



Medicaid after H.R. 1

Why Errors Will Rise Unless States Reduce Friction Before January 2027

By Jim Garrity
Chief Client Officer
SingleStone Consulting

Contents

- 01 Abstract
 - 02 What H.R. 1 Changes Operationally
 - 03 The Capacity Trap
 - 04 Budget Pressure Is Constraining Capacity
 - 05 Why More Verification Produces More Errors
 - 06 Why Traditional Cost Controls Miss the Problem
 - 07 Administrative Friction Is the Hidden Cost
 - 08 What Actually Works Under Load
 - 09 Design for the Reality States Are In
 - 10 Where to Start
 - 11 Appendix: H.R. 1 Statutory Text
-

Abstract

H.R. 1 significantly increases Medicaid verification workload at a time when state systems are already at capacity and budgets are flat. States must implement work requirements by January 2027, and outreach infrastructure must be in place by summer 2026. That leaves little runway.

When these systems are overloaded, the result is rarely tighter fraud detection. It is more procedural failures, more churn, and higher downstream costs.

What happens if states do nothing?

- Administrative errors rise as workload outpaces capacity.
- Eligible people lose coverage and cycle back through re-enrollment, driving up costs.
- Delayed care shifts to expensive settings like the emergency room.
- Traditional cost controls like hiring freezes and rate cuts make the problem worse.

What can states do about it?

- Reduce friction through real-time, two-way communication.
- Adopt ex parte-first workflows that reserve manual effort for complex cases.
- Design operations for surge conditions, not ideal ones.

In this article, you will find the data behind these dynamics, why conventional responses fall short, and a practical framework for redesigning operations before the capacity gap becomes a coverage crisis.

BACKGROUND

What H.R. 1 Changes Operationally

H.R. 1 introduces three changes that directly increase the volume and complexity of eligibility work for state Medicaid agencies.

First, adults aged 19 to 64 enrolled through the [ACA Medicaid expansion](#) must now meet community engagement requirements, documenting 80 hours per month of work, education, job training, or community service to maintain coverage.

Second, eligibility redeterminations move from [once a year to every six months](#), doubling the processing volume for the largest segment of Medicaid enrollment.

Third, the law [delays Biden-era rules](#) that would have streamlined enrollment and renewal processes, freezing in place the paper-heavy, manual workflows states were already working to modernize.

These requirements land on systems that just finished the largest eligibility processing effort in Medicaid's history.

During the pandemic, continuous enrollment rules prevented states from removing anyone from the rolls. When those rules ended, states spent the better part of two years working through a backlog of redeterminations. That process, known as unwinding, is largely complete.

H.R. 1 does not arrive in a recovered environment. It arrives in a depleted one.

— The capacity trap is already forming.

The implementation timeline is compressed. HHS must issue an interim final rule by June 2026. States must have outreach infrastructure in place between June and August 2026. Work requirements take effect by January 2027.

Jan
2027

Work requirements take effect

Outreach infrastructure required by summer 2026

H.R. 1's Subchapter D requires expansion-population adults to document **80 hours per month** of qualifying activity. Redeterminations now happen every six months instead of annually. States may not waive these requirements, though exceptions exist for short-term hardships and individuals with serious medical conditions or dependent children aged 13 or younger. [Read the full bill here.](#)

At an operational level, the strain shows up in three places:

- **More touches per case** — Every new verification step adds work to systems already stretched thin.
- **Less tolerance for backlog** — When timelines slip, systems default. In many workflows, that default is closure.
- **No automatic capacity increase** — Federal oversight has repeatedly flagged that backlogs translate into [wrongful procedural outcomes](#) during high-volume periods.

ANALYSIS

The Capacity Trap

The Capacity Trap is the cycle where increased requirements, applied to systems already running at their limits, produce more procedural failures than they prevent.

For instance, a single mother working two jobs did everything right. She reported her income changes as required. She never lost eligibility.

What failed was the system handling her renewal.

The caseworker assigned to her case was managing a caseload well above recommended levels. Processing deadlines stacked up faster than they could be cleared. When the renewal was not processed in time, the system applied its default logic.

Coverage ended automatically.

She had been managing Type 2 diabetes with daily medication. Without insurance, she could not afford her insulin. She rationed doses for three weeks before a coworker found her disoriented at work and called 911.

The hospital admitted her for diabetic ketoacidosis. The bill ran into tens of thousands of dollars. The state ultimately covered it.

Nothing about this outcome involved fraud or ineligible enrollment. She qualified. The failure came from a process that could not absorb additional workload without breaking.

That dynamic puts states in a bind, with two realities hitting at once:

- **New federal requirements** that expand verification activity across eligibility and renewal workflows.
- **Budget pressure** that limits the ability to expand capacity before those requirements take effect.

When systems already operating near their limits are asked to do more without reducing friction, the predictable result is not tighter integrity. It is more procedural failure, more churn, and higher downstream cost.

CONTEXT

Budget Pressure Is Constraining Capacity

Take Virginia as one example. A [November 2025 briefing](#) from the Virginia Senate Finance and Appropriations Committee shows Medicaid facing a projected \$410.3M general fund shortfall in FY 2026 and \$2.8B across FY 2026–2028. Of that, \$167M is tied directly to a federal matching rate decrease.

\$410.3M

Projected Virginia Medicaid general fund shortfall, FY 2026

One state among many navigating the same post-unwinding reality

Virginia is not an outlier. While figures vary by state, many are navigating the same post-unwinding reality: rising administrative workload, reduced federal matching support, and constrained budgets. These pressures are colliding just as federal oversight increases expectations around verification accuracy and timeliness.

When states must close gaps like these while taking on more eligibility work, capacity tightens, timelines compress, and systems default to closure rather than resolution.

ANALYSIS

Why More Verification Produces More Errors

Over the past two years, Medicaid agencies have already been under sustained pressure as they unwound [pandemic-era continuous enrollment](#). H.R. 1 adds another layer by expanding verification requirements and pushing more cases into “active handling” paths instead of automatic renewal paths.

A key distinction often gets lost in public debate: [what an “error” represents](#) in Medicaid oversight. In many cases, an error does not mean someone was ineligible or that fraud occurred. It means a reviewer [could not confirm compliance](#) because documentation was missing, incomplete, or not retrievable within required timeframes.

[Payment error reviews](#) consistently show that a large share of findings are tied to documentation and process breakdowns, not improper enrollment.

As verification workload rises, error rates rise for a structural reason: friction converts routine work into rework. Capacity constraints turn compliance into procedural failure.

Here is what compounding friction looks like:

- A notice is sent to an incomplete or outdated address.
- The individual never receives it.
- The system records “no response.”
- The case closes.
- The individual reapplies or appeals.

The result is more work than the original renewal would have required.

During unwinding, federal reviews [documented procedural disenrollments](#) driven by workflow breakdowns, communication failures, and capacity limits — rather than eligibility changes alone.

Analysis from the [Urban Institute](#) shows that increasing redetermination frequency raises churn and administrative cost while increasing coverage loss among people who remain eligible.

Recognizing the Capacity Trap in Your Own Operations

Operationally, the capacity trap shows up in recognizable patterns:

Procedural closure rates are rising faster than ineligibility findings. The system is terminating more people — not because more are ineligible, but because more cases are timing out.

Re-enrollment volume is climbing. People who were terminated are coming back — which means the original closure didn’t resolve anything. It just created more work.

Backlog timelines exceed notice response windows. By the time a caseworker gets to a renewal, the deadline for the beneficiary to respond has already passed.

Any one of these is a warning sign. Together, they confirm a system generating more work than it can absorb.

ANALYSIS

Why Traditional Cost Controls Miss the Problem

When pressure rises, states often reach for familiar levers.

Staffing constraints and hiring freezes

Hiring freezes are a common response to budget stress. The operational result is predictable: vacancies go unfilled, backlogs grow, and timelines compress. During unwinding, CMS [repeatedly reinforced](#) timely processing expectations precisely because of this risk. Increasing verification work while constraining staffing leads to more procedural errors.

Automation without guardrails

Automation can help, but not if it accelerates closure without safeguards. Litigation surrounding [Tennessee's TennCare unwinding](#) illustrates what happens when automated eligibility systems fail legal and procedural requirements at scale.

Provider rate cuts

Provider rate cuts may reduce short-term spending, but they carry access risks. Analysis from [MACPAC](#) shows that lower reimbursement rates are frequently cited as reasons providers limit or refuse new Medicaid patients. Reduced access increases the likelihood of delayed care and shifts utilization to higher-cost settings.

ANALYSIS

Administrative Friction Is the Hidden Cost

Procedural disenrollment creates churn, and churn is expensive.

The clearest evidence is how aggressively federal agencies pushed [ex parte renewals](#) during unwinding. Ex parte renewals reduce staff workload and paperwork burden by using data states already have. Data gaps break the automated renewal path — cases are forced into manual workflows built around mail cycles and delayed feedback, where each handoff increases delay, cost, and the risk of termination for people who remain eligible.

[Virginia is one example](#). Many states are navigating the same mix of post-unwinding cost pressure, federal match changes, and rising administrative workload.

The question is whether states can reduce friction fast enough to prevent Medicaid systems from collapsing under combined workload and budget pressure.

We have seen this pattern before. During the pandemic, state unemployment systems were overwhelmed by sudden demand. Outdated infrastructure, manual verification processes, and fragmented data systems created massive backlogs. Millions of eligible citizens waited weeks or months for benefits because the operational systems could not scale. Medicaid now faces a similar capacity trap.

FRAMEWORK

What Actually Works Under Load

There is no single fix. Solutions must operate at multiple levels. Each of the following layers targets a different pressure point in the capacity trap.

Layer 1: Reduce friction inside renewal workflows

Resilient, two-way communication — such as [text messages](#) and secure uploads — helps prevent small issues from becoming closures. In practice, [simpler requests and timely prompts](#) consistently improve response rates across public programs.

[Ex parte first](#) — manual only when needed — should be the default operating model, supported by clear controls and quality checks. Automation should accelerate correct outcomes, not accelerate closures.

Layer 2: Protect operational capacity

States that limit churn treat renewals as an operational discipline:

- Prioritizing high-risk populations for proactive outreach.
- Creating specialized queues for complex eligibility categories.
- Tracking time-to-resolution and closure reasons.
- Running surge “war room” models during peak periods.

States that treat renewals as a managed system — rather than a transaction queue — tend to see measurable drops in procedural churn within a single renewal cycle.

Layer 3: Address budget reality in parallel

Even a perfect renewal process does not erase funding gaps. With post-unwinding cost pressure and reduced federal matching already in play, states are being pushed toward broader strategies:

- Focusing integrity efforts where the biggest dollars are — such as provider payment accuracy.
- Preserving access to care through models that reduce avoidable emergency and hospital use, [including hybrid and virtual care](#).

Pushing eligible people off coverage rarely delivers durable savings. It shifts cost — it doesn't reduce it.

IMPLICATIONS

Design for the Reality States Are In

Verification requirements are rising. Administrative workload is rising. Budget pressure is real. And the January 2027 deadline is not moving.

If systems remain paper-heavy and delay-driven, the failure mode is predictable: backlogs, procedural terminations, rework, and higher downstream costs. It is the capacity trap.

When friction drops, throughput increases. When throughput increases, the system keeps eligible people enrolled, preserves staff capacity for complex cases, and limits the churn that drives avoidable spending.

But friction reduction alone is not enough. High-volume programs like Medicaid need intelligent systems designed to operate reliably under stress. That means workflows that scale, automation with guardrails, real-time visibility into failure points, and operational models built for surge conditions — not ideal ones.

ACTION

Where to Start

The emergency room visit in the opening story did not happen because Medicaid “overcovered” someone. It happened because a system exceeded its capacity. With January 2027 approaching, that is the scenario states need to design against now.

For state leaders navigating this environment, three moves create the most immediate leverage:

1. Know where the trap is binding.

Pull procedural closure rates, re-enrollment volume, and backlog-to-response-window timelines. If closures are rising faster than ineligibility findings, the system is generating work — not resolving it.

2. Reduce friction before adding capacity.

The fastest way to free up throughput isn't hiring — it's eliminating the handoffs, notice cycles, and manual steps that turn routine renewals into rework. Ex parte first, digital communication, and automation with guardrails all reduce volume at the source.

3. Design for surge, not steady state.

The preparation window is closing. States need outreach infrastructure by summer 2026 and compliance systems by January 2027. War room models, specialized queues, and real-time visibility into failure points are how high-volume systems absorb spikes without breaking.

[SingleStone](#) works with state agencies on exactly this kind of operational redesign — building systems that hold up under real conditions, not ideal ones. If your team is preparing for what H.R. 1 means operationally, we'd welcome the conversation.

About the Author

Jim Garrity is Chief Client Officer at SingleStone Consulting. He works with state agencies and regulated organizations on modernizing high-volume systems where operational reliability, compliance, and human impact intersect.

About SingleStone

[SingleStone](#) is a data and technology consultancy that partners with public sector and highly regulated organizations to design resilient systems that operate reliably at scale — with a focus on workflow modernization, data-driven decision support, and capacity-aware system design

Appendix: H.R. 1 Statutory Text, Subchapter D

The following is the relevant statutory text from H.R. 1, Subchapter D, Increasing Personal Accountability. Provided for reference. [Read the full bill here.](#)

Section 71119: Community Engagement Requirements

This section requires, beginning not later than the first quarter after December 31, 2026 (or earlier, at the option of the state), individuals who are eligible for Medicaid as part of the Medicaid expansion population to engage in community service, work, or other activities in order to qualify for Medicaid.

Specifically, the section requires these individuals to, on a monthly basis, (1) work at least 80 hours, (2) complete at least 80 hours of community service, (3) participate in a work program for at least 80 hours, (4) be enrolled at least half-time in an educational program, or (5) engage in any combination thereof for a total of at least 80 hours.

Individuals who are applying for Medicaid must demonstrate compliance for one to three months consecutively and immediately prior to filing an application; individuals already enrolled must demonstrate compliance for one month or more during the period between the individual's last eligibility determination and the next scheduled eligibility determination.

States must verify compliance upon a determination or redetermination of eligibility but may also choose to verify compliance more frequently. States may not waive the new requirements. However, states may provide an exception for individuals experiencing short-term hardships (e.g., hospitalization).

The section excludes certain individuals from these requirements, including those with serious medical conditions or with dependent children aged 13 or younger.

Upon request, CMS may exempt a state from fully implementing these requirements until December 31, 2028. The section provides \$200 million to states and \$200 million to CMS for FY2026 to implement these requirements.

Section 71120: Cost-Sharing Requirements

This section requires, beginning in FY2029, states to institute cost-sharing requirements for individuals eligible for Medicaid as part of the Medicaid expansion population whose family income exceeds the federal poverty line. Cost sharing may not exceed \$35 for an item or service; total cost sharing for all individuals in a family may not exceed 5% of the family's income.

The requirements do not apply to (1) services for which cost sharing is already prohibited (e.g., emergency services); (2) primary care, mental health, or substance use disorder services; or (3) services provided by federally qualified health centers, certified community behavioral health clinics, or rural health clinics.

The section provides \$15 million for FY2026 for CMS to implement these provisions.