

HR-1 · ONE BIG BEAUTIFUL BILL ACT

MEDICAID MCO READINESS PLAYBOOK

A practical field guide for Medicaid managed care plan operators preparing for the most significant restructuring of the program since the Affordable Care Act.

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NINE DOMAINS. ONE READINESS POSTURE.

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EXECUTIVE SUMMARY

PLANS THAT ARE WAITING ARE ALREADY BEHIND.

<p>11.8M</p> <p>PROJECTED NEWLY UNINSURED</p> <p>KFF national projection from HR-1 Medicaid changes over a 10-year window.</p>	<p>\$1T</p> <p>FEDERAL SPEND REDUCTION</p> <p>10-year decrease in federal health spending. Costs shift to states and plans.</p>	<p>6 PROVISIONS</p> <p>LIVE BEFORE END OF 2027</p> <p>Redeterminations, CE requirements, retro coverage, immigrant eligibility, SDP caps, provider tax.</p>
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HR-1 / OBBBA is the most significant restructuring of Medicaid since the ACA. Six major provisions take effect before the end of 2027. Federal guidance is still arriving. Early-mover MCOs are already deploying without all the answers, and they will define the operating framework the rest of the market inherits.

A HOW TO USE THIS PLAYBOOK

The playbook is organized around six readiness domains: **Policy, State Engagement, Financial, People, Process, Platform,** and **Member Engagement,** plus a working **Readiness Tracker.** Each section delivers a situation assessment, the key decisions your plan must make, recommended actions, and questions to ask your state regulator. The status columns are built to be used as a live tracker. **This is a living document:** Siftwell will update assumptions through December 2026 as CMS guidance, state decisions, and operational realities evolve.

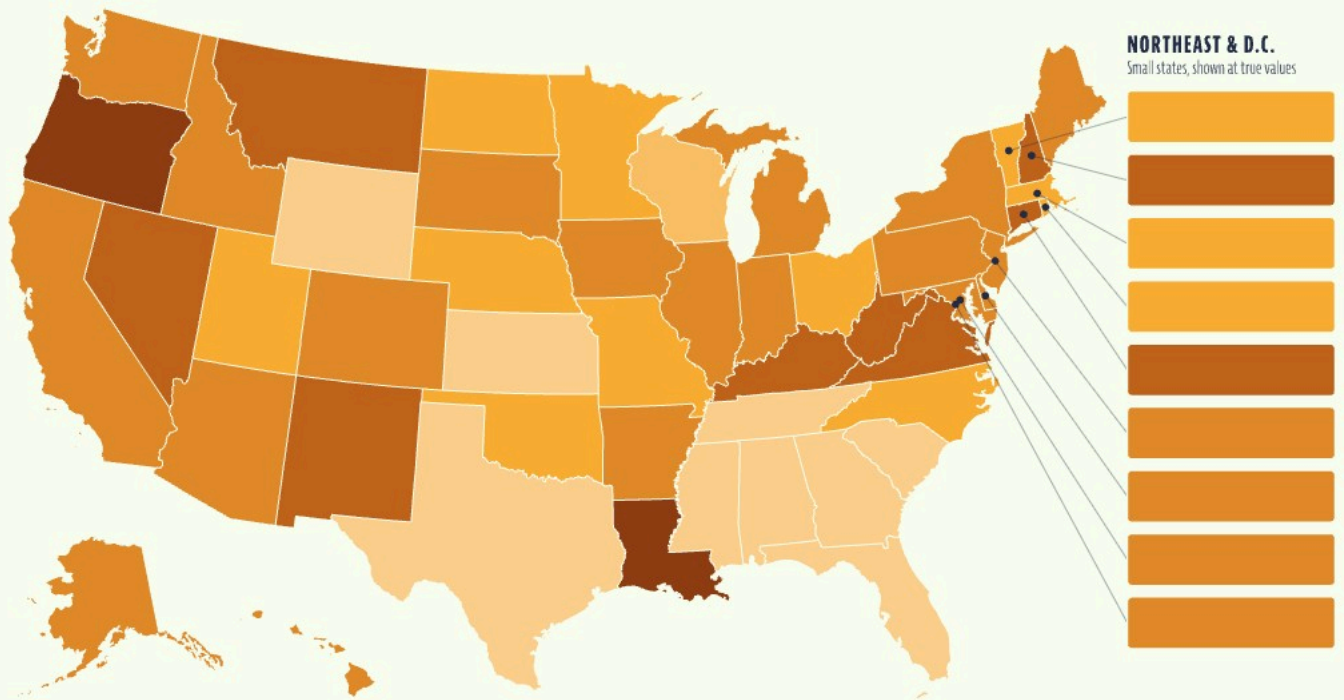
B THE THESIS, IN FIVE TAKEAWAYS

<p>01</p> <p>STATE ENGAGEMENT IS THE HIGHEST IMPACT ACTIVITY RIGHT NOW</p> <p>Medical frailty definitions, messaging governance, data-sharing protocols, and transition options are all being set state-by-state. Move first or live with what's decided.</p>	<p>02</p> <p>FINANCIAL EXPOSURE IS BROADER THAN MEMBERSHIP LOSS</p> <p>Provider tax phase-down and State Directed Payment (SDP) caps will reshape capitation rates independently of enrollment. Model capitation rates now; advocate during the next rate cycle.</p>	<p>03</p> <p>ADMINISTRATIVE CHURN IS THE DOMINANT RISK</p> <p>The PHE unwinding taught us that procedural terminations, not actual ineligibility, drive the costliest re-engagement. Prioritize high-cost, high-churn cohorts.</p>	<p>04</p> <p>MCOs SUPPORT, STATES VERIFY</p> <p>Plans cannot conduct Community Engagement (CE) compliance checks. They can educate, navigate, document, and refer. Build workflows that stay within that boundary and use the navigation space fully, i.e. educating members, helping them document exemptions, and connecting them to resources.</p>	<p>05</p> <p>DON'T WAIT FOR COMPLETE GUIDANCE</p> <p>Build a plan now and make assumptions when you need to. Flag assumption dependencies explicitly. Establish a rapid-cycle update process for when guidance lands. Start with the Tracker on p. 21.</p>
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COVERAGE LOSS, STATE BY STATE

Estimated one-year decline in Medicaid enrollment under the House-passed One Big Beautiful Bill Act (H.R. 1), shown as a share of each state's projected FFY 2028 enrollment, using the midpoint of Manatt's modeled range.

Siftwell is working with health plans across 14 different states, and our numbers are matching up with what Manatt outlines in this model.



SHARE OF ENROLLMENT LOST



NATIONAL TOTALS · FFY 2028 · MIDPOINT ESTIMATE

9.2M
fewer people enrolled in Medicaid

\$127B
total cut in Medicaid spending

FULL STATE DETAIL
See the complete state-by-state midpoint ranges on page 25.

Source: Patricia M. Boozang & Jocelyn A. Guyer, "House Budget Bill Medicaid Proposals: State-by-State Estimates of Impact," *Manatt Health Highlights*, June 3, 2025 (shvs.org). Shading reflects the midpoint estimate of enrollment decline as a share of each state's FFY 2028 baseline (Table A). Nine non-expansion states reflect a single estimate rather than a range.

01 SECTION ONE POLICY LANDSCAPE & IMPLEMENTATION TIMELINE

HR-1 introduces sweeping Medicaid provisions with staggered effective dates spanning 2026 through 2028. No single provision operates in isolation. Their combined effect will reshape enrollment patterns, eligibility operations, provider financing, and plan–state relationships at the same time.

1.1 WHAT CHANGED AND WHY IT MATTERS

The Working Families Tax Cut Legislation, also referred to as the One Big Beautiful Bill Act (OBBBA / HR-1/OB3), was signed into law on July 4, 2025, and represents the most significant restructuring of Medicaid since the Affordable Care Act. For Medicaid managed care organizations, the stakes are high: membership loss, capitation revenue reductions, operational disruption, and reputational risk all hinge on how well plans prepare for implementation.

PROVISION	EFFECTIVE DATE	MCO IMPACT SUMMARY
SIX-MONTH REDETERMINATIONS SEC. 71107	JAN 1, 2027	Doubles eligibility verification events for expansion adults; high administrative-churn risk; significantly higher member outreach burden.
WORK / COMMUNITY ENGAGEMENT SEC. 71119	DEC 31, 2026 (state option to delay to Dec 2028)	Compliance verification required at application and every 6 months. MCOs cannot conduct compliance checks but should support member navigation.
RETROACTIVE COVERAGE REDUCTION SEC. 71112	JAN 1, 2027	1-month retro window for expansion adults; increased uncompensated-care risk for providers; back-dated enrollment disruptions for plans.
COST SHARING FOR EXPANSION ADULTS SEC. 71120	OCT 1, 2028	Up to \$35/service for adults >100% FPL; likely to reduce utilization and increase provider abrasion.
PROVIDER TAX PHASE-DOWN SEC. 71115	2027+	Reduction in allowable provider tax thresholds has the potential to directly affect capitation rate construction and network stability.
STATE DIRECTED PAYMENT CAPS SEC. 71116	2026-2028 PHASED	Legacy SDP arrangements sunset; renegotiation of contracting structures required.
IMMIGRANT ELIGIBILITY RESTRICTIONS	OCT 1, 2026	Enrollment reductions in states with immigrant populations enrolled in Medicaid.
ACA PREMIUM TAX CREDIT EXPIRATION	NOV 1, 2025 (in effect)	Some members transitioning from marketplace back to Medicaid; others becoming uninsured.

1.2 THE GUIDANCE GAP: WHAT WE STILL DON'T KNOW

June 1, 2026, CMS published the Interim Final Rule (with comment period) (IFC) for the Medicaid Program Community Engagement Requirement for Certain Individuals. While an interim rule with comment period expiring July 31, 2026, CMS also states their intent to make the rule final on July 31, 2026. Plans should consider the interim rule as likely final as they make implementation plans, policies, and strategies towards a December 31, 2026/January 1, 2027 go-live.

GUIDANCE NEEDED	STATUS / EXPECTED DATE
FINAL CMS RULE ON COMMUNITY ENGAGEMENT REQUIREMENTS	INTERIM FINAL RULE (IFC) PUBLISHED - JUNE 1, 2026 WITH FINAL RULE INTENDED TO GO-LIVE JULY 31, 2026.
DEFINITION OF "MEDICALLY FRAIL" FOR CE EXEMPTION	NEGOTIATED STATE-BY-STATE WITH CMS; FINAL PARAMETERS TBD BY STATE PLAN AMENDMENTS
ALLOWABLE DATA SOURCES FOR VERIFICATION (UI, SNAP, EDUCATION)	EC-PARTE SOURCES IDENTIFIED: WAGE/EMPLOYMENT RECORDS, SNAP, VEC, VA, NATIONAL STUDENT CLEARINGHOUSE, CORRECTIONS DATA. OTHER STATE SPECIFIC SOURCES CAN BE INCLUDED.
SIX-MONTH REDETERMINATION OPERATIONAL GUIDANCE	MEDICAID DIRECTOR LETTER ISSUED MAR 6, 2026
STATE DIRECTED PAYMENT CAP RULEMAKING	CMS RULEMAKING PENDING; PHASED 2026-2028
COST-SHARING OPERATIONAL GUIDANCE	CMS / STATE PLAN ACTION EXPECTED 2027; EFFECTIVE OCT 2028

PLANNING PRINCIPLE

Do not wait for complete guidance before acting. Build a plan now using what is known, and make assumptions when you need to. Flag assumption dependencies explicitly. Establish a rapid-cycle update process as guidance arrives. *Plans that are waiting are already behind.*

1.3 MANDATORY VS. STATE-DISCRETIONARY PROVISIONS

Some parts of HR-1 are fixed. Knowing which is which tells you where to push and where the call belongs to the state. The IFC sets the federal floor for community engagement, but it leaves states real room to make their own design choices, and those choices are where you have the most leverage.

1.3 MANDATORY VS. STATE-DISCRETIONARY, IN DETAIL

● MANDATORY (FEDERAL FLOOR)	● STATE DISCRETION AVAILABLE
Six-month redeterminations for expansion adults.	States must decide whether to accelerate eligibility redeterminations to transition individuals to the new requirements beginning January 1, 2027, or maintain existing renewal schedules. If a state maintains its current schedule, individuals will be assessed under the new requirements at their next regularly scheduled eligibility redetermination after January 1, 2027. <i>As of publication, all states represented in the collaborative plan to maintain their existing renewal schedules.</i>
80 hrs/month community engagement (CE) for most expansion adults 19–64.	States must determine their look-back period at the time of renewal (1-month vs. 2–3 month). CMS has signaled that states can use MCOs to support members in gathering information or providing data directly to states to verify an exclusion, exemption or to satisfy a CE requirement.
Reduce retroactive coverage for expansion adults from 3 months to 1 month; 2 months for all other covered groups.	States have the option to implement retroactive coverage for CHIP from three to two months.
Medically frail individuals, among other stipulated criteria, can be exempt from CE requirements.	States shall define the scope of medical frailty and other temporary hardship exemptions: hospital / SNF / ICF-IID care, residing in counties with unemployment > 8% or > 150% of national average, natural disaster, or required medical travel.
Six (6) required notice types via mail + additional modality	States will determine outreach roles, responsibilities, and messaging, while MCOs can play a complementary role by supporting members in understanding and complying with new requirements.
Provider tax threshold phase-down (pertains to state directed payment financing strategies).	States will have to determine which provider classes to protect; rate vs. SDP rebalancing strategy.

SO WHAT

The right-hand column is where MCO engagement matters most. Each row of "state discretion" is a decision your state is making, sometimes without much MCO input. Section 02 (State Engagement) of this guide turns each of these into a concrete engagement move.

1.4 STATE VARIATION: WHAT PLANS SHOULD BE TRACKING

The HPA cohort snapshot (March 2026) shows implementation posture varies significantly across states. Plans operating in more than one market will face different regulatory requirements in each one. While the interim final rule signals the federal floor, many state-level decisions remain.

EARLY-MOVER COHORT

ARKANSAS · NEBRASKA · WISCONSIN

- Going live on community engagement requirements as early as late 2026 / January 2027.
- Expect operational friction from "going first," procedural terminations likely in early months.
- Advocacy opportunity: engage now on member communication governance and data-sharing protocols.

PLANNING-STAGE COHORT

NEW YORK · OREGON · WASHINGTON · RHODE ISLAND

- Targeting 2027 implementation with phased renewal transition.
- Data integration challenges and workforce constraints are primary barriers.
- MCOs have a window to influence medical frailty definitions and MCO data-contribution agreements.

SIGNALS TO MONITOR REGARDLESS OF STATE

- State Plan Amendment (SPA) comment periods, RFIs, Sole Source rationales, and APD drafts for IT systems modernization
- Data sharing agreement drafts with SNAP / TANF, wage data, and education enrollment agencies
- Proposed legislation and budget language affecting Medicaid financing
- Public notices for stakeholder meetings on community engagement program design

02 SECTION TWO · PROMOTED FROM §7 STATE ENGAGEMENT STRATEGY

Most of the design decisions that will affect MCO operations are still being made at the state level. Plans that engage early will shape decisions that late-movers must live with.

2.1 WHY STATE ENGAGEMENT IS YOUR HIGHEST-LEVERAGE ACTIVITY NOW

Medical frailty definitions, data-sharing agreements, messaging governance, outreach role delineation, and transition option selection are all in play. Each is a state-level decision that will impact MCOs for years to come, and most state Medicaid agencies are under-resourced and time-constrained. Plans that bring innovative proposals, backed by data and supported by credible impact, will likely be welcomed.

2.2 PRIORITY ENGAGEMENT TOPICS BY STATE FUNCTION

STATE DECISION AREA	MCO ENGAGEMENT APPROACH
MEDICAL FRAILTY DEFINITION	The IFC defines medically frail/special medical needs by 5 sub categories. (1) blind/SSI-disabled; (2) SUD who have less than 5 years of stable recovery; (3) disabling mental disorder; (4) Physical, intellectual, and developmental disability impairing >1 ADL; (5) Serious or complex medical condition. States are still required to define specific operational thresholds such as diagnoses and ICD-10 codes to substantiate these categories. MCO claims and encounter data are specifically noted as key inputs and MCOs have the opportunity to use data to inform definitional thresholds. To maintain continuity of enrollment, discuss with your state whether your MCO can provide member ICD-10 codes and diagnoses to help verify medical frailty for members.
CE VERIFICATION SYSTEM DESIGN	The IFC requires ex-parte verification to be conducted before any documentation is requested from the enrollee. Additionally, the rule signals the intent for CMS to give states until January, 2028 to fully implement CE verification processes, policies, and procedures. MCOs should advocate for system view access to help support enrollees when needed to obtain CE verifications or exemption data.
OUTREACH ROLE DELINEATION	Propose a written framework for MCO outreach activities with clear permitted / not-permitted guidelines. Offer to co-develop member communication materials with state oversight.
HARDSHIP WAIVER ADOPTION	Advocate for adoption of all optional hardship categories. Provide county-level unemployment data supporting waiver eligibility in areas affecting your network.

2.3 MCO ENGAGEMENT PRINCIPLES

There are four operating principles that differentiate proactive state engagement from reactive compliance or regulatory management.

PRINCIPLE 01

COME WITH SOLUTIONS, NOT JUST CONCERNS

States are under-resourced and time-constrained. MCOs that arrive with proposals, data, and implementation-ready ideas are far more welcome than those who simply document objections.

PRINCIPLE 02

ACKNOWLEDGE THE STATE'S CONSTRAINTS

States cannot delegate compliance to MCOs. Acknowledge this boundary explicitly in your engagement and work creatively within it. The navigation space is large.

PRINCIPLE 03

COORDINATE WITH PEER MCOs

On issues like medical frailty definitions or messaging governance, a unified MCO position carries more weight than individual submissions. The HPA Collaborative and your corresponding state alliance or association is exactly where this should happen.

PRINCIPLE 04

DOCUMENT EVERYTHING

State decisions will evolve. Keep a running log of commitments, agreements, and positions to enable rapid response when circumstances change.

RECOMMENDED CADENCE

These principles only matter if they show up on a calendar. The cadence below turns them into a standing routine, so engagement is steady and proactive rather than reactive.

CADENCE	ACTIVITY
MONTHLY	Tracker review of state SPA filings, Advance Planning Document (APD) submissions, RFIs, and stakeholder notices. Update positions log.
MONTHLY / QUARTERLY	Executive or designated project leader meeting with state Medicaid director on HR-1 readiness. Bring fresh ideas, data and one concrete proposal.
PER RATE CYCLE	Capitation rate advocacy package incorporating HR-1 operational and acuity-shift implications (see Section 03).
AD-HOC	Formal comments on proposed rules, definitions, and procurements. Joint MCO submissions where peer alignment exists.

03 SECTION THREE · PROMOTED FROM §6 FINANCIAL MODELING & EXPOSURE ANALYSIS

HR-1 creates multiple, overlapping pathways to membership loss and reshapes capitation rates independently of enrollment. CFOs and actuarial leaders need detailed, scenario-based modeling now, not after the first redetermination wave.

3.1 MEMBERSHIP-LOSS SCENARIOS

KFF projects 11.8 million people will lose coverage, alongside \$1 trillion in reduced federal health spending over 10 years, with costs shifting to states and plans. The IFC adds understanding to CE exclusions, exemptions, and applicable individuals as well as qualifying CE activities. Additional context is provided regarding the CE non-compliance termination pathway, all allowing plans to model scenarios with assumed regulatory parameters. The revenue exposure compounds the risk: a member can lose coverage, cost the plan months of capitated revenue, then return through the ED with higher-acuity needs, all while the plan collects only a partial year of payment. Model capitation-revenue loss alongside utilization to size the true exposure.

LOSS PATHWAY	KEY DRIVERS & MODELING VARIABLES
ADMINISTRATIVE CHURN six-month redeterminations	Historical ex-parte rate; address match rate; contact rate; mail response rate; estimated procedural termination rate from PHE unwinding (<i>reference: 15–25%</i>).
CE NON-COMPLIANCE TERMINATION	% of expansion adults unable to document that they meet a CE exclusion or exemption. % of expansion adults subject to CE requirements after exemptions; % likely non-compliant based on employment / activity profile; good-faith extension utilization. There is a 30 day notice window before disenrollment and coverage continues during the notice period. Individuals may reapply immediately after termination.
IMMIGRANT ELIGIBILITY RESTRICTIONS	% of current enrollment flagged as potentially affected.
ACA MARKETPLACE MIGRATION	% of members who may prefer marketplace; income distribution of current expansion members.
PROVIDER NETWORK DISRUPTION	Impact of provider tax phase-down and SDP changes on network adequacy; potential network exits driving voluntary disenrollment.

FINANCIAL MODELING PRIORITY

The highest-priority cohort for financial exposure is members who are high-cost AND high administrative churn risk. These members will re-engage with the healthcare system during coverage gaps, often through emergency settings. This generates uncompensated care risk and insufficient capitation rates while driving quality measure failures for the plan. Retention investment in this cohort has the highest ROI.

3.2 PROVIDER TAX & SDP FINANCIAL SCENARIOS

Provider tax phase-down and SDP constraints will affect capitation rate construction independent of membership changes. Finance and actuarial teams should begin understanding and modeling:

- To what extent does the state currently rely on provider taxes and SDPs to finance Medicaid, and what share of the overall Medicaid budget do these mechanisms represent?
- What % of current capitation rates are derived from SDP pass-through arrangements that will sunset?
- How will states rebalance provider financing across base rates, remaining SDPs, and other mechanisms?
- What is the likely impact on provider network stability if rates decline materially?
- What contractual protections or renegotiation rights does the plan have if SDPs change significantly?
- Once the provider tax phase-downs and SDP caps are fully in effect, how will the state Medicaid budget be reshaped, and what financing levers will the state realistically have available to offset the resulting shortfalls?

3.3 CAPITATION RATE ADVOCACY

Plans should engage with states on the actuarial implications of HR-1 for rate-setting. The IFC explains that MCOs will have an administrative roll in outreach and engagement with members, but the costs for these types of activities cannot be included in the development of capitation rates nor automatically counted as value-added services. If plans voluntarily elect to provide services that meet the definition of a value-added service under § 438.3(e)(1), and meet state requirements for value added services, the services could be included in the medical loss ratio (MLR) numerator as incurred claims. Four perspectives that bare merit:

ARGUMENT 01 · ACUITY

CHURN PRODUCES HIGHER-ACUITY RE-ENROLLMENT

Increased administrative churn produces higher-acuity members at re-enrollment, which is not captured in base rate assumptions.

ARGUMENT 02 · ADMIN LOAD

MEMBER SUPPORT CARRIES REAL COST

The IFC does not permit states to include admin costs in capitation rate development. Outreach and navigation work needed to meet member-support obligations should be mapped to value-added service offerings, so those efforts can count in the MLR numerator as incurred claims.

ARGUMENT 03 · SYSTEMS

COST-SHARING IMPLEMENTATION IS NOT FREE

Standing up cost-sharing means changing systems, updating claims adjudication, and handling new grievances. These are real administrative costs, and rates should reflect them.

ARGUMENT 04 · QUALITY

QUALITY SCORES, AND THE PAYMENTS TIED TO THEM, ARE AT RISK

When members lose coverage, gaps in care drag down quality scores. Many state contracts tie payment to those scores, so disruption can cost the plan money directly. Rate construction should account for this possible reality.

ENGAGEMENT PAIRING

Ensure your finance and GR (government relations) teams are at the table in advance of every rate cycle. Bring claims data and informed projections, not just talking points.

04 SECTION FOUR

PEOPLE: WORKFORCE & ORGANIZATIONAL READINESS

HR-1 implementation is not a single-department effort. Plans must assess readiness across multiple functions simultaneously and prepare for two or three roles that most plans have never staffed at scale.

4.1 ORGANIZATIONAL FUNCTIONS IMPACTED

FUNCTION	PRIMARY HR-1 READINESS ACTIONS
GOVERNMENT AFFAIRS & REGULATORY	Monitor and respond to the state's State Plan Amendment (SPA) filings, waiver amendments, APD submissions, and CMS guidance. Advocate for MCO-favorable definitions (medical frailty, hardship waivers, data sharing). Submit formal IFC comments to CMS by July 31, 2026 and remain vigilant on rate impact.
MEMBER SERVICES & OUTREACH	Train staff on new redetermination timelines. Develop scripts for CE requirement questions such as all six qualifying CE activity categories, nine specified excluded individual categories, and five mandatory exception categories. Establish exemption documentation escalation pathways and state-specific application protocols. Make it easy for members to access plan information that supports verification for CE exclusions, exemptions, and compliance.
CARE MANAGEMENT	Identify members impacted by redetermination and CE requirements. Identify who may be exempt using clinical and claims data. Proactively identify members who are required to comply with CE activities or verify an exemption and engage these members ahead of redetermination windows.
ELIGIBILITY & ENROLLMENT	Monitor 834 transaction volumes for termination spikes. Build bridge processes for members who lose and regain coverage. Consider the best workflow for the 30-day notice of noncompliance window, including engagement and outreach ahead of termination effective date.
IT / DATA & ANALYTICS	Build HR-1 segmentation models. Develop personas for those most likely to drop coverage. Establish data pipelines for exemption identification. Integrate with state-provided verification data when available.
FINANCE & ACTUARIAL	Model membership-loss scenarios by segment. Update rate projections for provider tax and SDP changes. Build financial exposure dashboards. Engage GA / regulatory to elevate rate concerns early.
QUALITY & COMPLIANCE	Assess quality measure impact of increased member churn. Update grievance / appeals workflows for cost-sharing. Track care gap exposure for churned members.
LEGAL & COMPLIANCE	Review outreach permission parameters (education vs. advertising) and refine internal protocols accordingly. Ensure MCO activities comply with prohibition on conducting CE compliance checks.
PROVIDER NETWORK / CONTRACTING	Plan for provider abrasion. Provider–payer relationships are already strained; the collapse of retroactive eligibility, together with open questions about uncompensated care and payer responsibilities, will further exacerbate this tension. Communicate changes and corresponding timelines early.

4.2 NEW ROLES AND CAPABILITIES YOUR PLAN WILL NEED

The complexity and novelty of HR-1 requirements will demand capabilities that most plans have not needed at scale.

ROLE 01

CE EXCLUSION AND EXEMPTION VERIFICATION NAVIGATORS

Staff or vendor-supported roles to assist members in documenting CE exclusions and exemptions (medical frailty, caregiver, incarceration, SUD treatment). HIPAA-compliant workflows; warm handoffs to state agencies.

ROLE 02

CE LIAISON / EMPLOYMENT NAVIGATOR

MCOs cannot verify CE compliance, but they can educate members on qualifying activities and connect them with workforce development partners. An emerging role at the intersection of SDOH and coverage retention.

ROLE 03

HR-1 ANALYTICS SPECIALIST

Dedicated analyst or team to maintain HR-1 segmentation models, exemption gap flags, redetermination timelines, and financial exposure dashboards. Distinct from general population health analytics. Siftwell can support this.

ROLE 04

STATE POLICY LIAISON

Point person with deep familiarity in each state market who tracks SPA filings, waiver amendments, APD submissions, and stakeholder engagement opportunities in real time. Pairs with Section 02 cadence.

4.3 TRAINING PRIORITIES

All member-facing staff need baseline literacy on HR-1 changes before member communications begin. Sequence training ahead of your state's go-live timeline.

TRAINING TOPIC	TARGET AUDIENCE
What is HR-1 / OBBBA and why are changes happening, in plain language	ALL MEMBER-FACING STAFF
Six-month redetermination: what it means for members, what the plan can and cannot do	MEMBER SERVICES, CARE MANAGEMENT, OUTREACH
Community engagement requirements: qualifying activities, exemptions, look-back periods	MEMBER SERVICES, CARE MANAGEMENT, COMMUNITY HEALTH WORKERS
Exemption documentation: how to assist members; referral workflows	CARE MANAGEMENT, COMMUNITY HEALTH WORKERS, ENROLLMENT STAFF
What MCOs are NOT permitted to do: compliance checks, eligibility determination	ALL STAFF (ESP. MEMBER-FACING & SUPERVISORS)
Cost-sharing changes effective 2028: provider impact, member communication	MEMBER SERVICES, PROVIDER RELATIONS
Escalation and grievance pathways for coverage loss and HR-1 appeals	MEMBER SERVICES, COMPLIANCE, QUALITY

05 SECTION FIVE PROCESS: OPERATIONAL WORKFLOWS & READINESS

Redeterminations, community engagement, coverage continuity, and cost-sharing all impact the same operational teams. Prioritize building the redetermination and CE workflows first so they are fully operational by January 2027, then layer other processes onto that foundation in a coordinated and scalable manner.

5.1 SIX-MONTH REDETERMINATION OPERATIONS

Six-month redeterminations will double the eligibility verification workload for expansion adults beginning January 1, 2027. Plans will experience the downstream effects of state eligibility processing decisions regardless of their direct involvement.

KEY PROCESS RISKS

- Administrative churn: members procedurally terminated (failure to respond, incorrect contact info, system errors) rather than for actual ineligibility.
- Household cycle fragmentation: members in the same household may hit renewal dates at different intervals, increasing confusion and outreach complexity.
- Coverage gap bridging: members who lose and regain coverage within 90 days create acute clinical and financial exposure, particularly for those with chronic conditions.
- Eligibility processing delays: eligibility determinations may get backlogged. While states may continue coverage, there could be a reconciliation process for members whose coverage is ultimately terminated.

MCO PROCESS CHECKLIST: SIX-MONTH REDETERMINATIONS

- | | |
|---|---|
| <input type="checkbox"/> Identify all expansion adult members on 834 roster and flag for HR-1 applicability | <input type="checkbox"/> Establish monitoring protocol for termination & reason codes in 834 transactions |
| <input type="checkbox"/> Build outreach workflow triggered 60–90 days prior to anticipated redetermination window | <input type="checkbox"/> Develop member-facing communications in plain language, multi-lingual |
| <input type="checkbox"/> Create rapid re-enrollment support for members who lose coverage within 90 days | <input type="checkbox"/> Coordinate with state to understand transition option (accelerate vs. maintain) |
| <input type="checkbox"/> Assess care continuity obligations for active care plans or post-discharge windows | <input type="checkbox"/> Update grievance & appeals workflows to capture HR-1 coverage-loss complaints |

5.2 COMMUNITY ENGAGEMENT REQUIREMENT OPERATIONS

The community engagement (CE) requirement is the most operationally complex provision of HR-1. States make every compliance decision, but MCOs play an important role in helping members through the process. The IFC defines three populations that map directly to the tiers below: specified excluded individuals, those who qualify for a mandatory exception, and applicable individuals.

CRITICAL CONSTRAINT

States cannot delegate compliance verification to managed care entities. MCOs may educate, navigate, document, and refer, but cannot determine compliance, and must not represent to members or states that they are conducting compliance assessments or making exemption determinations.

THREE-TIER EXEMPTION IDENTIFICATION FRAMEWORK

MCOs should build a segmentation model classifying expansion adult members into three tiers for outreach and prioritization.

TIER	DESCRIPTION	RECOMMENDED ACTION
TIER 1 SPECIFIED EXCLUDED INDIVIDUALS 9 STATUTORY CATEGORIES	Fully excluded from CE under one of nine statutory categories: <ul style="list-style-type: none"> Former foster care children Parent / caretaker / family caregiver Medically frail / special needs In drug/alcohol treatment & rehab Pregnant & postpartum women American Indian / Urban / California Indian Veteran, 100% VA disability rating TANF or SNAP work-requirement compliant Inmate of a public institution 	Use plan data to flag these members. Ask the state to integrate or share data to notify of likely status and potentially, ex-parte redeterminations. Keep extra outreach light beyond standard renewal support.
TIER 2 MANDATORY EXEMPTION SHORT-TERM HARDSHIP, IF STATE-ELECTED	Five mandatory exemptions (determined compliant): <ul style="list-style-type: none"> Under age 19 for part or all of a month Medicare Part A or B for part or all of a month In a specified-excluded category for part or all of a month (e.g., child turns 14 mid-review) Pregnant for part or all of a month Released from incarceration within the prior 3 months Short-term hardship (state-elected): <ul style="list-style-type: none"> Institutional services Declared emergency / high unemployment Travel for medical care 	Reach out early. Push for a way to share the plan's exception data with the state, or help members gather the documents the state needs.
TIER 3 APPLICABLE INDIVIDUALS	Able-bodied adults 19–64 who qualify for Medicaid under the state plan adult group, who do not have dependents, and who do not meet other specified-excluded or mandatory-exception criteria.	Priority outreach; education on process and qualifying CE activities; connect with workforce and CE resources. Highest administrative-churn risk.

5.3 COVERAGE CONTINUITY & CARE GAP MITIGATION

The PHE unwinding (2023–2024) taught plans that coverage disruptions impact both the clinical and financial performance of plans. Members who lose coverage tend to reengage when they have an urgent or emergent care need, driving up cost and driving down quality measure performance simultaneously.

KEY LESSONS FROM PHE UNWINDING TO APPLY NOW

- Members with the highest administrative-churn risk are not necessarily the highest clinical risk, so prioritize outreach using both dimensions.
- One-way communication (mail only) had low response rates; multichannel outreach (SMS, phone, pharmacy, CHW) significantly improved retention.
- Plans that engaged proactively before termination saw better outcomes than those focused on re-enrollment after loss.
- State–plan collaboration on unified messaging governance was critical to avoiding confusion.

5.4 COST-SHARING WORKFLOW PREPARATION

While cost sharing does not take effect until October 2028, the operational groundwork (system configuration, provider education, member communication, and grievance workflows) must begin in 2026–2027 to be ready.

WHAT'S REQUIRED

COST SHARING FOR > 100% FPL

Cost sharing required for expansion adults with income > 100% FPL for most services (up to \$35 per service; cumulative cap at 5% of annual income).

WHAT'S EXEMPT

SERVICES EXCLUDED FROM COST SHARING

Primary care, substance use disorder & mental health services, FQHCs, rural health clinics, behavioral health clinics.

ACCESS RISK

PROVIDERS MAY DENY FOR NON-PAYMENT

Direct member access risk. Provider education and grievance workflow setup are critical. Anticipate ED diversion patterns.

PLAN RESPONSIBILITY

COST-SHARING CAP TRACKING

Plans will likely be responsible for tracking each member's cumulative cost-sharing toward the 5% cap and notifying members when the cap is reached.

06 SECTION SIX

PLATFORM: DATA, SYSTEMS & ANALYTICS READINESS

Effective HR-1 readiness depends on your plan's ability to segment, score, and track members at the intersection of eligibility, clinical, and demographic data. Most plans will need to build net-new analytics capabilities or significantly enhance existing tools.

6.1 HR-1 ANALYTICS: WHAT YOUR SYSTEMS NEED TO DO

ANALYTICS CAPABILITY	DESCRIPTION & DATA SOURCES
POPULATION SIZING & HR-1 EXPOSURE	Identify total expansion adult population. Understand who will be impacted by 6-month redetermination cycles, and prepare CE modeling to the extent possible by segmenting applicable individuals, specified excluded individuals, and those likely to meet a mandatory exception, using 834 enrollment data.
CE EXEMPTION ID & GAP FLAGGING	To inform CE modeling, cross-reference claims (ICD codes, service types), case management data, and 834 indicators to identify members who will likely meet criteria as a specified excluded individual or exception status. Flag members with incomplete documentation or those likely to need support when complying with CE documentation requests.
ROLLING REDETERMINATION TIMELINE	Track upcoming redetermination dates for each expansion adult. Calculate 60–90 day outreach windows and prepare policies for outreach, aligned to the state implemented timeline.
ADMINISTRATIVE CHURN RISK SCORE	Use historical coverage gap data (PHE unwinding) plus SDOH, demographic, and engagement history to score members by procedural disenrollment risk. Use this score as one component to inform the outreach and engagement strategy.
CLINICAL & COST OVERLAYS	Combine churn risk with clinical complexity to prioritize outreach and quantify financial exposure (capitation loss × PMPM by segment).
CAMPAIGN / OUTREACH TRACKING	Use analytics to inform outreach and engagement strategies ahead of January 2026, and ongoing. To determine efficacy and value, track outreach attempts, contact rates, and outcomes by channel and cohort. Measure retention rate pre / post intervention.

6.2 DATA SOURCES & INTEGRATION REQUIREMENTS

DATA SOURCE	USE CASE IN HR-1 CONTEXT
STATE MMIS / ELIGIBILITY (834)	Core enrollment and redetermination date tracking; termination reason code monitoring.
STATE WAGE / UI DATA	Work requirement compliance verification support; exemption identification for earners near minimum wage thresholds.
SNAP / TANF PROGRAM DATA	Identify members already compliant with work requirements (categorical exemption); coordinate renewal cycles.
CLAIMS DATA (MEDICAL, RX, BH)	Identify members who will likely be deemed as an applicable individual, required to meet CE requirements, and those that are specified excluded due to being medically frail or meeting other exclusion criteria, along with those that are likely to meet the mandatory exception status
CASE MANAGEMENT RECORDS	Verifiable exemption documentation; active care plan status for continuity-of-care triggers.
SDOH / CONSUMER DATA	Refine outreach channel selection; identify housing instability or mobility that predicts contact difficulty.
NATIONAL STUDENT CLEARINGHOUSE	Education enrollment verification for CE compliance (used by Oregon and others).
CORRECTIONS AGENCY DATA	Identify members recently released from incarceration (90-day exemption window).

6.3 KEY QUESTIONS TO ASK YOUR STATE

- What system is the state building or procuring for tracking community engagement compliance and exemptions? How will MCOs integrate, view or access data from that system?
- What data-sharing agreements is the state establishing with other agencies (SNAP, UI, corrections, education)?
- How can MCO data (claims, case management) contribute to the state's verification workflow? Propose ideas where feasible.
- What is the state's plan for near real-time data aggregation across multiple verification sources, and what latency is expected between activity completion and system reflection?
- What role does the state envision for MCOs in the outreach ecosystem, and what messaging governance structure is the state establishing?

07 SECTION SEVEN MEMBER ENGAGEMENT & COMMUNICATIONS

Member engagement sits at the strategic center of HR-1 readiness: downstream of whatever messaging governance your state establishes, and upstream of every retention outcome your plan cares about, including membership stability, quality performance, and financial exposure.

States may be cautious about relying on MCOs for HR-1 administration, and for good reason: federal law prohibits delegating compliance verification to managed care entities, and states bear ultimate accountability for eligibility (re)determinations. This legal boundary, clearly understood and respected, is precisely what can make the MCO–state partnership workable.

Plans that arrive at the table with a clear, written framework give states the confidence to say yes to collaboration. Consider an approach that spells out what we will do (educate members on qualifying activities, assist with exemption documentation, connect members to community resources, flag exemptions from claims data) and what we will not do (conduct compliance checks, make preliminary eligibility determinations, or represent ourselves as an authoritative source on CE status).

7.1 OUTREACH PERMISSIONS AND GOVERNANCE

● PERMITTED (EDUCATION & NAVIGATION)	● NOT PERMITTED / USE CAUTION
Informing members about upcoming redetermination timelines and what to expect.	Suggesting the plan checks compliance or decides exemptions.
Explaining qualifying community engagement activities and how to document them.	Outreach that looks like marketing and breaks state advertising rules.
Helping members understand their exemption status based on their circumstances.	Going beyond the outreach the state has authorized on CE compliance.
Assisting members in gathering and submitting documentation to the state.	Presenting the plan as the final word on eligibility or compliance.
Connecting members with community partners, workforce programs, and navigators.	Telling members exactly which CE activities to do in ways that expose the plan to liability.

7.2 MULTICHANNEL OUTREACH STRATEGY

CHANNEL	STRENGTHS	CONSIDERATIONS
DIRECT MAIL	Typical and customary outreach channel, often required by the state	Low response rate; does not confirm receipt; address accuracy critical.
SMS / TEXT	High open rates; low cost; effective for reminders and deadlines.	Opt-in requirements vary; language accessibility needed.
OUTBOUND PHONE	Two-way conversation; good for complex situations.	High cost per contact; declining answer rates; staffing-intensive.
CARE MANAGER / CHW	Highest engagement for high-risk members; warm handoffs.	Limited scalability; use data to inform this strategy. E.g., who is high risk for churn but a high utilizer, who is likely to lose coverage due to administrative barriers.
PHARMACY TOUCHPOINT	High-frequency interaction; trusted relationship.	Requires partnership and education; HIPAA-compliant protocols needed.
PROVIDER COORDINATION	Trusted source; direct connection to clinical relationship.	Requires provider education; may not reach members between visits.
CBO / COMMUNITY NETWORK	Reaches hard-to-contact members; deep community trust.	Partnership investment needed; messaging governance required.

7.3 MEMBER COMMUNICATION PRINCIPLES

- **Simplicity first.** All member-facing materials must align to any state specific requirements, translate requirements into plain language, describe concrete actions, and clear deadlines. Members do not read policy documents.
- **Act before termination.** Outreach should begin 60–90 days before anticipated redetermination or compliance deadlines, not after coverage loss.
- **Unified voice.** Coordinate messaging with the state and community partners. Fragmented messages from state, MCO, and CBO erode trust and increase confusion.
- **Acknowledge anxiety.** Coverage changes are stressful. Member communications should be empathetic, specific with easy to follow instructions, and not bureaucratic.
- **Accessibility.** All materials should be available in the primary languages of your membership, with accessible formats for members with disabilities.
- **Track and iterate.** Build response tracking into all outreach campaigns. Adjust messaging, messenger, channels, and timing based on observed response rates.

08

SECTION EIGHT

READINESS TRACKER & ACTION DASHBOARD

Use this tracker to assess your plan's readiness across all HR-1 domains. Update quarterly or as guidance evolves. Recommended statuses: Not Started · In Progress · Complete · Blocked.

DOMAIN	ACTION ITEM	STATUS
POLICY	Subscribe to CMS, state Medicaid agency, and external guidance trackers like KFF / NASHP	<input type="checkbox"/>
POLICY	Map all HR-1 provisions to effective dates and assess applicability by state market	<input type="checkbox"/>
POLICY	Identify state's implementation posture and go-live timeline for each provision	<input type="checkbox"/>
POLICY	Engage government affairs team on state SPA, APD, and legislative monitoring	<input type="checkbox"/>
STATE	Schedule executive-level meeting with state Medicaid director on HR-1 readiness	<input type="checkbox"/>
STATE	Submit formal input on medical frailty definitions	<input type="checkbox"/>
STATE	Propose data-sharing framework for MCO data contribution for ex-parte processes	<input type="checkbox"/>
FINANCIAL	Build membership-loss scenarios by pathway and segment	<input type="checkbox"/>
FINANCIAL	Model provider tax / SDP financial impact on capitation	<input type="checkbox"/>
FINANCIAL	Develop capitation rate advocacy materials for rate cycle negotiations	<input type="checkbox"/>

8.1 TRACKER CONTINUED: PEOPLE & PROCESS

DOMAIN	ACTION ITEM	STATUS
PEOPLE	Conduct HR-1 impact assessment across all internal functions	<input type="checkbox"/>
PEOPLE	Identify gaps in current roles; define new capabilities needed	<input type="checkbox"/>
PEOPLE	Develop training curriculum for all member-facing staff	<input type="checkbox"/>
PEOPLE	Hire or contract for HR-1-specific analytics and state policy liaison roles	<input type="checkbox"/>
PROCESS	Build expansion adult segmentation for redetermination and clearly establish methods for identifying CE applicable individuals, specified excluded individuals, and those that likely meet a mandatory exception status	<input type="checkbox"/>
PROCESS	Establish 834 termination monitoring protocol	<input type="checkbox"/>
PROCESS	Develop 60–90 day pre-redetermination outreach workflow	<input type="checkbox"/>
PROCESS	Create rapid re-enrollment support for members losing coverage	<input type="checkbox"/>
PROCESS	Update grievance / appeals workflows for HR-1 coverage disputes	<input type="checkbox"/>
PROCESS	Begin cost-sharing operational planning (2028 effective date)	<input type="checkbox"/>

SUGGESTED CADENCE

Treat the tracker as a monthly working document. Each row should have a named owner, specified work plan with dependencies identified, and a target implementation date. Review status frequently

8.2 TRACKER CONTINUED: PLATFORM & ENGAGEMENT

DOMAIN	ACTION ITEM	STATUS
PLATFORM	Conduct HR-1 analytics capability gap assessment	<input type="checkbox"/>
PLATFORM	Build or procure HR-1 segmentation / financial exposure dashboard	<input type="checkbox"/>
PLATFORM	Establish 834 integration for redetermination timeline tracking	<input type="checkbox"/>
PLATFORM	Engage state on IT procurement and data-sharing agreement opportunities	<input type="checkbox"/>
ENGAGEMENT	Develop plain-language member communication suite for redeterminations and CE	<input type="checkbox"/>
ENGAGEMENT	Establish multichannel outreach infrastructure (SMS, outbound, CHW)	<input type="checkbox"/>
ENGAGEMENT	Map CBO / community partner network for CE navigation referrals	<input type="checkbox"/>
ENGAGEMENT	Engage state on messaging governance and outreach role delineation	<input type="checkbox"/>



DEMO VIDEO

SEE THE REDETERMINATIONS DASHBOARD IN ACTION

Scan to watch a demo video of Siftwell's redeterminations & HR-1 readiness dashboard, the platform reference behind the capability column in this tracker. Or visit siftwell.ai/hr1-readiness-dashboard-demo.

09 SECTION NINE KEY RESOURCES & SOURCES

The primary sources, trackers, and reference documents behind this playbook. Bookmark the federal and state-tracker links; they are updated more frequently than this document.

SOURCE	RELEVANCE
CMS MEDICAID DIRECTOR LETTER (March 6, 2026)	Initial implementation guidance on six-month redeterminations.
CMCS INFORMATION BULLETIN (December 8, 2025)	Requirements for states establishing community engagement requirements.
KFF: AN EARLY LOOK AT POLICY DECISIONS (April 30, 2026)	National survey of state implementation decisions (43 states).
HHS / CMS INTERIM FINAL RULE WITH COMMENT PERIOD (IFC) ON CE REQUIREMENTS FOR CERTAIN INDIVIDUALS (CMS-2454-IFC)	Interim (definitive by July 31, 2026) federal parameters for CE program design.
NASHP HR-1 STATE TRACKER	Ongoing state-by-state implementation signals.
HPA MEDICAID COLLABORATIVE MODULES 1-3 (Jan.–Mar. 2026)	Source materials for this playbook; available to HPA members.
PUBLIC CONSULTING GROUP OBBBA SUMMARY (July 2025)	Comprehensive provision-by-provision analysis.
SELLERS DORSEY HR-1 SUMMARY (June 2025)	Legal and regulatory summary of Medicaid provisions.
CONGRESSIONAL RESEARCH SERVICE R48569	Legislative history and provision analysis.
STATE MEDICAID AGENCY WEBSITES	VA · MD · WI · WA · OR · RI · NY · UT · PA · ID: state implementation plans and readiness materials.

LIVING DOCUMENT

This playbook will be updated as CMS guidance lands, state SPAs are filed, and operational realities clarify. V2 is targeted for September 2026, following the CMS Final Rule on CE Requirements.

COVERAGE LOSS, STATE BY STATE DETAIL

Estimated one-year impact of the House-passed One Big Beautiful Bill Act (H.R. 1) on each state, using the midpoint of Manatt's modeled range. Enrollment is the number of people; spending is the total federal-plus-state reduction in Medicaid outlays for FFY 2028.

STATE	ENROLLMENT	%	SPENDING REDUCTION	%	STATE	ENROLLMENT	%	SPENDING REDUCTION	%
Alabama ★	-53,940	-4.7%	-\$473,900,000	-4.9%	Montana	-30,510	-14.3%	-\$501,300,000	-20.3%
Alaska	-27,480	-11.6%	-\$390,100,000	-11.7%	Nebraska	-31,260	-8.8%	-\$494,800,000	-9.5%
Arizona	-248,460	-11.5%	-\$4,702,600,000	-15.5%	Nevada	-122,920	-16.7%	-\$1,255,200,000	-16.8%
Arkansas	-106,930	-13.2%	-\$1,332,400,000	-13.8%	New Hamps...	-25,700	-14.2%	-\$308,700,000	-12.3%
California	-1,895,960	-13.0%	-\$23,404,600,000	-13.3%	New Jersey	-240,390	-13.0%	-\$3,812,500,000	-13.4%
Colorado	-161,030	-13.2%	-\$1,514,800,000	-10.7%	New Mexico	-128,820	-14.7%	-\$1,502,500,000	-12.5%
Connecticut	-175,030	-16.0%	-\$1,896,200,000	-14.6%	New York	-862,110	-12.1%	-\$11,700,700,000	-9.3%
Delaware	-32,860	-13.1%	-\$437,900,000	-11.5%	North Carolina	-269,100	-8.2%	-\$4,274,000,000	-11.7%
District of Col...	-36,380	-13.7%	-\$492,000,000	-9.2%	North Dakota	-11,050	-10.2%	-\$189,400,000	-10.4%
Florida ★	-192,980	-4.3%	-\$2,616,600,000	-6.5%	Ohio	-336,710	-10.7%	-\$5,125,800,000	-11.6%
Georgia ★	-90,990	-4.1%	-\$1,070,300,000	-5.7%	Oklahoma	-101,090	-10.2%	-\$1,699,300,000	-13.2%
Hawaii	-63,670	-13.9%	-\$503,900,000	-11.4%	Oregon	-252,160	-19.6%	-\$3,240,700,000	-15.3%
Idaho	-42,210	-11.8%	-\$521,700,000	-11.8%	Pennsylvania	-359,160	-11.6%	-\$5,168,900,000	-9.1%
Illinois	-351,710	-11.5%	-\$5,029,700,000	-12.3%	Rhode Island	-33,220	-10.4%	-\$422,500,000	-9.7%
Indiana	-240,300	-12.9%	-\$3,368,800,000	-15.0%	South Caroli...	-22,760	-1.6%	-\$864,600,000	-8.0%
Iowa	-76,570	-12.5%	-\$1,010,300,000	-12.9%	South Dakota	-17,500	-12.6%	-\$161,600,000	-9.9%
Kansas ★	-12,770	-3.4%	-\$301,200,000	-5.1%	Tennessee ★	-53,340	-3.3%	-\$1,088,700,000	-6.7%
Kentucky	-221,390	-15.5%	-\$3,148,400,000	-14.8%	Texas ★	-150,000	-3.3%	-\$3,330,600,000	-6.4%
Louisiana	-335,670	-17.3%	-\$4,009,600,000	-16.5%	Utah	-34,960	-9.9%	-\$661,400,000	-11.9%
Maine	-54,660	-13.8%	-\$612,500,000	-11.6%	Vermont	-16,690	-9.8%	-\$204,400,000	-8.9%
Maryland	-184,570	-12.4%	-\$2,523,700,000	-11.4%	Virginia	-277,060	-14.7%	-\$4,432,900,000	-15.1%
Massachuset...	-180,830	-8.8%	-\$2,832,800,000	-9.0%	Washington	-262,370	-13.9%	-\$3,908,000,000	-15.5%
Michigan	-320,610	-12.6%	-\$3,772,800,000	-13.9%	West Virginia	-75,710	-14.3%	-\$766,800,000	-12.0%
Minnesota	-107,070	-8.7%	-\$1,979,500,000	-9.2%	Wisconsin	-91,030	-6.9%	-\$958,800,000	-6.5%
Mississippi ★	-32,620	-4.6%	-\$542,400,000	-7.2%	Wyoming ★	-2,490	-3.4%	-\$26,800,000	-3.1%
Missouri	-137,330	-10.7%	-\$2,357,800,000	-13.0%					

U.S. TOTAL ENROLLMENT **-9,192,140 (-10.7%)** SPENDING REDUCTION **-\$126,947,600,000 (-11.4%)**

★ Non-expansion state not subject to the work requirements; Manatt reports a single estimate rather than a range.

Source: Patricia M. Boozang & Jocelyn A. Guyer, "House Budget Bill Medicaid Proposals: State-by-State Estimates of Impact," *Manatt Health Highlights*, June 3, 2025 (shvs.org). Figures reflect the midpoint estimate of the enrollment and expenditure impact for FFY 2028 (Table A). Nine non-expansion states reflect a single estimate rather than a range.