Outpacing Washington:

How state Medicaid policies are moving faster—and how MCOs should respond

HealthScape Advisors

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Managed care organizations (MCOs) must simultaneously prepare to navigate both federal and state-level Medicaid policy shifts. While Congress's budget has garnered a well-founded level of discourse recently, state requirement changes also warrant MCOs' attention. This brief highlights notable state-level Medicaid policy changes and offers strategies for MCOs to steadfastly support members and ensure operational and financial sustainability amid market headwinds.

Federal shifts spur state-level action

Congress has advanced changes to Medicaid through the federal budget process, reflecting priorities aligned with the Trump Administration. Lawmakers are seeking to reduce Medicaid spending by implementing policies such as work requirements, more frequent (e.g., semi-annual) eligibility redeterminations, and tighter restrictions on state financing tools like provider taxes. These changes are part of a broader push to increase oversight and control spend on the program over time.

Based on current projections, Medicaid enrollment could decrease across states by anywhere from 4% to 26% by 2034, with states that have expanded Medicaid seeing the greatest losses.[1]

Some states are proactively considering different responses to meet stated federal objectives. Some states intend to fully align with or even exceed the new federal requirements, while others are developing alternative strategies to maintain or advance their existing program scope. For instance, New Mexico's S.B. 88 establishes a trust fund to maintain Medicaid funding in the face of federal cuts.[2]

This dynamic interplay between federal and state actions contributes to a complex and challenging policy landscape for payers, especially those operating across multiple state markets.

Our previous Medicaid executive briefing overviews potential federal policy changes and associated strategic recommendations for health plans.

MCOs must consider the nuances of the states they operate within, given that state governments are already showing signs of either expanding upon or deviating from the federal objectives. MCOs operating in states that intend to proactively meet or exceed federal requirements should start planning operating and business model changes now to support member retention and financial stability.

MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Work requirements

OVERVIEW

At least 15 states are developing and passing legislation that requires adult beneficiaries without underlying health conditions to maintain and regularly report a set number of working hours to remain eligible for Medicaid. Some states are considering implementing work requirements as early as 2026, preceding the effective date of federal requirements.

MCO IMPLICATIONS

States such as Arkansas and Georgia that have previously implemented work requirements struggle to manage administration of these programs. Administrative complexity impacts enrollment levels; a report on Georgia's program infers that beneficiaries with valid qualifying hours may not be enrolling due to reporting complexities.[3] *(Read on for learnings from Georgia's program.)*

MCOs should prepare to experience fluctuating enrollment within the adult population in the near-term and plan to see risk profile shifts as healthy adult members are disenrolled.

STRATEGIC QUESTIONS FOR MCOs

- How many current members would be subject to work requirements under state and federal policies?
- How would the risk profile of membership change in scenarios with a lower proportion of Expansion members? How will these changes in the risk pool impact its financial planning strategy?
- What level of experience does a given state have with administering work requirements? What level of support is expected of MCOs in reporting/validating? Where can or should MCOs proactively lobby regulators for the role of MCOs in work requirement administration?
- What resources and/or education can MCOs provide to members, providers, or other stakeholders, to reduce risk of eligibility termination due to non-compliance with work requirements?

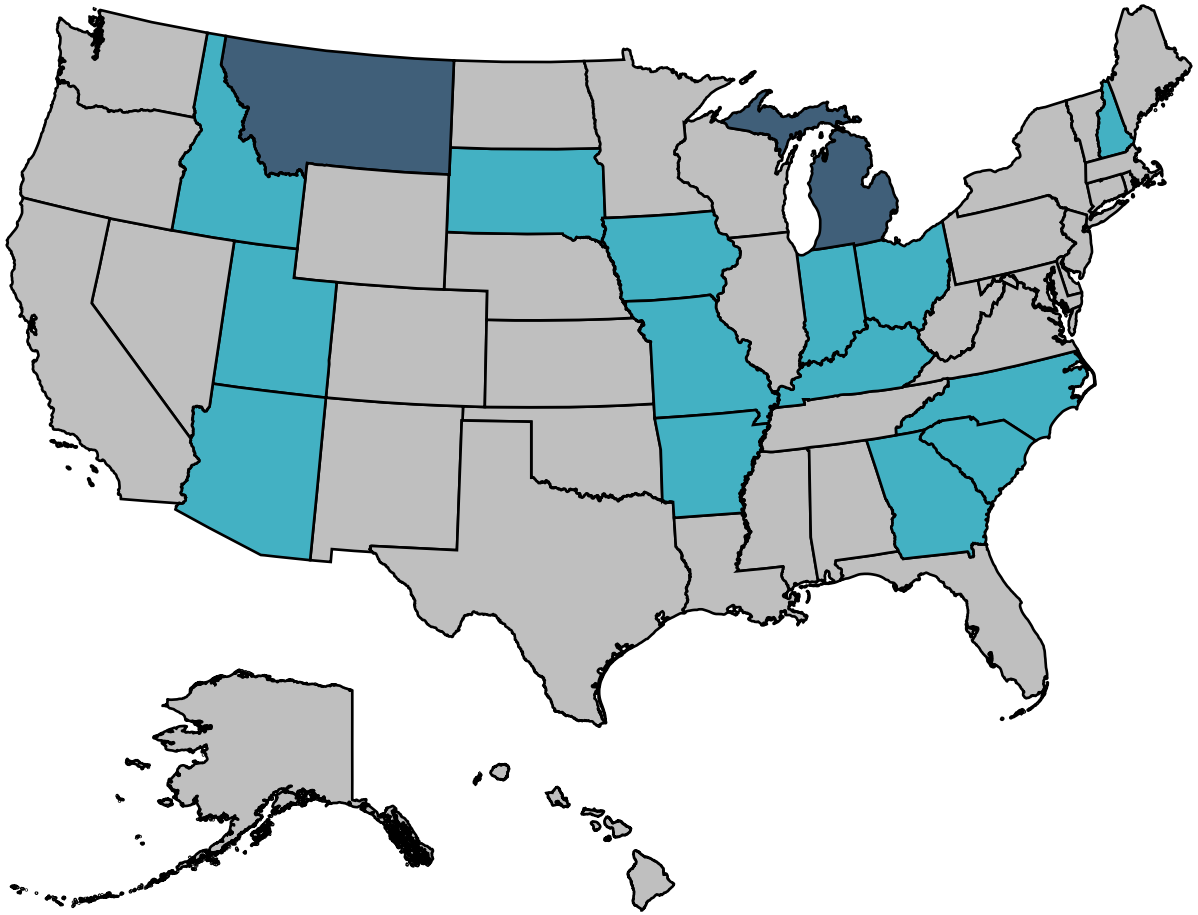
MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Work requirements

Medicaid Work Requirements Policy Map

1. *Work requirements*
2. *Eligibility determinations*
3. *Expansion limitations*



Policy actions tracked here reflect activity from December 2024 – June 2025.

POLICY IN ACTION:

Georgia Pathways work requirements overview

- **Ambitious beginnings:** Launched in July 2023, the state estimated that the program would serve **345,000 eligible individuals.**[4] Pathways offers Medicaid coverage to adults with income up to 100% of the Federal Poverty Level (FPL) who maintain 80 hours of employment, job readiness programs, community service, and/or education per month.[5]
- **Operational challenges:** Since implementation, **the program has faced administrative challenges** such as faulty software, application backlogs, and applicants' difficulty navigating enrollment processes.[6]
- **Dismal enrollment:** As of October 2024, **enrollment reached just over 1%** of original eligibility estimates, with just 4,903 individuals enrolled in Pathways.[7]
- **Lessons from the ground:** Georgia's program demonstrates the challenges states face with work requirements from an administrative perspective and the disruptions and barriers to coverage that can occur as a result. **Payers in states considering work requirements need to consider eligibility maintenance support they can offer members** to reduce risk of coverage disruption and membership fluctuation.
- **MCO strategies for member support:** One way Pathways plans support member eligibility is by offering education around reporting qualifying hours, with some even going as far as connecting members to coaches that support them in finding employment or pursuing a GED.

MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Eligibility determinations

1. *Work requirements*
2. *Eligibility determinations*
3. *Expansion limitations*

OVERVIEW

Some states are looking to increase eligibility determination frequency to disenroll non-eligible individuals. Certain states are considering eligibility determinations that occur more frequently than the new federal requirements, with some proposals requiring eligibility checks as often as monthly.

MCO IMPLICATIONS

While increased eligibility determinations may help states reduce spending, they also increase potential for administrative errors, risking disenrollment of individuals with valid eligibility.

MCOs should anticipate fluctuating enrollment. Eligibility changes may result in more frequent coverage gaps and membership churn. MCOs should ensure they have resources in place to support continuity of care for their members.

STRATEGIC QUESTIONS FOR MCOs

- What kinds of navigation support can MCOs offer to members to reduce risk of eligibility termination? How could MCOs proactively identify members at risk of termination and reach out to them?
- How can MCOs leverage care coordination strategies to support certain populations at risk of fluctuating coverage? What data is available to identify high-risk, high-need patients who may be cycling on and off coverage?
- How can MCOs proactively notify providers of expected eligibility fluctuations and reduce provider abrasion?
- Are MCOs' platforms appropriately configured to handle increased eligibility and membership fluctuations? What other operational changes do MCOs need to consider to adequately prepare for anticipated fluctuations?

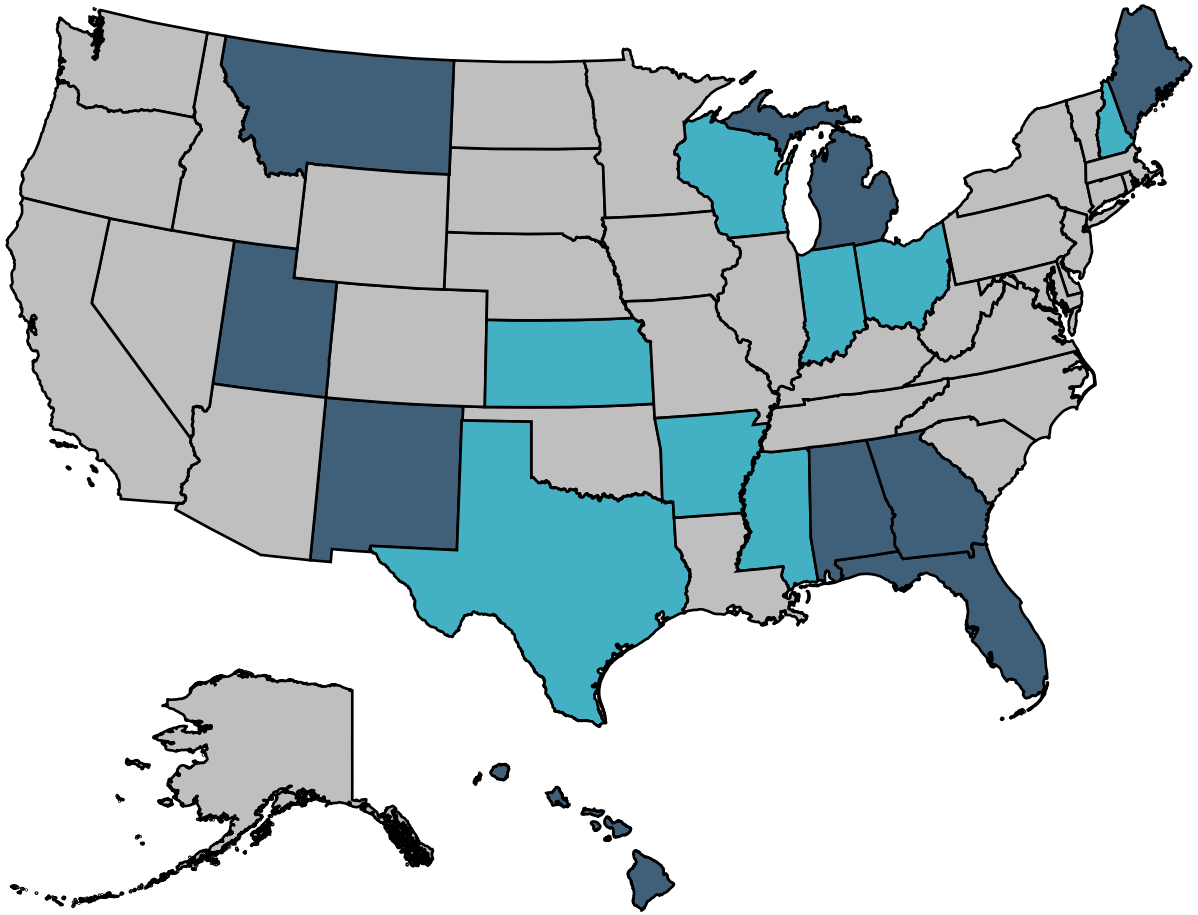
MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Eligibility determinations

Medicaid Eligibility Determination Status Map

1. *Work requirements*
2. *Eligibility determinations*
3. *Expansion limitations*



State Policy Stance

- Loosening requirements
- No notable policies
- Stricter requirements

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MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Expansion limitations

1. *Work requirements*
2. *Eligibility determinations*
3. *Expansion limitations*

OVERVIEW

Many states are falling in line with federal objectives to scale back Expansion population coverage. Several states have either sought to narrow Expansion coverage eligibility criteria or opted to leave trigger laws in place, which would end their Expansion programs if federal funding decreases.

MCO IMPLICATIONS

MCOs should expect to experience lower or plateaued enrollment and associated capitation revenue over time. They should also expect an increase in population risk level, given that Expansion membership typically represents a healthier risk profile.

STRATEGIC QUESTIONS FOR MCOs

- What volume of current members are at risk of losing coverage with eligibility changes?
- Do financial projections and growth strategies account for enrollment changes across markets?
- How can MCOs help members maintain continuity of care? Do they have other low-cost coverage options for newly ineligible members? How will decreased federal subsidization of ACA coverage impact the sustainability of these products?

Note: Any limitations at the federal level to provider tax policies will have varying impacts to providers' reimbursement and corresponding financial sustainability. Any system closures or service scope limitations would also impact MCOs' network adequacy performance. This piece by our Chartis colleagues begins to explore the impact Medicaid cuts could have on rural and safety net providers. Given the lack of state action to date in response to the recent federal limitations on provider taxes, this topic will be covered further in future briefings.

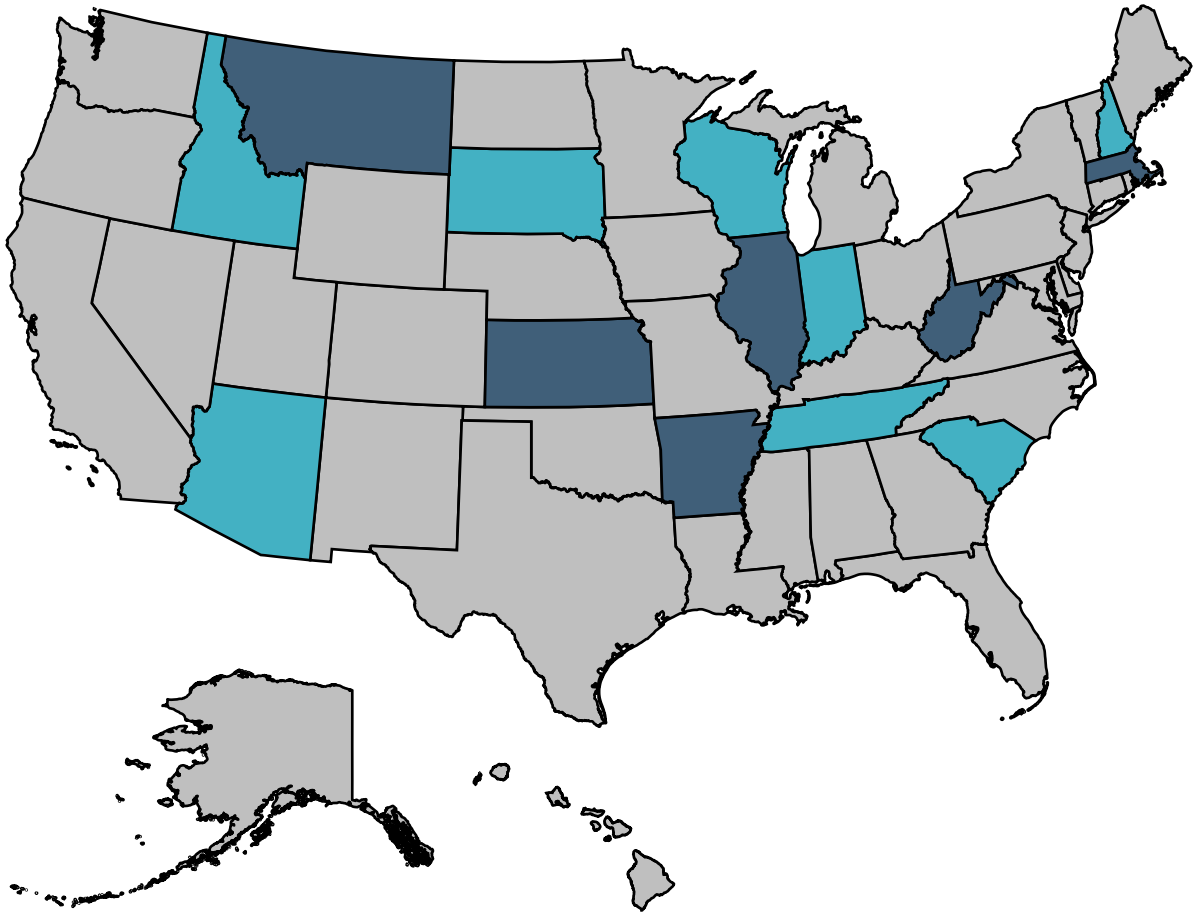
MCOs must proactively prepare for state-level shifts

POLICY CATEGORY

Expansion limitations

Medicaid Expansion Policy Map

1. *Work requirements*
2. *Eligibility determinations*
3. *Expansion limitations*



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MCOs must adapt to upcoming policy changes now

The path forward for MCOs requires vigilance and proactive action. MCOs must monitor relevant state policy environments to understand operational, financial, and strategic impacts of upcoming changes. Below are examples of steps that MCOs can begin to take today to prepare for policy changes at all levels. MCOs must remain active participants in the state landscape and offer critical insights into the potential impacts of different pathways forward.

Market disruption impact assessment

- Inventory relevant policy changes and engage with state agencies and lawmakers on impact mitigation options.
- Create modified enrollment projections and risk profile.
- Update pro forma modeling.

Operational readiness assessment

- Identify future state capabilities driven by state or federal requirement changes. Conduct gap analysis.
- Identify and size investments necessary to ensure readiness and compliance.

Implementation planning

- Prioritize operational changes or other enhancements as near-, mid-, or long-term focus areas.
- Begin implementation of near-term needs, and continue monitoring policy landscape.

By proactively identifying impacts on their business models from different policy scenarios, MCOs can begin planning for necessary adjustments and position themselves for success as state- and federal-level policies, including any federal guidance based on recent federal budget reconciliation activities, are finalized. Sustainable business models will allow these MCOs to continue serving their member populations and continue supporting their provider partners while maintaining strong performance in the market.

Sources

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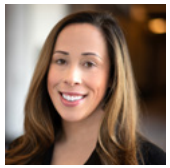
Authors



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The authors would like to thank Ricki Le and Colleen Leahy for their contributions to this research and brief.

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