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THE VOICE FOR HEALTH CARE CONSUMERS

Medicaid Managed Care: Top Issues for Advocates in 2026

With the looming cuts to Medicaid as a result of federal policy changes through the 2025 budget reconciliation law (H.R. 1), state consumer advocates have a significant role in building needed political support to encourage policymakers to use the many tools and levers available to ensure continued access to high-quality care through their states' Medicaid programs. Given that Medicaid managed care is now the dominant delivery system for Medicaid enrollees, with 75% of Medicaid beneficiaries enrolled in a comprehensive managed care organization (MCO) nationally, Medicaid MCOs play an outsized role in ensuring consumers continued access to needed health care services.

Families USA integrated multiple upcoming federal law and regulatory changes into one comprehensive timeline to help advocates understand the evolving landscape and how they can leverage opportunities to enhance managed care oversight and improve care quality for Medicaid beneficiaries enrolled in managed care, even in a time of new funding restrictions and coverage loss. The timeline integrates the implementation dates of H.R. 1 together with implementation dates under the following federal regulations:

- Medicaid Managed Care Rule
- Medicaid Access Rule
- Interoperability and Prior Authorization Rule
- Medicaid Eligibility and Enrollment Rule

Based on the larger timeline, this document explores five major issues facing state Medicaid programs in 2026 — Medicaid enrollment, outreach and education to consumers, Medicaid benefits, network adequacy and provider payment, and future state planning — examining the changes in state laws, regulations and MCO contracts that may be required to ensure Medicaid beneficiaries served by MCOs have adequate access to health care services and provider networks despite the many changes brought by H.R. 1. In addition, this document outlines areas where oversight may be needed and ways advocates can support consumers in managed care states.

For questions or additional information, please contact healthpolicy@familiesusa.org.

1. MEDICAID ENROLLMENT

New Medicaid eligibility requirements under H.R. 1 — including "community engagement" requirements and requirements to redetermine enrollment every six months for populations enrolled in the Affordable Care Act's (ACA's) Medicaid expansion — mean that most states will require significant updates to Medicaid enrollment and other information technology (IT) systems. Planning for and implementation of these systems will advance quickly in 2026 as states prepare to meet the 2027 implementation deadlines. MCOs are a key stakeholder in connecting with their eligible members to ensure they can renew Medicaid coverage despite new eligibility hurdles. Changes in state laws and regulations or updates to plan contracts may be needed to ensure MCOs can assist in redeterminations in ways that mitigate the Medicaid coverage losses expected from H.R. 1.

Changes to state laws/ regulations that may be required	MCO procurement/contracting issues to consider	Oversight/monitoring needed
States should: • Implement all aspects of the 2024 Medicaid Eligibility and Enrollment Rule despite rule moratorium. • Allow MCOs to submit applications and track eligibility determinations on behalf of individuals. • Update enrollment transaction fields to include disenrollment reason (for example, procedural denial, income change) and provide MCOs with monthly termination files. • Provide plans with data on who the state is not able to verify through the "ex parte" process. • Request authority under Section 1902(e)(14)(A) to support operational burden associated with new eligibility requirements. • Extend enrollment simplifications to nonexpansion populations. • Update applications to include country of origin to ensure enrollment for immigrants who remain eligible for Medicaid.	**Contract language should:** • Require MCOs to identify and reach out to members at high risk for not renewing coverage. • Require plans to assist with "ex parte" data verification for members who may be eligible for various exceptions/exclusions. • Require MCOs to help eligible members maintain enrollment in Medicare Savings Programs. • Require plans to obtain and update member address information regularly and provide assistance to members to update their contact information directly with the state agency. • Require MCOs to partner with community-based organizations to reach vulnerable populations. • Underscore the prohibition on Children's Health Insurance Program (CHIP) waiting periods and annual/lifetime limits (areas of the Medicaid Eligibility and Enrollment Rule that remain intact).	**Advocates can:** • Document lessons learned from Medicaid unwinding to help states determine where they may need to improve enrollment processes. • Ensure their state implements those portions of the 2024 Medicaid Eligibility and Enrollment Rule that are still intact and urge states to monitor MCOs to ensure they follow through with new CHIP requirements. • Push state leaders to extend any enrollment simplifications to other Medicaid populations as states and MCOs design IT/enrollment systems for determining expansion population eligibility. • Push states to deploy funding received for H.R. 1 implementation for IT/enrollment upgrades in ways that improve enrollment for all Medicaid beneficiaries.

2. OUTREACH AND EDUCATION TO CONSUMERS

H.R. 1 requires states to conduct outreach to Medicaid expansion enrollees beginning between June and August of 2026 concerning new community engagement requirements. This is a very tight timeline for states to generate quality outreach materials and to deliver them to impacted individuals and communities. In addition, Medicaid applicants and enrollees need to be aware of other changes brought by H.R. 1, such as changes to retroactive coverage and more frequent redeterminations. MCOs may be an important source of information for beneficiaries to understand new requirements and key stakeholders in ensuring information reaches consumers. States should use all available avenues to facilitate outreach and education for current enrollees and future applicants.

Changes to state laws/ regulations that may be required	MCO procurement/contracting issues to consider	Oversight/monitoring needed
States should: • Invest H.R. 1 implementation dollars in public education campaigns. • Provide MCOs with access to monthly termination files. With this information, plans can conduct specific outreach to members terminated for procedural reasons to help them reenroll or otherwise provide them with information on ACA marketplace enrollment. (Once terminated, a consumer is no longer considered a plan "member" so marketing regulations apply, but MCOs can offer general outreach on meeting H.R. 1 requirements and the reenrollment process.)	**Contract language should:** • Set expectations for MCOs to launch ongoing education initiatives for their members to understand new community engagement requirements, exceptions/exclusions and six-month redeterminations. • Require MCOs to conduct specific outreach to members in advance of renewal dates. • Require MCOs to communicate to new members about retroactive coverage and their options for seeking coverage for past services. • Require MCOs to use multiple modalities for sending educational materials (for example, mail, email, text). • Specify manner of outreach (including language accessibility) and number of attempts required; set clear policies for how MCOs should respond to returned mail. • Require MCOs to partner with community-based organizations to reach and educate vulnerable populations.	**Advocates can:** • Support their state in constructing a multifaceted outreach plan that involves a range of stakeholders — including Medicaid MCOs and community-based organizations — that can reach vulnerable populations and support their understanding of new eligibility requirements under H.R. 1. • Encourage states to invest H.R. 1 implementation dollars in public education campaigns. • Inform states of important lessons learned during the Medicaid unwinding concerning consumer outreach (highlighting successes in their state or others). • Review educational resources offered by states or MCOs to ensure information is in plain language and accessible in multiple languages; ensure MCO outreach materials do not improperly suggest that members must reenroll in their plan.

3. MEDICAID BENEFITS

Provisions from H.R. 1 directly impact access to important Medicaid benefits (for example, reproductive health services or nursing facility services), and the financial impacts of H.R. 1 on state Medicaid budgets may mean states will look to cut or scale back "optional" benefits (such as home- and community-based services (HCBS) or behavioral health services) in response to funding gaps. However, MCOs still have obligations to provide benefits to their members as outlined by their contracts, and MCO contracting offers an opportunity to mitigate some of the negative impact of H.R. 1 on access to care. In addition, Medicaid funding cuts do not happen all at once. (For example, states have until fiscal year 2028 before reductions to provider taxes begin.) That means states have time to plan, and advocates have the opportunity to identify which optional benefits should be prioritized amid constrained funding and how innovative service delivery can help mitigate benefit cuts.

Changes to state laws/ regulations that may be required	MCO procurement/contracting issues to consider	Oversight/monitoring needed
States should: • Reduce existing barriers that make it more difficult for beneficiaries to access evidence-based services provided in nontraditional settings (for example, state laws/regulations that limit telehealth services) and provided by nontraditional provider types (for example, state laws/policies that limit Medicaid reimbursement for community health workers). • Seek Centers for Medicare & Medicaid Services (CMS) approval to address health-related social needs through the broader definition of "in lieu of services." • Leverage the Section 1915(c) waiver mechanism for HCBS to increase access to HCBS (thereby leveraging the faster timeline and circumventing H.R. 1's more stringent Section 1115 waiver budget neutrality definition). • Set Medicaid cost sharing at the lowest possible level required under H.R. 1 and ensure that no cost-sharing requirements are in place prior to the October 1, 2028, statutory mandate.	**Contract language should:** • Allow MCOs to provide alternate services to address health-related social needs in place of standard state Medicaid plan services through the broader definition of "in lieu of services," such as, for example, medically tailored meals for people with diabetes that reduce the need for future costly diabetes-related care. • Require plans to clarify which services are eligible for freedom of choice protection to ensure enrollees have access to a wide array of reproductive health services out of network (including postpartum services, testing for sexually transmitted infections and cancer screening). • Require MCOs to invest in quality improvement strategies aimed at improving care in nursing facilities. (MCOs are important stakeholders to drive nursing care quality amid H.R. 1's moratorium on improved staffing standards.) • Include quality metrics related to HCBS to ensure plans have the incentive to offer these services.	**Advocates can:** • Collaborate with their state's Medicaid Advisory Committee to identify which optional benefits should be prioritized and provide the evidence base for retaining high-value benefits. • Support the HCBS Interested Parties Advisory Group with data on the importance of HCBS. • Conduct secret shopper surveys to determine access to services and provide feedback to their state. Advocates with limited resources can focus on certain provider types (for example, reproductive health) or certain regions (for example, rural areas). • Document and track challenges MCO members face in accessing needed care; elevate these stories to policymakers and the media. • Uplift evidence-based and cost-effective services that can qualify as in lieu of services and encourage them in MCO contracts. • Closely monitor Section 1115 demonstration waiver activity and participate in comment processes to ensure states do not use this mechanism to reduce care access. • Closely monitor any state attempts to put cost sharing in place.

4. NETWORK ADEQUACY AND PROVIDER PAYMENT

H.R. 1's many restrictions may impact Medicaid health care provider networks, including by directly impacting access to providers that serve Medicaid beneficiaries (for example, reproductive health or nursing facility providers) and by reducing reimbursement (under new state-directed payment (SDP) restrictions), which may cause some providers to stop accepting Medicaid patients altogether. In response to general Medicaid funding gaps caused by H.R. 1, states may look to reduce Medicaid provider reimbursement further. However, MCOs still must comply with provider network requirements set by their state contracts and, by July 2027, have to meet new network adequacy standards. In addition, states may need to increase Medicaid provider reimbursement as a tool to mitigate some of H.R. 1's impact on access to care. States should maximize opportunities and flexibilities to keep Medicaid networks strong.

Changes to state laws/ regulations that may be required

States should:

- Seek approval from CMS for SDPs for health care services most at risk after H.R. 1, including nursing, reproductive health, primary care and rural hospital services.
- Pursue value-based SDP models that link provider payment to care quality to attract and reward providers who offer high-quality services to Medicaid enrollees.
- Require MCOs to increase funding for primary care.
- Reduce state administrative burdens that make it difficult for providers to participate in Medicaid (including streamlining the enrollment and credentialing process, reducing prior authorization burdens, improving payment processing times, and reducing incomplete payments).
- Oversee timeliness of prior authorization decisions and appropriateness of denials; set additional requirements (for example, to address retrospective denials).
- Eliminate "lesser-of" payment policies that lower payment for providers who care for dually eligible enrollees.

MCO procurement/contracting issues to consider

Contract language should:

- Underscore upcoming federal network adequacy standards and extend standards to additional provider types.
- Include requirements to reduce administrative barriers to providers to enroll in Medicaid.
- Set provider participation continuity as an additional measure of network adequacy.
- Encourage the use of strategies that can promote more efficient contracting with specialists.
- Require plans to clarify which services are eligible for freedom of choice protection to ensure enrollees have access to a wide array of reproductive health services out of network.
- Reinforce new prior authorization decision time frames (effective January 1, 2026); ensure MCOs provide a specific reason for denial of services from a standardized industry list.
- Through the SDP mechanism, require plans to enhance provider reimbursement to increase access to services and provider networks.

Oversight/monitoring needed

Advocates can:

- Identify where higher Medicaid rates or value-based payment models may be needed to support access, including by encouraging provider participation in underserved areas and among certain provider types (for example, HCBS).
- Collaborate with their state's Medicaid Advisory Committee to advance discussion about fair Medicaid provider rates and gaps in provider networks.
- Leverage implementation of new network adequacy requirements as a way to secure MCO support for higher payment rates.
- Comment on SDP preprints submitted by their state.
- Conduct secret shopper surveys to determine access to services and provide feedback to their state.
- Document and track access to care challenges among MCO members and elevate these stories to policymakers and the media.
- Raise awareness that freedom of choice protections allow MCO enrollees to obtain reproductive health services from out-of-network providers of their choice without a referral.

5. FUTURE STATE PLANNING

With steep provider tax reductions and other financial constraints ahead, state policymakers may be contemplating ways to scale back their Medicaid programs, including by reducing optional Medicaid benefits, adding eligibility restrictions or cost sharing, or lowering Medicaid provider payments. However, new pressures on the system can bring opportunities to rethink how care is financed and delivered, what services are prioritized, and how states can use accountability levers to ensure MCOs provide access to the highest-quality care. With time to plan before Medicaid funding cuts take effect (Medicaid expansion states have until fiscal year 2028 before reductions to provider taxes begin), advocates can work with their states now to identify solutions.

Changes to state laws/ regulations that may be required	MCO procurement/contracting issues to consider	Oversight/monitoring needed
States should: • Set a goal for primary care investment as a percentage of total health spending for commercial insurers. (Efforts like these can ensure higher payment to primary care and safety net providers even in a time of reduced Medicaid funding.) • Establish health care cost commissions (state agencies or independent entities that work to develop enforceable systemwide and sector-specific cost growth targets for state health care spending). • Focus on quality and preventive care programs by expanding coverage for evidence-based services provided in nontraditional settings (for example, telehealth services or services in community-based locations) and provided by nontraditional provider types (for example, community health workers). • Increase MCO oversight using all available mechanisms, including by publicly publishing data on MCO medical loss ratios and sanctions.	**Contract language should:** • Require a minimum medical loss ratio (MLR) of at least 85% (meaning 85% of the capitation rate paid by the state to the plan must be spent on services related to the health of MCO plan enrollees instead of administration expenses and profit) and require plans to repay the state if the plan fails to meet the MLR minimum. • Ensure MCOs have the ability to strengthen provider recruitment, retention and data accuracy to meet federal and state-defined quantitative benchmarks and wait time standards. • Contain corrective action plans or other enforcement actions when MCOs fail to meet quality performance standards.	**Advocates can:** • Uplift promising financing and care delivery models that may help their state retain Medicaid services while addressing cost (for example, pursuing models described here, here and here). • Determine where barriers exist (for example, state laws/policies that limit Medicaid reimbursement for community health workers) and engage with lawmakers to ensure that MCO enrollees have access to a robust set of evidence-based and cost-effective services outside traditional settings (where appropriate). • Urge states to use sanctions more effectively as an accountability tool. States vary widely in how often they impose sanctions and for what causes. • Illustrate systematic problems (for example, poor network adequacy or barriers to accessing care) that can be addressed in their state's managed care quality strategy or through procurement. Systematic issues may justify reprocurement in states that have stalled on entering a new procurement cycle.

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