

The Coordination Architecture

When timing decisions determine who maintains coverage

Exemption rules and verification systems mean nothing without coordination mechanisms determining when people face requirements, how long they have to respond, what happens during transitions, and how multiple systems synchronize. ***These timing choices create the difference between orderly implementation where people have realistic opportunities to comply and chaotic rollout where procedural failures cascade into coverage losses.***

The fundamental coordination question is whether states prioritize efficiency gains from synchronized processes or coverage protection from staggered timelines. Synchronized systems concentrate administrative burden into predictable periods enabling staffing optimization, employer preparation, and community organization capacity planning. Staggered systems distribute workload across time, preventing overwhelming volume spikes but creating continuous processing demands. The choice reveals whether states design for administrative convenience or individual protection.

This tension manifests in dozens of specific regulatory decisions. Redetermination scheduling either concentrates eligibility renewals in June and December or distributes them across twelve months. Grace periods either provide generous transition time acknowledging that change takes time or impose tight deadlines prioritizing rapid compliance determination. Appeals timelines either protect coverage during dispute resolution or terminate benefits during processing. Communication cadences either warn people months in advance or notify them shortly before deadlines. Each choice shapes coverage outcomes through procedural architecture rather than substantive eligibility criteria.

The Redetermination Synchronization Question

Expansion adults face semi-annual redetermination starting January 2027, six months after December 2026 work requirement implementation. ***States must decide whether everyone faces redetermination simultaneously in synchronized cycles or redetermination dates stagger across the year based on enrollment dates, birth months, or administrative assignment.*** This choice determines volume patterns, system capacity requirements, employer coordination needs, and individual attention possibilities.

Synchronized cycles concentrate all renewals in June and December, creating predictable volume spikes. Advantages flow from predictability itself. States can plan staffing surges hiring temporary workers for renewal months. Employers know verification requests arrive June and December, enabling preparation. Community organizations can concentrate outreach and assistance during renewal periods. Training and communication campaigns occur twice annually rather than continuously. System testing happens before known deadline periods. Exemption validity periods align clearly with six-month cycles.

But synchronized cycles create overwhelming volume during renewal months. Perhaps 500,000 to 2 million people in large states face simultaneous redetermination requiring verification review, exemption processing, and compliance determination within compressed timeframes. System capacity must handle peak load rather than average load, requiring expensive infrastructure used intensively two months yearly. Provider bottlenecks emerge as everyone seeks medical exemption documentation simultaneously. Eligibility workers cannot give individualized attention when processing thousands of cases monthly. Any system failures affect the entire population rather than subsets. The June and December months become frantic processing periods with limited error recovery time.

The political economy of synchronized cycles benefits administrators at the expense of individuals.

Concentrated processing enables administrative efficiency through specialization, batch operations, and temporary surge capacity. But individuals lose the flexibility of calling when convenient, submitting

documentation without competing against thousands of simultaneous requests, and receiving personalized assistance from workers not overwhelmed by volume. States choosing synchronized cycles prioritize administrative management over individual experience.

Staggered cycles distribute renewals across twelve months, typically tied to enrollment dates, birth months, or initial eligibility determinations. This creates continuous moderate volume rather than dramatic spikes. System capacity requirements drop significantly since infrastructure handles average daily load rather than peak monthly demand. Staff can provide individualized attention to cases since workload distributes across time. Provider capacity remains accessible year-round rather than overwhelming during specific months. System problems affect monthly cohorts rather than entire populations, enabling contained fixes.

The administrative challenges are real. Employers face continuous verification requests as different employees hit redetermination throughout the year. Tracking complexity increases since every individual has different renewal months requiring individualized monitoring rather than universal processing cycles. Communication must individualize to specific renewal dates rather than conducting mass campaigns. Grace periods and transitions vary by individual rather than following universal calendars. Exemption validity tracking requires individual expiration management rather than synchronized six-month periods.

The recommended approach varies by state size. Small states with under 100,000 expansion adults may find synchronized cycles manageable given lower absolute volumes. The advantages of predictability and concentrated resources outweigh system strain when peak load involves perhaps 50,000 biannual renewals. Large states exceeding 500,000 expansion adults face peak loads of 250,000-plus creating system overload risks. Staggered approaches become essential to prevent volume from overwhelming capacity.

Birth month staggering offers middle ground creating two large cohorts rather than twelve small ones. People born January through June renew in June. Those born July through December renew in December. This concentrates population into two groups maintaining some communication efficiency and employer predictability while reducing peak volumes by 50% compared to universal synchronization. Regional staggering by county creates geographic concentration enabling targeted support resources while distributing volume temporally.

Grace Period Philosophy

Grace periods determine how much time people have to respond to requirement changes, complete exemption applications, establish verification pathways, or transition between circumstances. These timing decisions reveal state assumptions about reasonable compliance timeframes, bureaucratic complexity, individual capacity, and appropriate consequences for delayed response.

First-time requirement transitions affect people who never faced work requirements before, whether from new enrollment, aging into requirements at 19, or exemption expiration. States can impose immediate compliance expectations or provide transition periods recognizing that understanding requirements, establishing verification systems, finding qualifying activities, or completing exemption applications takes time.

A 90-day grace period before requirements begin allows people to receive education about requirements, explore exemption eligibility, register with workforce systems, establish employment or qualifying activities, and set up verification pathways without coverage consequences. This acknowledges that compliance infrastructure takes time to establish. Someone turning 19 on March 15 gets grace period through June 15, with requirements beginning June 16 and first compliance determination end of July. This provides roughly four months from initial notice to first consequence, creating realistic compliance timelines.

Thirty-day grace periods reflect skepticism about whether people need extended time to understand and comply with requirements. States choosing shorter grace periods implicitly assume that requirements are



simple enough for rapid compliance or that longer grace periods enable avoidance behavior. The philosophical question is whether states design timing assuming people want to comply and need support, or assuming people will delay compliance without tight deadlines.

Job loss creates sudden transitions from compliant status to potential non-compliance. Someone working full-time loses employment unexpectedly through layoffs, business closures, firings, health crises, or family emergencies. Immediate requirement imposition means coverage loss within the month without time for job search, unemployment registration, or exemption application.

Sixty-day grace periods from job loss provide time for new job searches, unemployment benefit registration potentially creating automatic exemptions, assessment of whether barriers are temporary or require exemptions, and exemption applications if needed. Implementation requires job loss detection through employer reporting or verification gaps, triggering automatic grace periods. This prevents coverage loss during the immediate post-job-loss period when people are least equipped to navigate bureaucracy while dealing with economic stress.

States can impose shorter grace periods assuming rapid re-employment for people recently working, or eliminate grace periods entirely treating job loss as immediate requirement failure. These choices reflect assumptions about labor market tightness, re-employment ease, and whether coverage maintenance during transitions serves policy goals or enables avoidance.

Exemption Expiration Transitions

Temporary exemptions eventually expire when conditions resolve. Someone recovers from surgery, completes substance use disorder treatment, or finishes caregiving responsibilities. States must decide whether transitions from exempt status to requirements occur immediately at expiration or include grace periods acknowledging recovery and adjustment time.

Grace periods proportional to original exemption duration create graduated transitions. A 30-day surgical recovery exemption includes 30-day grace period totaling 60 days before full requirements begin. Six-month substance use disorder treatment exemption gets 180-day grace period totaling 12 months. Twelve-month pregnancy and postpartum exemption receives 180-day grace period totaling 18 months. The logic is that longer exemptions indicate more significant barriers requiring more transition time after resolution.

This proportionality creates administrative complexity tracking individual grace periods rather than applying universal standards. But it acknowledges that someone recovering from major surgery needs different transition time than someone completing brief treatment. Substance use disorder recovery particularly requires extended transition since early recovery involves treatment engagement, support groups, and counseling incompatible with immediate full-time work.

States can impose universal grace periods, perhaps 90 days regardless of exemption type, simplifying administration while providing consistent transition time. Or states can eliminate grace periods entirely, requiring immediate compliance at exemption expiration. This last approach assumes that exemption expiration means full capacity restoration, ignoring realities that medical clearance for work often precedes practical ability to find employment or rebuild work capacity.

The Appeals Architecture

Appeals determine whether exemption denials or non-compliance determinations can be challenged while maintaining coverage. Coverage continuation during appeals prevents harm from erroneous determinations but extends coverage during dispute periods. States must balance protecting people from wrongful coverage loss against concerns about extended coverage based on disputed determinations.

Standard appeals allow 90 days to file after denial notices, recognizing that people need time to understand denials, gather documentation, and file challenges. Coverage continues presumptively during appeals preventing gaps while disputes resolve. State review completes within 45 days, creating maximum 135-day dispute periods from denial to final determination. This timeline balances individual protection against extended coverage uncertainty.

Compressed appeals impose shorter filing periods, perhaps 30 days, and faster state review, perhaps 15 days, creating 45-day maximum dispute periods. This reduces coverage extension during appeals but may not provide adequate time for people to respond, particularly those dealing with circumstances that caused exemption needs. The question is whether states prioritize administrative finality or protection from erroneous determinations.

Coverage continuation during appeals is the critical choice. States maintaining coverage presumptively during disputes prevent harm from wrong denials. Someone whose medical exemption is erroneously denied doesn't lose healthcare access during appeal, preventing health deterioration from coverage gaps. The cost is providing coverage during disputes that may ultimately confirm ineligibility, extending coverage perhaps 60-90 days beyond appropriate termination dates for people legitimately ineligible.

States terminating coverage during appeals create immediate consequences from denials, incentivizing rapid appeals but causing harm when denials are wrong. Someone whose exemption should have been approved experiences coverage loss during the appeal process, potentially lasting months and causing health consequences. Even successful appeals don't undo harm from coverage gaps during dispute resolution.

Medical exemption appeals particularly require specialized review. Eligibility workers lack medical training to evaluate functional capacity determinations made by physicians. States can require medical exemption denials be reviewed by medical professionals not employed by the state, creating independent assessment with appropriate expertise. This costs more than standard appeals but provides legitimate medical judgment in disputes about work capacity. States can save money using standard eligibility workers for medical reviews but risk inappropriate overrides of clinical determinations.

Expedited appeals become available for urgent medical circumstances where continued treatment depends on coverage. Active cancer treatment, chronic conditions requiring continuous medication, pregnancy, mental health crises, and dialysis create situations where coverage loss causes immediate health harm. Expedited appeals require state review within three business days, preventing prolonged coverage gaps during urgent medical need.

System Failure Accommodation

Even well-designed verification and exemption systems fail. Employer submission systems crash. Provider portals experience outages. State eligibility systems have bugs. Mail gets lost. Internet access interrupts. The coordination architecture must accommodate predictable system failures without penalizing people for infrastructure problems.

Automatic extensions when state systems are unavailable protect people from consequences of government system failures. If verification portals are down during reporting periods, deadlines extend automatically by the outage duration plus grace periods for submission after restoration. This is administratively complex requiring tracking system availability and individual deadline adjustments, but prevents coverage loss from state technical failures.

Alternative submission pathways provide backup when primary systems fail. Someone unable to access web portals can email verification. Someone without internet can mail paper forms. Someone without employer

reporting can self-attest with audit risk. These alternatives reduce efficiency gains from automation but prevent single points of failure from creating coverage loss.

Error correction processes determine what happens when people discover verification mistakes after deadlines pass. Maybe employer submitted wrong hours. Maybe state system didn't receive submission that went through. Maybe individual thought exemption was still valid when it expired. States can allow retroactive corrections within reasonable timeframes, preventing permanent coverage loss from fixable errors. Or states can treat deadlines as absolute, refusing corrections even when errors are obvious.

The recommended approach maintains coverage during error investigation and correction, accepting short-term coverage uncertainty to prevent harm from technical or administrative mistakes. States refusing error accommodation create irreversible coverage losses from problems outside individual control, undermining legitimacy of work requirements as employment promotion rather than coverage restriction.

Multi-System Synchronization

Work requirements interact with redetermination, managed care enrollment, provider networks, and unemployment insurance. Coordination across these systems determines whether timing creates supportive infrastructure or systemic barriers.

Redetermination and work requirement timing must align to prevent double jeopardy where people face both eligibility renewal and work requirement compliance simultaneously with compressed deadlines.

Synchronized timing creates concentrated challenges. Staggered timing with work requirement compliance midway between redetermination periods distributes burden across time. States can choose concentration for administrative efficiency or distribution for individual protection.

Managed care enrollment changes create verification disruption when members switch plans midyear. Someone losing MCO verification assistance mid-compliance period faces scrambling to establish new submission pathways. States can minimize mid-year plan changes for people approaching compliance deadlines, or allow unrestricted changes accepting verification disruption as cost of choice. The balance between enrollment flexibility and verification stability varies by state priorities.

Provider network changes affect exemption access when someone's physician leaves networks. Medical exemption applications may require establishing new provider relationships midway through exemption periods. States can mandate that MCOs maintain provider access during exemption periods, or accept that network changes occasionally disrupt exemption processes. The first protects exemption access, the second prioritizes health plan flexibility.

Unemployment insurance interaction creates automatic exemptions during benefit receipt but timing gaps between job loss and benefit approval. Someone laid off in January may not receive unemployment approval until March, creating two-month gaps between job loss and automatic exemption. Grace periods during unemployment processing prevent these gaps from causing coverage loss.

The coordination architecture ultimately determines whether procedural systems support people or systematically exclude them. States have eight months between OB3 passage and December 2026 implementation to build coordination systems. The regulatory choices made during this period determine whether timing creates realistic compliance opportunities or procedural traps. The difference between synchronized and staggered systems, generous and minimal grace periods, protective and restrictive appeals, and accommodating versus rigid error correction determines coverage outcomes as much as substantive eligibility rules.

Next in series: Article 7D, "The Delegation Architecture"

Previous in series: Article 7B, "The Verification Architecture"

References

1. Sommers, Benjamin D., et al. "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." *Health Affairs*, vol. 39, no. 9, 2020, pp. 1522-1530.
2. Government Accountability Office. "Medicaid Demonstrations: Improved Oversight Needed for Implementation." GAO-19-315, March 2019.
3. National Academy for State Health Policy. "State Strategies for Medicaid Administrative Simplification." NASHP.org, 2024.
4. Center on Budget and Policy Priorities. "Lessons from SNAP and TANF for Medicaid Work Requirements." CBPP.org, August 2025.
5. Kaiser Family Foundation. "Medicaid Managed Care: State Contracting Practices." KFF.org, June 2025.
6. Mathematica Policy Research. "Evaluation of Early Implementation of Medicaid Work Requirements." Mathematica.org, September 2025.
7. Urban Institute. "Technology Requirements for Work Requirement Implementation." Urban.org, April 2025.
8. National Association of Medicaid Directors. "Work Requirement Implementation Toolkit." NAMD.org, 2025.
9. Georgetown University Health Policy Institute. "Administrative Burden in Medicaid: Evidence and Policy Implications." Georgetown.edu, 2024.
10. Arkansas Department of Human Services. "Arkansas Works Administrative Review and Lessons Learned." DHS.Arkansas.gov, 2019.