Medicaid Coverage Retention

The 2027 Business Case

Preventing avoidable, procedural coverage loss under H.R.1 / OBBBA Medicaid work requirements

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The bottom line

Jan 1, 2027

Federal enforcement

80 hrs/mo

Work / activity rule

~1 in 4

Lost coverage in Arkansas

$600M+

Pledged — to eligibility, not outreach

> *Eligible people will lose Medicaid over paperwork, not eligibility. That is a fixable, fundable communications problem.*

What changed: H.R.1 / OBBBA

- Signed July 4, 2025 — first nationwide Medicaid community-engagement (work) requirement
- Many expansion adults (19–64) must complete ~80 hrs/month of work, school, training, or service — and report it
- Renewal cycle for expansion adults cut from annual to every six months
- Enforcement begins January 1, 2027

The dates that matter

The 2025–2028 implementation clock

> *The member-notice window (Jun–Aug 2026) is the action deadline. Procurement happens in 2026.*

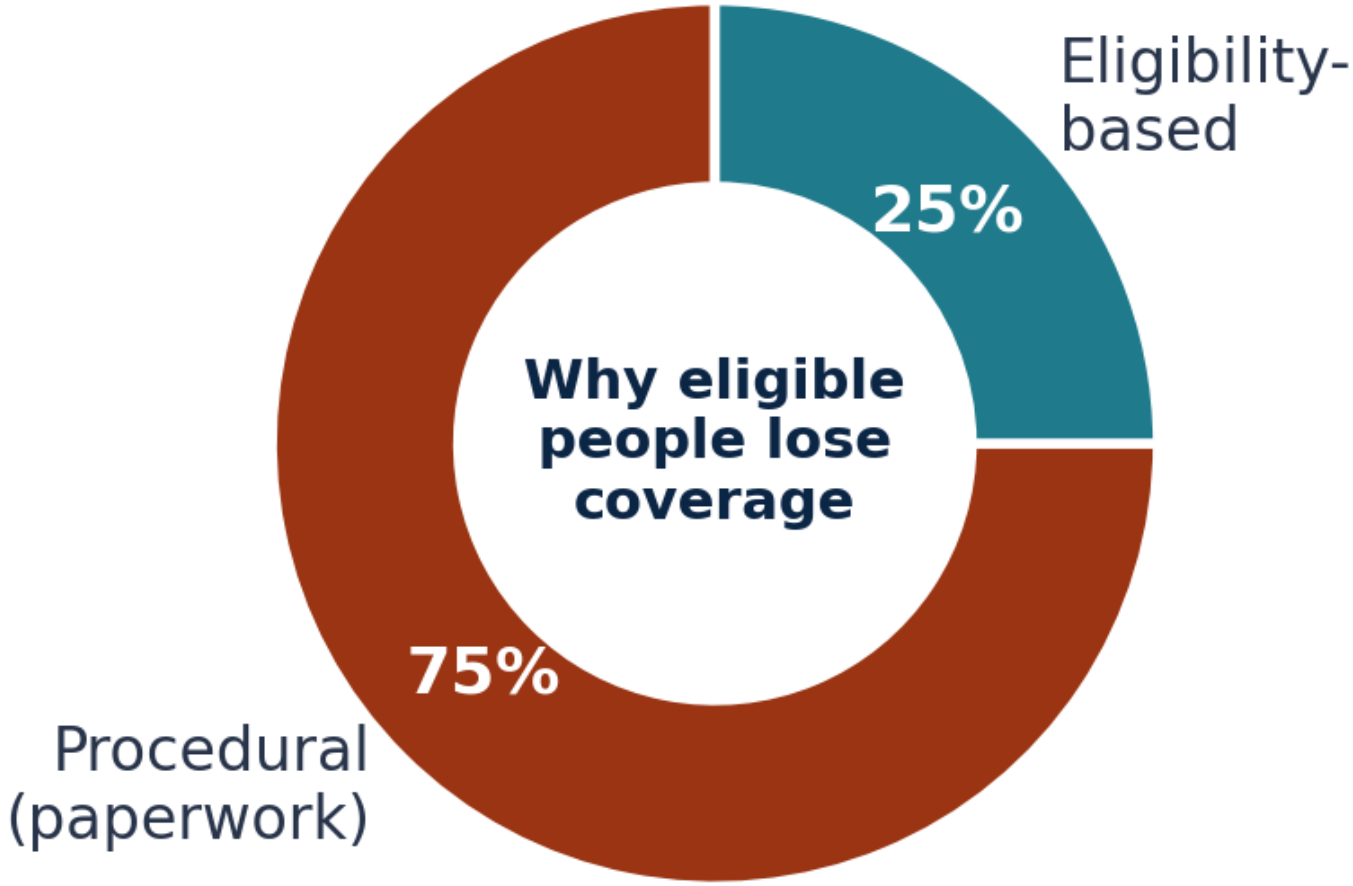
The new six-month renewal

- Redeterminations for expansion adults now twice a year, not once
- Doubles the administrative touchpoints where an eligible member can fall off
- Makes retention a permanent operating discipline — not a one-time 2027 event

Who is subject — and who is exempt

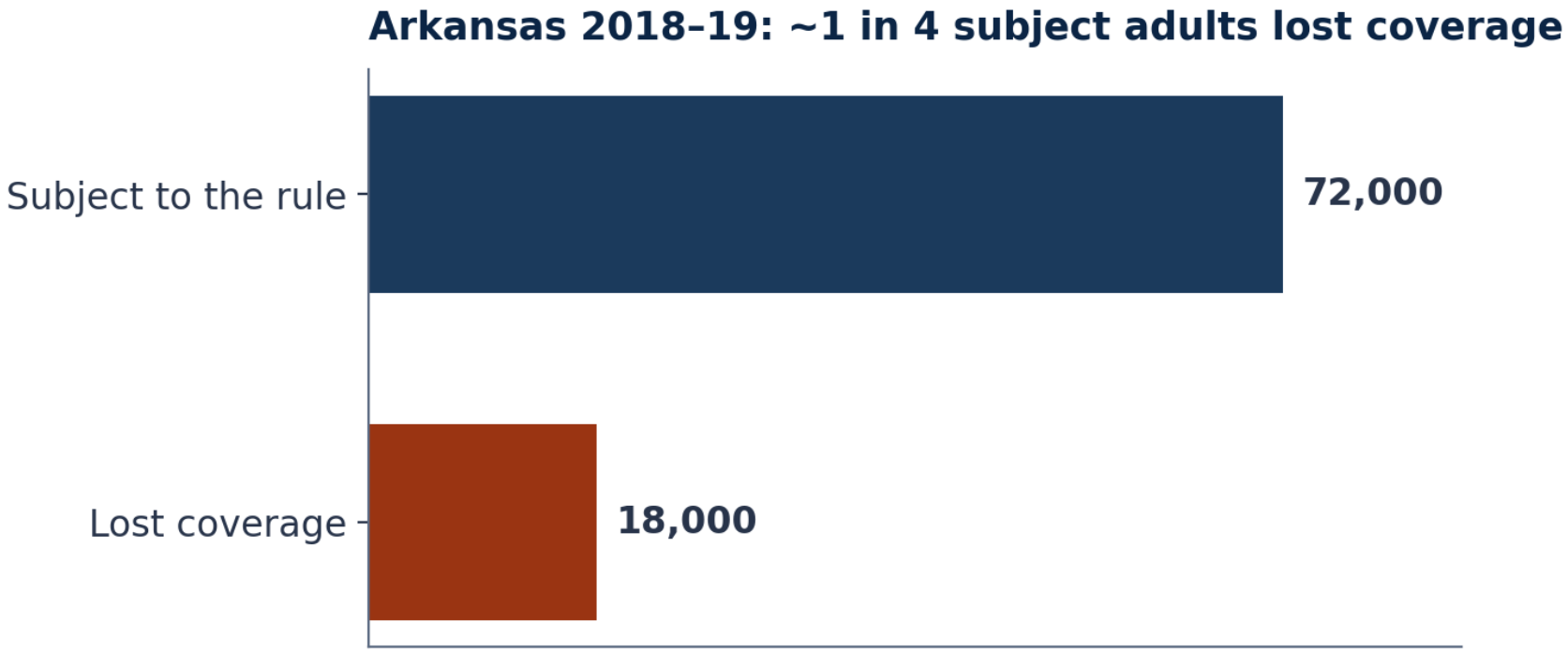
- Applies to the ACA Medicaid expansion adult population
- Exempt categories include: caregivers of a child <14, pregnant/postpartum, disabled/medically frail, AI/AN, SUD treatment, certain students, short-term hardship
- An exemption only protects a member the state can identify and document — itself a communication problem

The core problem: procedural disenrollment



> *Most coverage loss is procedural — a paperwork failure, not an eligibility failure.*

The Arkansas precedent

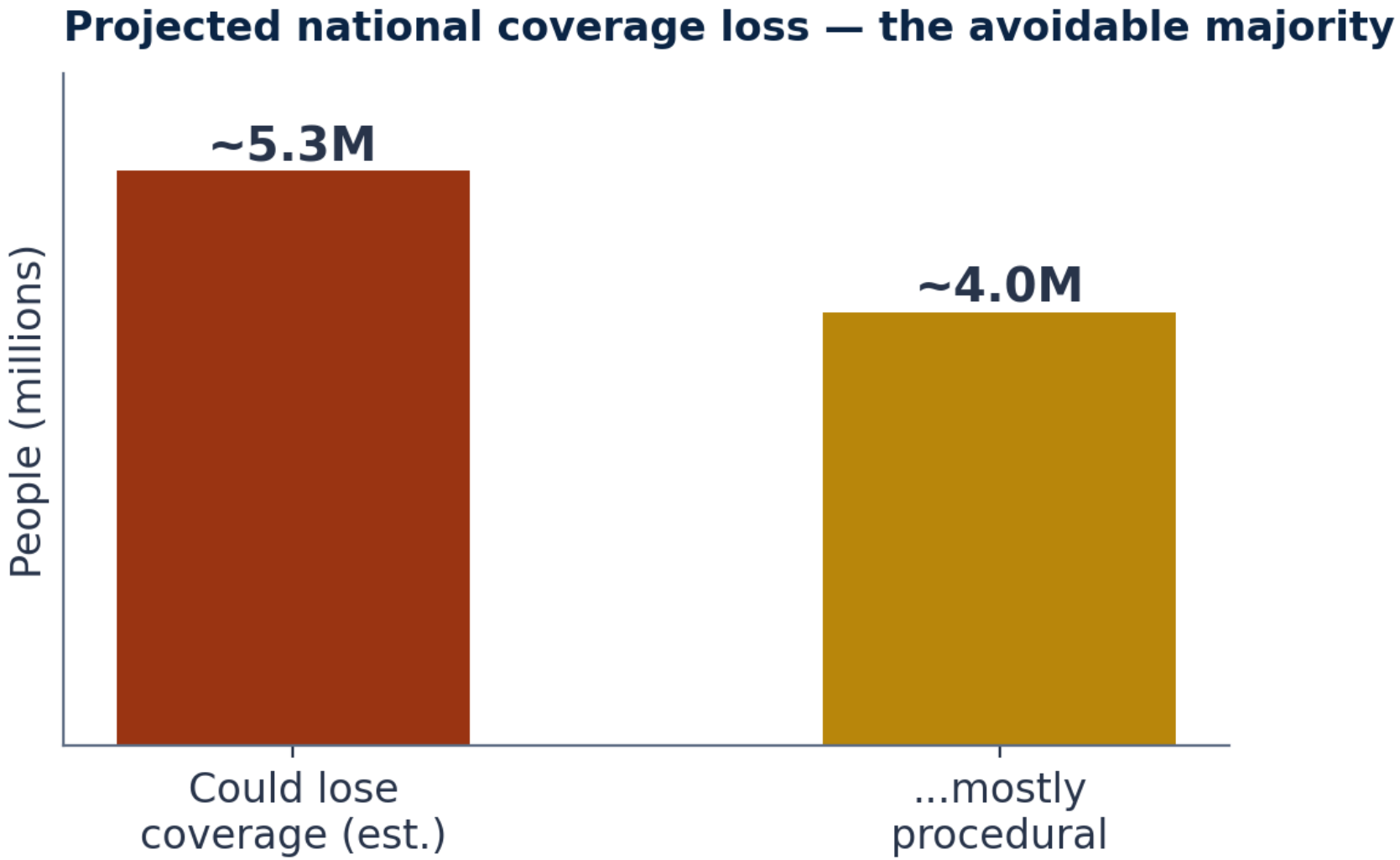


2018–19: ~18,000 lost coverage — about 1 in 4 subject adults — with no measurable employment gain.

The unwinding confirmed it at scale

- 2023–24 Medicaid unwinding: a large share of disenrollments were procedural, not eligibility-based
- States that automated renewals + invested in clear, multilingual outreach retained far more eligible members
- Ex-parte (automatic) renewals are associated with materially lower procedural-denial rates

It scales now



Independent estimates project millions could lose coverage nationally — the avoidable majority procedural.

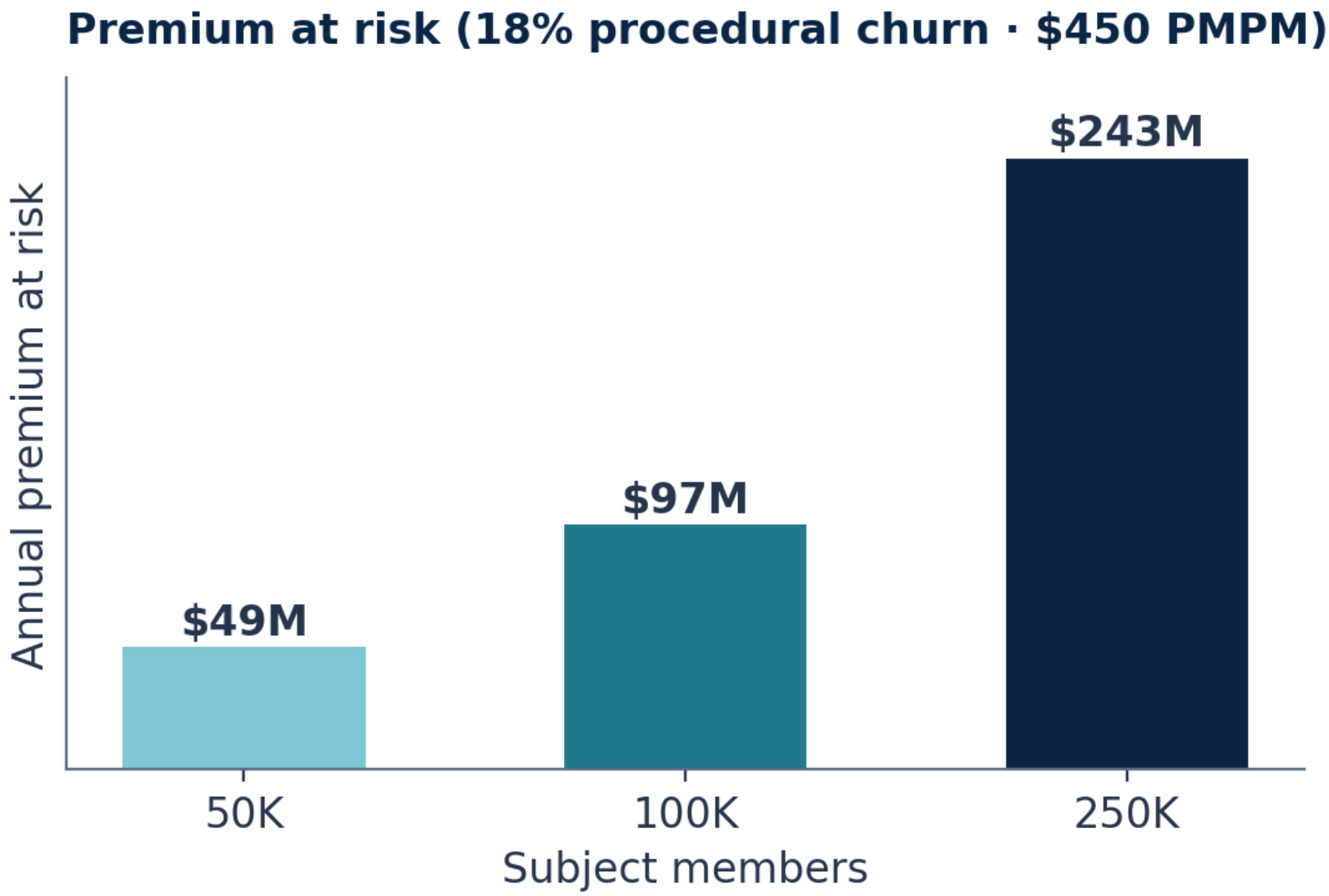
Market & population at risk

- 70M+ Americans on Medicaid; tens of millions in managed care
- Requirement applies across ~40 expansion states + DC
- Four buyer types: MCOs, state agencies, eligibility primes, and FQHCs/CBOs

Four buyers, one capability

- MCOs (~290) — feel churn as lost capitation; can contract fast
- State agencies (~40 + DC) — on the hook for the member-notice mandate
- Eligibility primes (~10) — need a member-comms layer they don't staff
- FQHCs / CBOs — trusted messengers absorbing the bad-debt cost

The financial impact: MCO economics

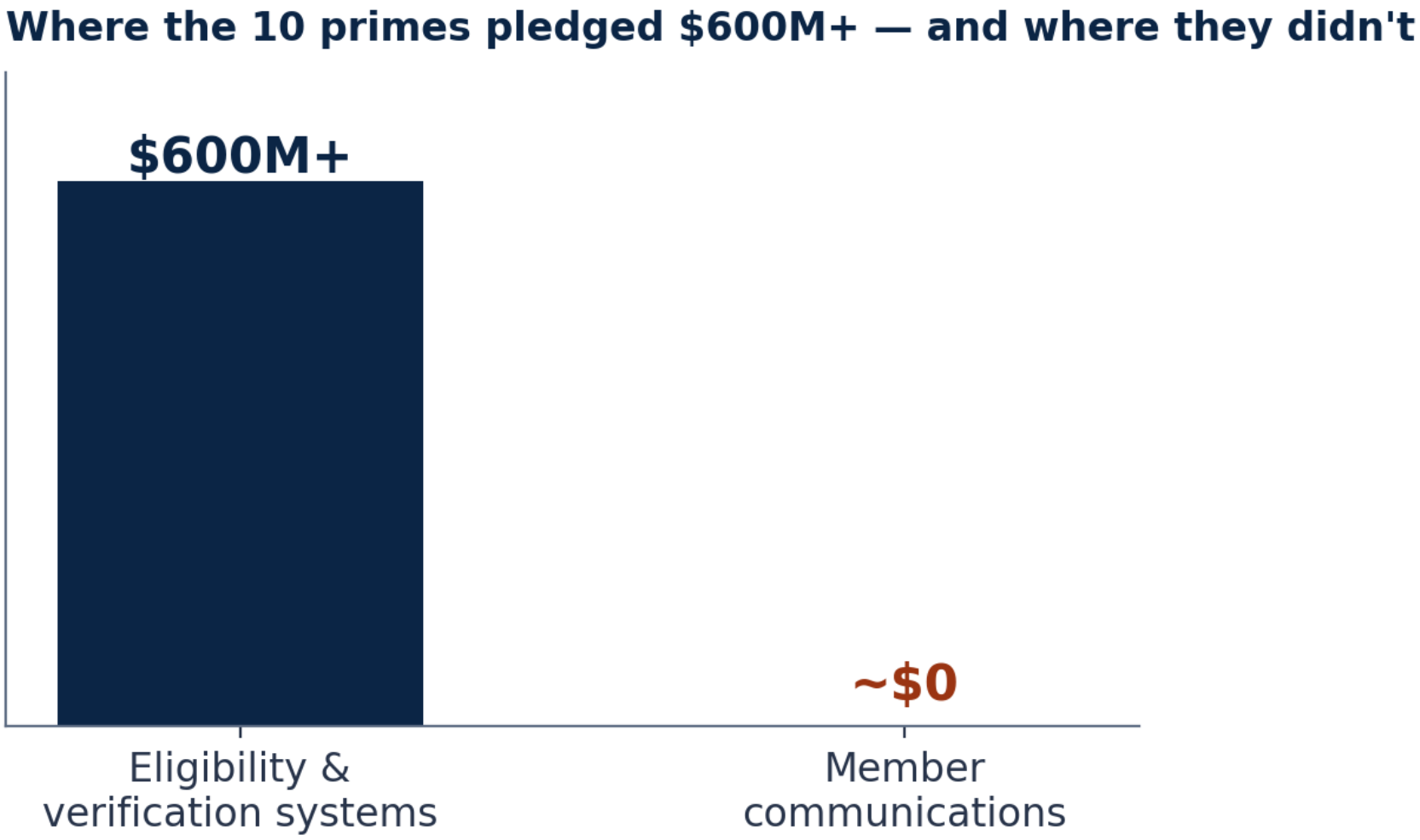


Every procedurally-disenrolled member is lost capitation, month after month.

State exposure

- FMAP exposure on wrongly-terminated eligible members
- Improper-termination liability + downstream uncompensated-care cost
- Political risk of mass coverage loss
- Administrative cost to stand up the requirement — tens of millions per state

The vendor landscape



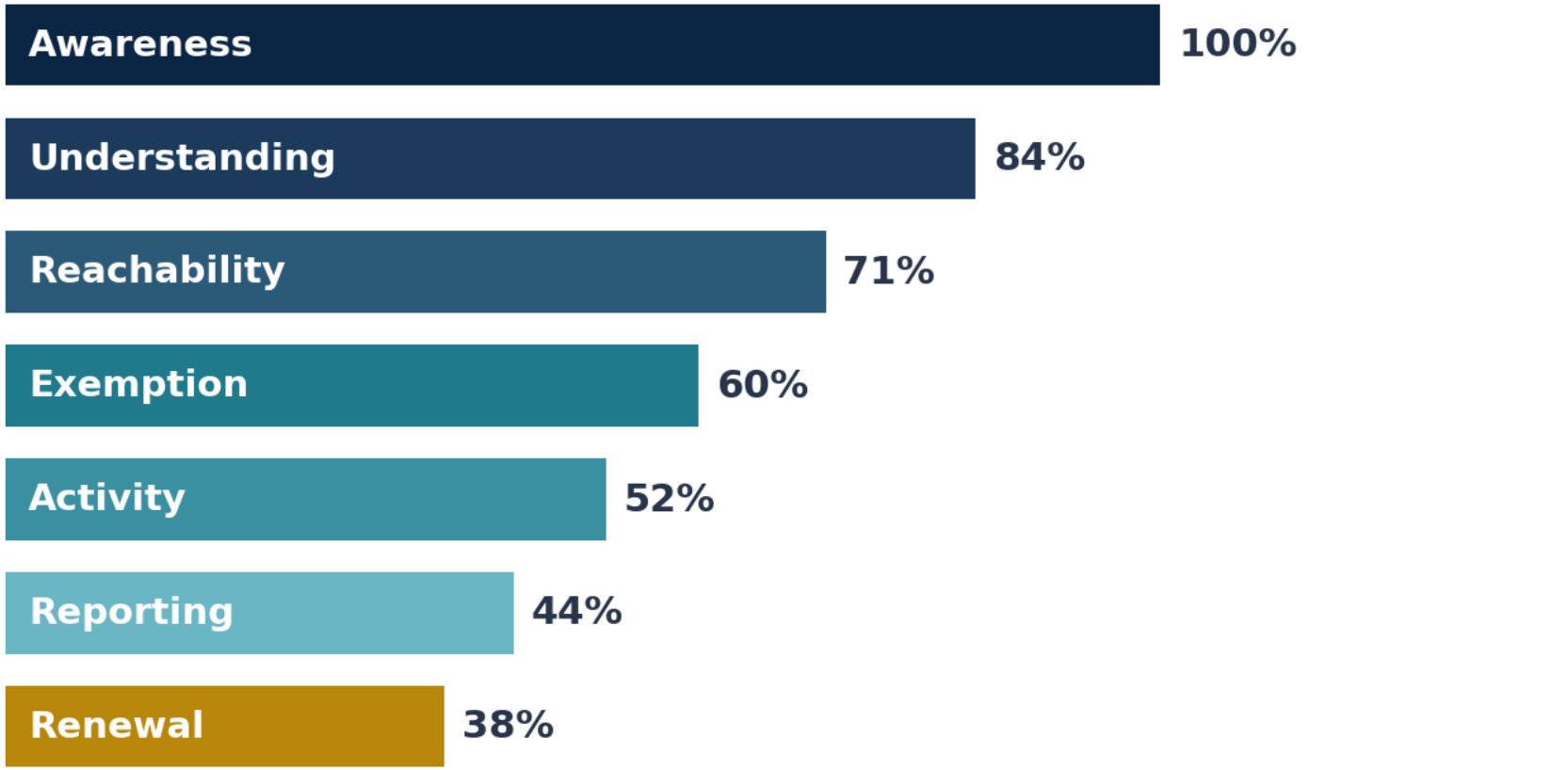
10 primes pledged $600M+ — concentrated on eligibility/verification, not member communications.

The unowned layer — our wedge

- We do NOT build eligibility or verification systems
- We are the member-engagement layer on top of them
- Plain-language, multilingual notices · exemption education · omnichannel outreach · measurement
- Sold to MCOs and states directly, or as a subcontractor to the primes (incl. BEP goals)

The member journey

Members reaching each stage — every step sheds eligible people



> *Every administrative stage sheds eligible people. Retention is funnel optimization.*

The compliance perimeter

- Plain language — 4th–6th grade reading level, one action per notice
- Language access — native-quality translation, not machine alone
- Accessibility — Section 508, IITAA, ADA, WCAG 2.1 AA (ADA Title II web rule effective Apr 24, 2026)
- TCPA consent for SMS/IVR · HHS marketing-rule aware · PHI-appropriate

The retention playbook

- 1 — Identify & segment: flag likely-exempt members from data; segment by language, geography, risk
- 2 — Communicate: plain-language, multilingual notices across mail/SMS/IVR/CBO
- 3 — Exemptions & reporting: prompt exemptions; make reporting simple; ex-parte first
- 4 — Measure: equity KPIs disaggregated by language, geography, disability

Channel-by-channel outreach

- Mail — the legal notice; fix addresses + readability + language
- SMS — highest response; TCPA-compliant consent & opt-out
- IVR & live phone — scale reminders; warm-transfer the hardest cases
- Web/portal — mobile-first, accessible, ex-parte renewal first
- Trusted messengers (CBO/FQHC) — reach the hardest-to-reach

Exemptions: the highest-leverage save

- Most avoidable loss among eligible people is unclaimed exemptions
- Pre-identify likely-exempt members from claims & cross-program data
- Prompt them and make documentation effortless
- SNAP/TANF data-matching is the single biggest automation

Language access & accessibility

- Spanish first, plus the locally-dominant languages; human translation + community review
- Telephonic & in-person interpretation at every live touchpoint
- 508 / IITAA / ADA / WCAG 2.1 AA; accessible alternatives to every PDF
- Design for low digital literacy and screen readers

Measurement: the KPI framework

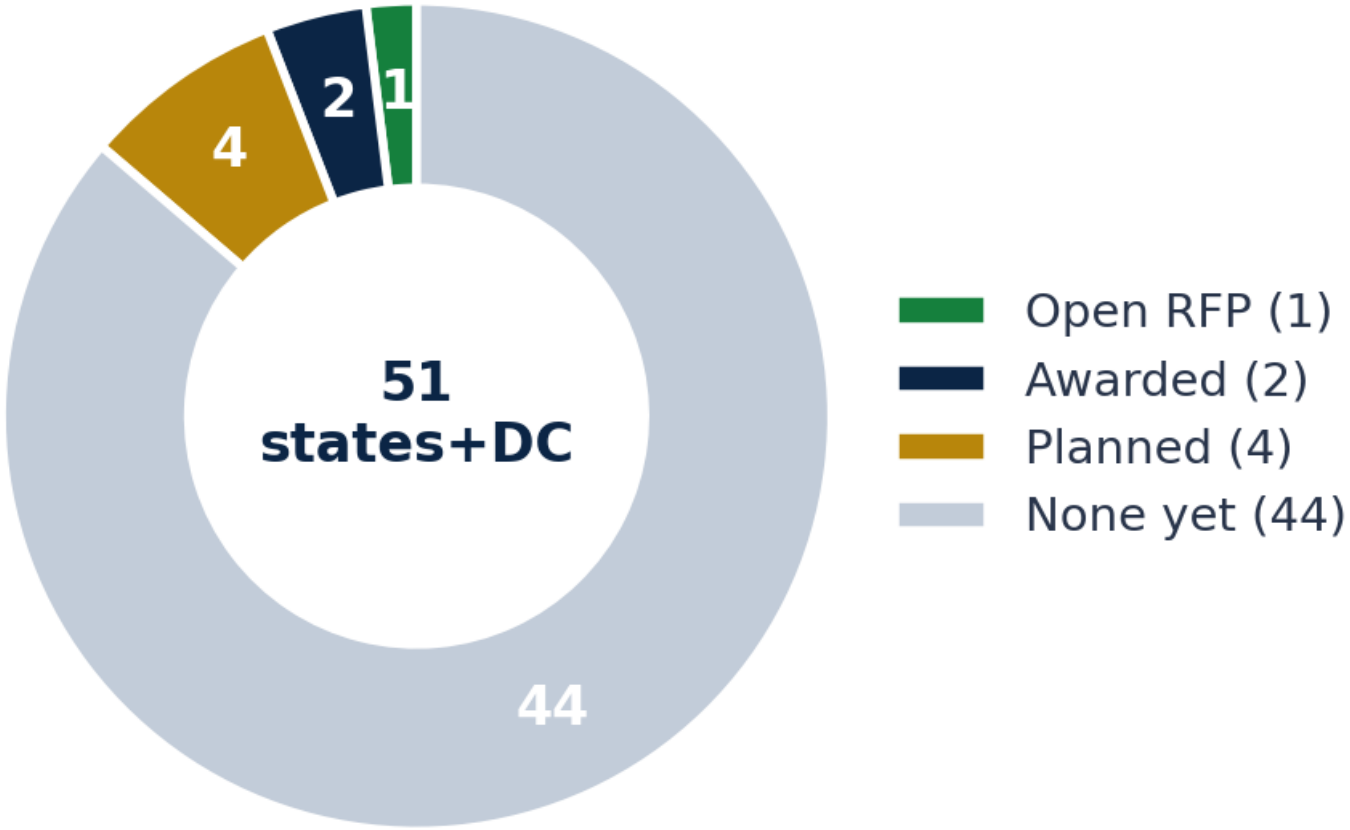
- Procedural disenrollment rate — the headline number
- Notice reach · exemption capture · reporting completion · ex-parte renewal · reinstatement
- Equity gap — spread by language, geography, disability
- Baseline before the Jun–Aug 2026 window; track the first two 2027 cycles

Procurement & teaming: how to win

- State RFPs — watch the portals; bid early; lead with the deadline
- MCO direct — lead with premium-at-risk; price as a fraction of loss prevented
- Prime subcontracting — be the engagement sub; help meet BEP/diversity goals
- Awarded states are teaming targets, not dead ends

The 50-state RFP map

Procurement activity across 51 jurisdictions



> *Most jurisdictions have NOT yet solicited member-comms work. Early movers and pre-positioning win.*

Near-term targets

- Open RFP — Connecticut
- Awarded (teaming plays) — Arizona (AHCCCS), Illinois (HFS)
- Planned / budgeted — California (DHCS), Arkansas, Missouri, Ohio
- 44 states not yet solicited — the pre-positioning opportunity

The 90-day readiness roadmap

- Weeks 1–2 — quantify exposure; map the member journey; find the gaps
- Weeks 3–6 — build CMS-compliant, plain-language, multilingual notice set + SMS/IVR + exemption guides
- Weeks 7–10 — run outreach inside the Jun–Aug window; capture response & exemption data
- Weeks 11–13 — measure retention lift; convert to ongoing managed outreach

Why us

- Built solely for Medicaid coverage retention — not a general agency
- The rare mix: technology, Medicaid policy, and marketing in one team
- U.S.-led with native-Spanish production capacity
- Full delivery team stood up per engagement across policy, language, compliance, production

How to start

- Rapid Pack — CMS-compliant EN/ES notices, SMS/IVR scripts, exemption one-pagers in 2–3 weeks
- Readiness Audit — quantify exposure + a prioritized retention plan
- Managed Outreach — run the program end-to-end through the 2027 cycles
- State rules pack & briefing — deeper, source-cited, per state

Don't let eligible people lose Medicaid over paperwork.

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Talk to us about a state- or plan-specific readiness audit before the August notice window.