E-GUIDE

Navigating the New Era of Medicaid Redetermination

The 2027 Guide to Eligibility Engagement and Renewal

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A New Era for Medicaid: More Frequent Renewals & New Community Engagement Requirements

Medicaid eligibility management is entering a new phase. Beginning January 1, 2027, states must implement new community engagement requirements for certain Medicaid adults, alongside more frequent eligibility redeterminations. For state Medicaid agencies and managed care organizations, eligibility engagement is becoming a continuous operational responsibility—not an annual event.

More eligibility touchpoints mean more opportunities for eligible people to lose coverage because of missed notices, incomplete paperwork, documentation requirements, outdated contact information, language barriers, or confusion about what action they need to take.

During the Medicaid unwinding period following the end of continuous coverage protections, approximately 71% of disenrollments were procedural-meaning individuals lost coverage due to paperwork or administrative reasons rather than con rmed ineligibility.

Who is subject to the new community engagement requirements—and who is exempt?

Beginning January 1, 2027, certain Medicaid adults must demonstrate **80 hours per month** of qualifying work, education, training, or community service to maintain eligibility. But the requirement does not apply to everyone. States must identify who is subject, who is exempt, and who already satisfies the requirement through another qualifying status.

Group	Status	What it means
Certain Medicaid adults ages 19–64	Subject	Must meet the monthly community engagement requirement
People meeting applicable TANF work requirements or qualifying through SNAP	Meets requirement / exempt	No separate community engagement showing required
Medically frail individuals	Exempt	Includes individuals with qualifying medical or functional needs
Pregnant or postpartum individuals	Exempt	Not subject to the requirement
Certain parents, caregivers and caretaker relatives	Exempt	Includes qualifying caregivers of young children or individuals with disabilities
American Indians and Alaska Natives	Exempt	Not subject to the requirement
Veterans with a total disability rating	Exempt	Not subject to the requirement
Participants in qualifying drug or alcohol treatment programs	Exempt	Not subject to the requirement

The operational challenge goes beyond determining eligibility. States must communicate the new requirements, identify applicable exemptions, verify compliance, request missing information when needed, and give individuals an opportunity to demonstrate compliance or an exemption before coverage is lost.

Source: CMS-2454-IFC, Medicaid Community Engagement Requirement for Certain Individuals, June 2026.

What Is Medicaid Redetermination?

Medicaid redetermination—also referred to as renewal or recertification—is the process by which states periodically review whether enrolled individuals continue to meet eligibility requirements, including income, household composition, and other qualifying criteria. Federal regulations require states to reassess eligibility and attempt renewal using available data before requesting additional documentation from beneficiaries.[2]

For state Medicaid agencies and Medicaid managed care organizations, redetermination requires coordinated communication and member support. States administer eligibility, while health plans can play an important role in helping members understand requirements, respond to notices, navigate state processes, and complete required actions on time.

What has changed is the cadence and complexity. Semiannual review cycles and expanded work requirement and verification standards have elevated administrative workload and procedural disenrollment risk. For plans, this means recurring outreach waves, higher inbound demand, and greater exposure to churn driven by process breakdown rather than ineligibility.

Transform redetermination engagement from reactive outreach to continuous orchestration—protecting coverage, reducing churn, and strengthening member trust during moments that matter most.

Why Medicaid Eligibility Engagement Demands a New Approach

The familiar cadence of annual redetermination has evolved. Twice-annual enrollment cycles and expanded verification requirements under H.R. 1 introduce greater complexity, compressed timelines, and increased compliance oversight.

Several converging forces define this new environment:

More Frequent Member Action Requirements: Members may now need to provide documentation or attestations multiple times per year. Many will also have to meet work requirements on a regular basis too. Missed deadlines—even procedural ones—can result in loss of coverage.

New Community Engagement Requirements: States must identify who is subject to the new requirements, determine exemptions, verify compliance, conduct outreach, and provide an opportunity to resolve missing or unverifiable information.

Higher Risk of Administrative Disenrollment: When documentation windows shorten and verification increases, even eligible members are at risk if communication fails.

Enrollment Volatility & Financial Impact: More frequent redetermination cycles increase churn risk, disrupt risk adjustment stability, and complicate quality performance management.

Operational Strain: Manual workflows and traditional outreach methods cannot scale sustainably across two enrollment cycles per year. Increased eligibility requirements, compressed timelines, and higher inbound volume place significant pressure on staffing, workflows, and budget predictability.

Communication Breakdown: Reaching members with timely, clear, and actionable information is more critical—and more difficult—than ever. Outdated contact information, language barriers, health literacy gaps, and the complexity of evolving requirements increase the risk of missed deadlines and preventable coverage loss.

Compliance Visibility: Audit readiness, documentation trails, and consent management have become more critical under H.R. 1-era scrutiny.

In this environment, incremental improvements are not enough. Medicaid leaders must build a continuous eligibility engagement strategy—one that proactively guides members through every phase of their enrollment lifecycle.

Reaching people is only the first ste

Traditional redetermination programs often focus on whether a notice was sent or a member was contacted. But successful eligibility engagement requires helping people move from **notification to completion.**

Reach

Connect through voice, SMS, email and web.

→

Understand

Explain requirements in plain language and answer questions.

→

Act

Gather information, documents and required attestations.

→

Complete

Guide people through forms and required next steps before deadlines.

The challenge is especially signi cant as states prepare for more frequent redeterminations and new community engagement requirements. Every additional action or documentation requirement creates another point where people can become confused, disengage, or fail to complete the process.

Case Study

Continuous Digital Engagement is Protecting Coverage at Scale

Inland Empire Health Plan (IEHP), a California-based Medicaid plan, demonstrates what happens when Medicaid engagement meets members where they are. By deploying Ushur's secure, interactive digital experiences, the health plan has reached members at scale, increased engagement and helped members take action on critical redetermination communications.

800+
campaigns in 4 languages

9.4M
secure interactive engagements launched

1.5M
members reached

3.4 - 4
CAHPs score boost

300%
of member engagement goal achieved for Medi-Cal redetermination outreach

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Four Pillars for Modern Medicaid Eligibility Engagement

A framework for state Medicaid agencies and health plans

Semiannual review cycles and expanded verification requirements have changed the operational demands of Medicaid eligibility. What was once managed as a seasonal renewal event must now function as a continuous, coordinated discipline.

Reducing procedural disenrollment in a recurring eligibility landscape requires more than outreach volume. It requires a structured framework that stabilizes enrollment, supports members in real time, reaches vulnerable populations proactively, and manages transitions with clarity and empathy. The following pillars define that framework.

Pillar 1: Reach and Educate Before Deadlines

Proactively reach people before critical eligibility deadlines with clear, personalized communications across voice and digital channels.

Key Objectives for Health Plans

- **Reduce Procedural Disenrollment:** Prevent eligible members from losing coverage due to missed documentation, incomplete submissions, or unclear requirements.
- **Protect Enrollment Predictability:** Minimize churn and revenue volatility across recurring eligibility cycles.
- **Preserve Continuity of Care:** Avoid preventable coverage gaps that disrupt quality performance and member health outcomes.
- **Manage Recurring Operational Surges:** Absorb increased eligibility volume without proportional staffing expansion.

Essential Capabilities Needed

- **Lifecycle-Based Engagement:** Align outreach to eligibility milestones rather than one-time renewal campaigns.
- **Predictive Risk Identification** Detect likely non-responders or incomplete submissions early.
- **Real-Time Renewal Visibility:** Maintain visibility into documentation progress and engagement gaps.
- **Automated Early Intervention:** Trigger follow-up before deadlines pass.
- **Audit-Ready Documentation:** Preserve structured records of outreach and member support.

Journey Phases and Use Cases for Medicaid Health Plans

Support effective engagement with automation and AI agents across constituents and journey phases

Sales, Enrollment, Retention

- Permission to contact
- Redetermination education and member contact information and document gathering
- Annual / open enrollment announcements and reminders
- Benefits and member support education
- Augmentation of other high volume live sales / enrollment related activities with digital self-service

Member Service

- Digital warm welcome
- Digital ID card distribution
- Surveys – HRA, SDOH, mock CAHPS, NPS and more
- SDOH and community resource and support (food, transport, etc)
- Portal & App adoption / utilization
- Benefits and support program education
- Rewards program education
- Information updates, ex. Address changes, new baby

Quality / HEDIS / Population Health

- Closing gaps in care (HEDIS)
- Care plan adherence
- Preventive care education
- Provider selection / change
- Appointment setting / reminders
- Emergency room diversion
- Readmission avoidance
- Pre and post-discharge engagement/ education
- Medication adherence support
- Medication therapy management
- Chronic condition care navigation
- Pregnancy care navigation

Claims & Administrative

- Inquiries (claim status, EOB explanations, eligibility, etc.)
- Proactive status notifications
- Data collection to enable straight through processing
- Coordination of benefits
- Grievance & appeals

Pillar 2: Provide Always-On Conversational Support

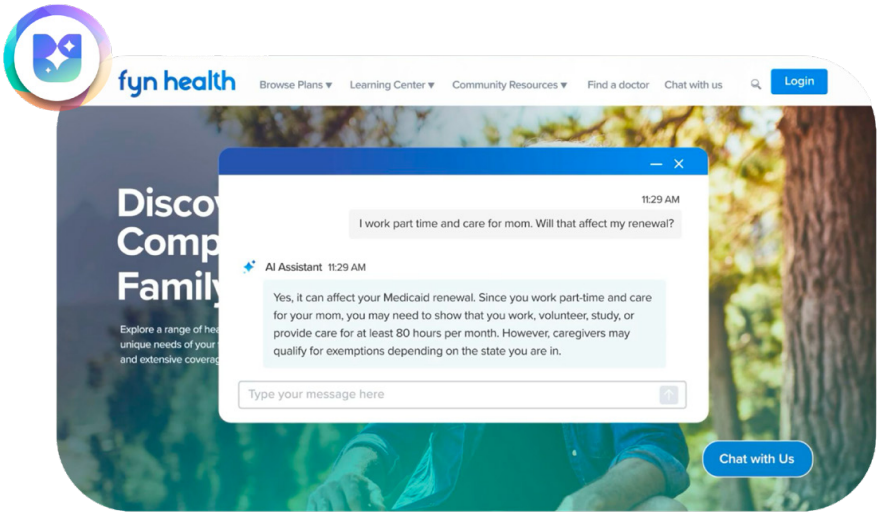
Give people 24/7 access to conversational support for questions about eligibility, renewal requirements, documentation and next steps.

Key Objectives for Health Plans

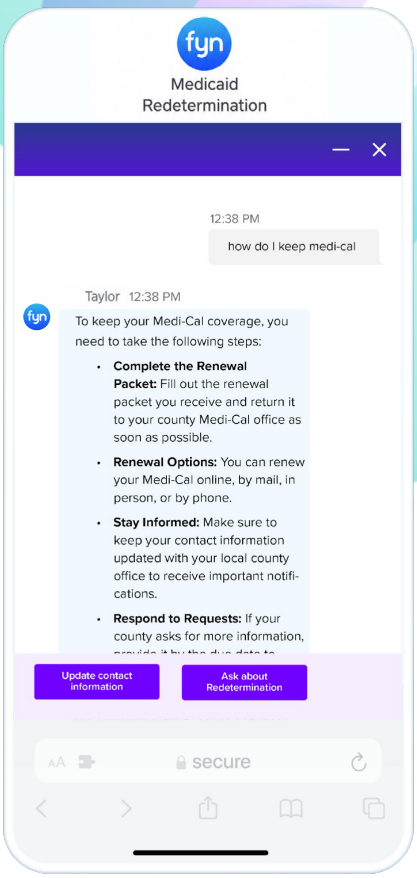
- **Deliver Immediate Clarifi ation:** Provide clear explanations of process and documentation requirements and timelines in real time.
- **Resolve Questions at First Contact:** Reduce repeat outreach by guiding members through required steps during the initial interaction.
- **Reduce Friction in Required Actions:** Simplify information sharing and gathering, confirmations, and verification steps.
- **Stabilize Inbound Demand:** Balance automation and live support during recurring redetermination peaks.

Essential Capabilities Needed

- **AI-Powered Voice and Digital Support:** Offer assistance across IVR, web, SMS, and chat environments.
- **Intent-Aware IVR:** Identify why a member is calling and respond dynamically rather than through rigid menus. Allow for digital self-service to reduce live agent burden where possible.
- **Guided Resolution Workflows:** Provide step-by-step digital and voice journeys for documentation and verification support.
- **Contextual Escalation:** Route complex cases to live representatives with full interaction history.
- **Cross-Channel Continuity:** Maintain connected experiences across phone and digital channels.



Pillar 3: Guide People Through Required Actions



Proactively identify members at risk of missing deadlines. Guide them to complete the actions required to maintain coverage—from gathering information and documentation to completing forms and confirming required information.

Key Objectives for Health Plans

- **Simplify Complex Requirements:** Clearly explain what information or action is required and guide people through each step.
- **Increase Completion:** Help people move from understanding what they need to do to actually completing required forms and documentation.
- **Reduce Incomplete Submissions:** Identify missing information and documentation before it delays the eligibility process.
- **Make Processes More Accessible:** Give people guided support across languages and channels without requiring them to navigate complex processes alone.

Essential Capabilities Needed

- **Guided Form Completion:** Help people complete Medicaid enrollment, renewal and state-specific forms step by step.
- **Conversational Data Collection:** Gather required household, eligibility and contact information through natural-language interactions.
- **Document Capture:** Securely collect required documents within the experience.
- **Signatures & Attestations:** Capture required confirmations, attestations and signatures as part of the workflow.
- **Validation & Follow-Up:** Identify missing information and automatically follow up when additional action is required.
- **Submission Support:** Prepare completed forms and documentation for download or submission, depending on available state or plan system access.

Pillar 4: Support People Through Coverage Transitions

Even with strong engagement and completion support, some people will lose Medicaid eligibility. Clear, timely guidance can help them understand what changed, take appropriate next steps, and minimize gaps in coverage or care.

Key Objectives for Health Plans

- **Communicate Coverage Changes Clearly:** Deliver understandable explanations when eligibility changes occur.
- **Guide Next Steps:** Support members in identifying appropriate alternatives without overwhelming them.
- **Minimize Gaps in Care:** Encourage timely action to reduce service disruption.
- **Preserve Member Trust:** Maintain goodwill even when coverage changes.

Essential Capabilities Needed

- **Structured Transition Workflows:** Coordinate targeted communication for members experiencing eligibility changes.
- **Clear Alternative Coverage Education:** Provide understandable information about next steps.
- **Appeal Guidance Support:** Assist members in navigating appeal processes appropriately.
- **Specialized Escalation Paths:** Route complex cases to trained representatives.
- **Transition Tracking and Reporting:** Monitor engagement and outcomes post-disenrollment.

From “contacted” to “completed”

Voice-Guided Experience keeps the conversation going while required tasks get done visually.

Instead of navigating a phone tree or trying to complete a complex form alone, a person can speak naturally with an AI Agent while following along on a synchronized mobile screen. Voice guidance and visual controls work together in real time—without forcing the person to switch channels or repeat information.

Start the conversation

Voice AI Agent explains the renewal requirement and answers questions.

Confirm information

Review and update household and contact information.

Complete the form

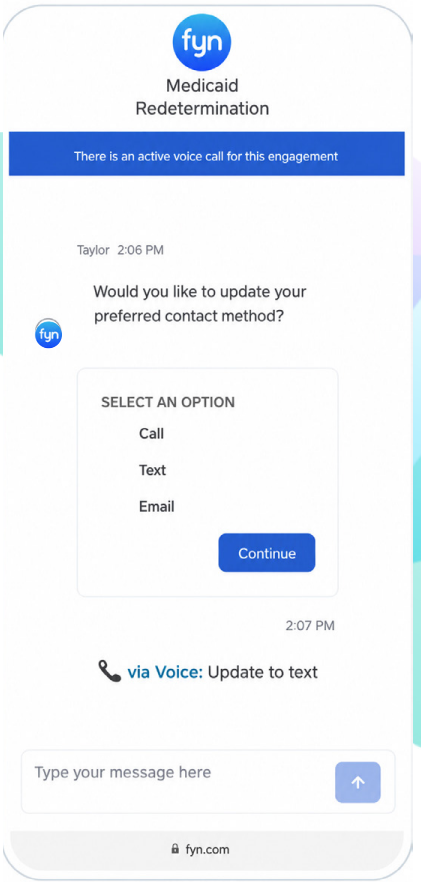
AI Agent asks questions conversationally while guiding the person through required fields.

Capture documentation

Upload documents, make selections and confirm information from the same mobile experience.

Prepare for submission

Prepare the completed form and supporting documentation for download or submission, depending on the agency or plan’s process.



Voice + visual, working together.

Persistent voice guidance | Synchronized mobile experience | Form completion | Document capture | 74 languages | Human escalation

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An Engagement and Completion Layer for Medicaid Eligibility

How Ushur Delivers on these Pillars for Medicaid MCOs Today

Ushur works alongside existing Medicaid eligibility and administrative systems—without requiring a core system replacement. AI Agents help state agencies and health plans engage people across voice and digital channels, answer questions, gather information and documentation, guide form completion, and follow up on incomplete actions.

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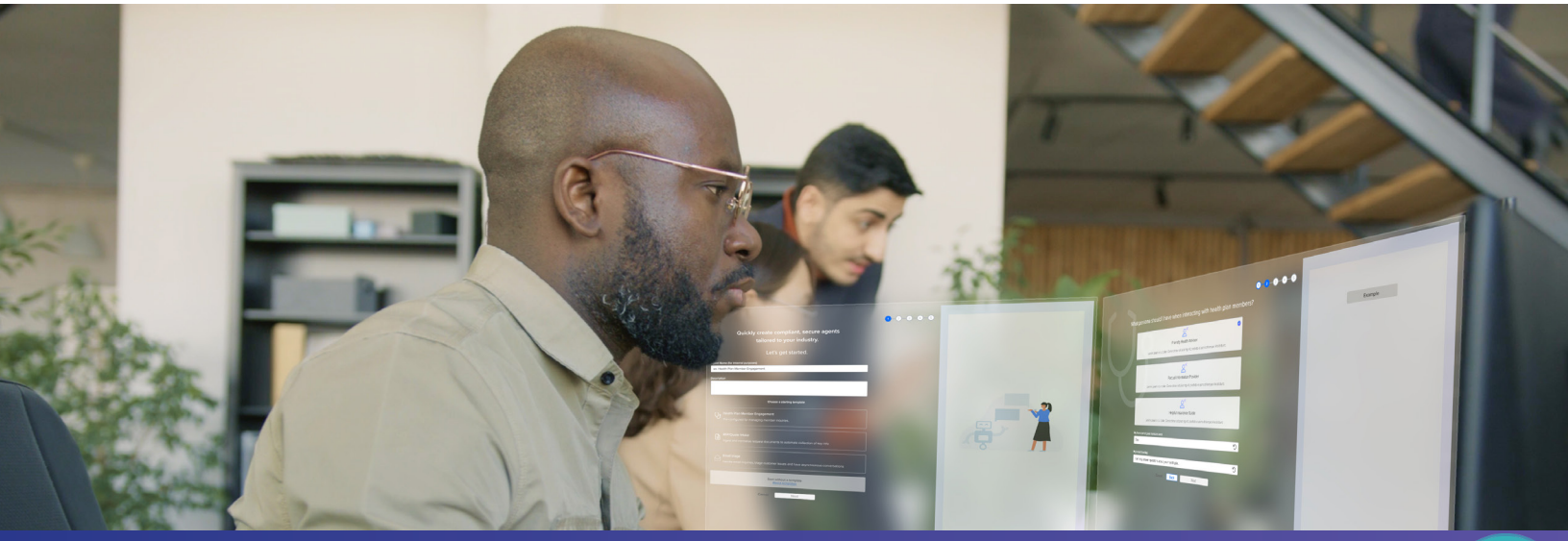
Through secure, bi-directional digital experiences and intelligent voice integration, Ushur helps plans:

- Coordinate proactive renewal and eligibility outreach
- Provide 24/7 conversational support across voice and digital channels
- Guide people through forms, documentation and verification requirements
- Capture information and documents securely
- Prepare completed forms for download or submission
- Trigger reminders and follow-up before deadlines
- Escalate exceptions to human teams with context
- Maintain governed, auditable interaction records

Plans leveraging Ushur have seen up to 5x higher engagement than legacy member apps and portals, particularly among hard-to-reach populations.

By eliminating logins, app downloads, and complex navigation, members can act immediately—submitting updated contact information, receiving educational messaging, contacting plan and community resources, and receiving next steps within the same interaction.

Unlike traditional communication systems built for static campaigns, Ushur functions as a continuous engagement infrastructure. It integrates with existing eligibility, CRM, and administrative systems without requiring core system replacement—allowing plans to modernize incrementally while maintaining compliance and security standards.



In a landscape where most coverage loss is procedural, reducing friction is the most powerful retention strategy available. Ushur enables health plans to protect coverage, stabilize enrollment performance, and improve the member experience across every eligibility cycle.

Craig Kennedy
CEO and President, Medicaid Health Plans of America

"Ushur's rigorous development of world-class, customized business applications to the healthcare and insurance sectors make the company a fitting partner in the Medicaid managed care space. Beyond that, Ushur's focus on areas like Redetermination, Medication Adherence, Maternal and Infant Health, and Chronic Condition Management have helped Medicaid Managed Care Organizations (MCOs) expand resources, connect vulnerable populations with quality, affordable care, and improve member outcomes."

Learn more about how Ushur supports Medicaid redetermination and continuous eligibility engagement at: https://ushur.ai/medicaid-redetermination

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Checklist: Assessing Your Medicaid Redetermination Engagement Strategy

Use this checklist to self-evaluate your existing processes and identify areas where your current approach to Medicaid redetermination and member engagement might need enhancement in light of today's challenges.

Member Communication & Understanding:

- ❑ How effectively can we currently reach all our Medicaid members, considering potential outdated contact information and diverse communication preferences?
- ❑ Do our current communication methods ensure members understand and can follow complex requirements (e.g., new work rules, documentation needs) in simple, accessible language?
- ❑ How easy is it today for members to receive timely redetermination information and guidance, as well as ask questions and receive timely, accurate answers?
- ❑ Are our communications personalized to the member's specific situation and preferred language?
- ❑ What are our current success rates for member response to critical communications?

Process & Workflow Efficien

- ❑ How well can our systems and teams handle **two redetermination cycles per year—plus expanded verification workload**—without substantial delays or increased error rates?
- ❑ How much of our current redetermination process relies on manual effort by live resources (e.g., data entry, inbound and outbound phone calls)?
- ❑ How quickly can we adapt our processes and communications as state or federal redetermination guidelines change?
- ❑ Can we guide people through required forms and securely collect supporting documentation as part of the same experience?
- ❑ Can we proactively identify and follow up with people who have incomplete eligibility actions or missing information?
- ❑ Do we have clear, efficient means of managing exceptions and cases requiring specialized attention?
- ❑ Can the solution scale to support two redetermination cycles per year without performance degradation?

Data & Systems Integration:

- ❑ How confident are we in the accuracy and timeliness of the member data our redetermination communication process relies on?
- ❑ Can our various systems (e.g., member engagement, core administration) seamlessly share data in real-time?
- ❑ Do we have a unified view of each member's redetermination communication status and interaction history?

Support for Transitions:

- ❑ For members who may no longer be eligible, do we have a clear, empathetic process to communicate this and guide them toward alternative coverage options?
- ❑ Are we equipped to provide information about Marketplace plans or other resources effectively?

Checklist: Evaluating Digital Solutions for Medicaid Redetermination

When considering technology partners to enhance your Medicaid redetermination process, use these questions to assess their capabilities and ensure they align with your strategic needs for effective member engagement, process automation, and compliance.

Member Engagement & Experience:

- ❑ Does the solution enable HIPAA-compliant communication across multiple channels (SMS, email, voice, secure web) to reach members effectively based on their preferences?
- ❑ Can it support true, intelligent two-way conversations, allowing members to ask questions and receive compliant automated or live-agent support in real-time?
- ❑ Can the solution simplify complex eligibility requirements and guide people through the actions needed to complete them?
- ❑ Can the platform manage communication consent and preferences effectively?

Inbound & Outbound Orchestration:

- ❑ Can sophisticated, multi-step digital communications be designed, customized, and deployed rapidly (i.e., in weeks rather than many months) using a no-code or low-code approach?
- ❑ Does the platform support always-on conversational assistance across voice and digital channels, with seamless escalation to live support when needed?
- ❑ Can the solution guide people through forms, document collection and required attestations within the same experience?
- ❑ Can the platform orchestrate proactive outbound outreach across channels and scale across two redetermination cycles per year?

Data Management:

- ❑ Does the solution provide the ability to receive and send back data securely through secure file exchange or APIs to existing core administrative systems (e.g., eligibility, CRM)?
- ❑ Can it ensure timely data synchronization to keep member information accurate and up-to-date across platforms?
- ❑ Does the platform offer strong data security, encryption, and access controls compliant with healthcare regulations for exchange of PII and PHI?

Platform & Vendor Considerations:

- ❑ Does the vendor have proven experience with Medicaid health plans, public sector agencies and other regulated environments?
- ❑ What level of support, training, and strategic partnership does the vendor offer post-implementation?
- ❑ Does the platform provide robust analytics and reporting capabilities to track performance, identify bottlenecks, and demonstrate compliance?
- ❑ Is the solution designed for ongoing innovation, incorporating advancements in AI and automation to meet future needs?


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