours. Geographic isolation prevents access to volunteer opportunities, job training, or appointments. Digital verification assumes reliable internet/cell service. Transportation barriers make everything harder.

What This Person Needs: Reduced hour requirements for high-unemployment rural areas. Phone-based (not app-based) verification systems. Mail or community organization intermediary for verification

submission. Medical exemption for arthritis during flare periods. Recognition that 15 hours weekly may be maximum available employment in rural area.

Prevalence: 12-18% in rural expansion states, higher in most remote areas.

Profile 9: The Immigrant with Limited English and No Documentation

Medical: Diabetes, hypertension, limited health literacy, never had regular healthcare before Medicaid **Employment**: Works in restaurant kitchen, paid cash, 40-50 hours weekly but employer won't provide documentation **Social**: Limited English (Spanish or other language primary), family support within immigrant community, fears authority due to mixed-status family **Administrative**: Employer pays cash to avoid taxes – no paystubs. Fears documentation could impact family members' immigration status. Limited English makes navigation nearly impossible. Doesn't understand work requirement system at all.

Why Traditional Systems Fail: Cash economy employment without documentation. Language barriers prevent understanding requirements. Fear prevents seeking help. Cultural differences in understanding bureaucracy.

What This Person Needs: Multilingual, culturally competent navigation support. Community organization intermediaries trusted in immigrant community. Simplified verification accepting employer letter rather than formal paystubs. Clear communication that work verification won't impact immigration status. In-language materials explaining system clearly.

Prevalence: 5-8% of expansion populations in immigrant-heavy states/cities, significantly underreported.

Profile 10: The Person Experiencing Homelessness

Medical: Serious mental illness (schizophrenia, managed with medication when accessible), diabetes, untreated hypertension, chronic foot problems from living outdoors **Employment**: Occasional day labor, irregular hours, sometimes staying at shelter with work program, sometimes on streets **Social**: Experiencing homelessness for 18 months, limited family contact, connected to street outreach team sporadically **Administrative**: No stable address for mail. No phone or loses phone frequently. Can't maintain documentation. Day labor provides no formal verification. Mental illness affects capacity to navigate any administrative process.

Why Traditional Systems Fail: Every assumption about administrative capacity is wrong. No address for correspondence. No reliable communication method. No ability to maintain documents or remember deadlines. Employment is survival-focused, not documented.

What This Person Needs: Automatic medical exemption based on homelessness plus serious mental illness. Street outreach team authorized to submit verification/exemptions on person's behalf. Healthcare delivered through outreach, not appointments person must attend. Housing first, then worry about work requirements.

Prevalence: 2-3% of expansion populations, concentrated in urban areas, severely underserved.

Common Intersectional Patterns

Across these profiles, certain intersections appear repeatedly:

Medical + Employment Instability: Chronic conditions making traditional employment difficult, leading to gig economy, part-time, or cash work that's hard to verify

Employment Instability + Administrative Barriers: Non-traditional employment (gig, seasonal, cash) creates verification documentation challenges

Medical + Social Isolation: Health conditions plus limited support networks, making navigation without assistance nearly impossible

Social Barriers + Administrative Barriers: Housing instability, language barriers, rural isolation, or transportation limits preventing engagement with verification systems

Multiple Medical Conditions + Age: Older adults not yet qualifying for age exemption but with multiple chronic conditions limiting work capacity

Mental Health + Administrative Capacity: Mental health challenges affecting ability to navigate bureaucracy, remember deadlines, maintain documentation

Trauma + System Distrust: Domestic violence, incarceration history, immigration concerns creating fear of documentation and authority

Using These Profiles

For Risk Stratification: These profiles help identify high-risk members. Someone matching multiple characteristics across profiles needs intensive support.

For Care Coordination Training: Care coordinators need to recognize these patterns and understand why traditional approaches fail.

For Intervention Design: Each profile suggests specific supports needed. Generic care coordination won't work – intersectional barriers require tailored interventions.

For Advocacy and Documentation: When requesting rate increases or policy changes, these profiles illustrate why standard capitation rates don't cover costs of serving multiply-burdened populations.

For System Design: Technology and processes must accommodate these complex situations, not just straightforward cases. If your system doesn't work for Profile 10 (homelessness + serious mental illness), it's not robust enough.

The Critical Recognition

These aren't separate populations requiring separate programs. These are simultaneous realities within your expansion enrollment. The same person might fit multiple profiles as circumstances change. The single mother with depression (Profile 2) who loses housing becomes Profile 5 if fleeing domestic violence, or Profile 10 if homelessness persists.

Effective MCO response doesn't create ten different programs. It creates flexible, adaptive support systems that accommodate intersectional complexity – systems that work for Profile 10 (most complex) will work for everyone else. Design for the hardest cases, and you've designed for the whole population.

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