



FROM ENGAGEMENT TO RETENTION

Get Ready For Medicaid Redeterminations Under H.R.1

By

- Suranjan Shome, CEO, Epiphany
- Jim Talley, President and COO, Epiphany
- Joe Moser, former Indiana Medicaid Director and special advisor to Epiphany





Why Redeterminations Matter to MCOs Today

The passage of H.R.1 — the Working Families Tax Cut Act — has set a countdown in motion that every Medicaid Managed Care Organization (MCO) in America that serves Medicaid expansion members needs to take seriously.

Starting January 1, 2027, eligibility redeterminations for Medicaid expansion adults must occur every six months rather than annually. And for the first time, members must demonstrate compliance with an 80-hour monthly work, education, or community service requirement.

These are two major obligations with one deadline. A combined impact that will effectively double outreach demands overnight.

The challenge is not simply operational. Industry research published this year found that 85% of Medicaid enrollees are unaware that redetermination frequency is changing. When outreach begins, it will reach a population starting from near-zero awareness.

For MCOs, the stakes are significant: member churn, financial impact, and compliance risk all arriving at once. Couple this with the biggest technology transformation around AI, and it is a huge undertaking.

Any one of those would be a major endeavor on its own. Together, they are a paradigm shift on the scale of the early internet era, except this time the stakes are people's healthcare coverage.

This guide sets out what is changing, why it matters, and how Epiphany is helping MCOs meet the moment.



MCOs are faced with three converging forces: significant budget cuts, sweeping new rules and regulations with tight timelines, and genuinely transformative technology like AI arriving in the middle of it.

Suranjan Shome

What Has Changed: The Policy Landscape

On July 4, 2025, H.R.1 was signed into law. Two provisions in particular will reshape how MCOs operate.

Section 71107 requires that eligibility redeterminations for adults enrolled through the ACA Medicaid expansion change from annual to every six months, effective January 1, 2027. Across the 42 states and Washington D.C. that have expanded Medicaid, this applies to roughly 20 million adults, and it means outreach volume doubles overnight.

Section 71119 introduces a new condition of eligibility: adults aged 19 to 64 must demonstrate 80 hours per month of qualifying work, education, job training, or community service. States must verify compliance at every renewal. Identifying who qualifies, who is exempt, and who needs support navigating the requirement adds a significant new layer of complexity to every member interaction.

The federal implementation deadline is January 1, 2027. States are required to begin enrollee outreach before that. Some, including Nebraska, are already enforcing requirements ahead of schedule. The window to prepare is not months away. It is now.



What This Means for Managed Care Organizations

For MCOs, the implications of H.R.1 extend well beyond compliance. The operational, financial, and reputational risks are real, and they arrive simultaneously.

The most immediate pressure is volume. Redetermination cycles that previously ran annually now run twice as often, with more documentation required at each renewal. Work requirement verification, exemption identification, and outdated member contact data all add complexity to every interaction. Existing outreach teams and infrastructure were not built for this cadence, and standing up internal capacity at the speed required is not a realistic option for most organizations.

The financial exposure is multi-dimensional. MCOs face:



The direct cost of additional staffing and resources to meet doubled outreach demand



Revenue loss from member churn driven not by ineligibility, but by process failure and disengagement



Adverse case mix, as healthier members disenroll and higher-need members remain

The post-pandemic unwinding period offers a cautionary precedent. When continuous enrollment protections ended in 2023, national Medicaid enrollment fell from a peak of 94 million to 74.9 million, a decline of 21%. Crucially, about 70% of those disenrolled lost coverage for failure to comply with paperwork requirements, many of whom were still eligible but didn't complete the process. That same risk now recurs at twice the frequency, with new documentation requirements layered on top.

For MCOs operating in states moving to early implementation, the runway is even shorter.



The Awareness Gap: Why Outreach Cannot Wait

There is an assumption embedded in most redetermination planning: that members, once notified, will engage. The data suggests otherwise.

Industry research published in 2026, based on a survey of 1,974 Medicaid enrollees in April 2026, found that 55% were completely unaware that work requirements are coming, and 85% did not know that redetermination frequency is changing. Among enrollees with chronic conditions, 62% say they would ration medication if they lost coverage.

Prior experience from Arkansas confirms the scale of the challenge. Even after the state sent 600,000 letters and made 230,000 phone calls, more than 70% of those subject to work requirements were still unsure whether the policy was in place.

For MCOs, coverage loss is not just a member welfare issue. It is a utilization, cost, and continuity of care problem that lands directly on the balance sheet. Effective outreach, delivered early and persistently, is the only intervention that changes this outcome.

The Epiphany Solution

Epiphany is a US-based, HIPAA-compliant contact center partner specializing in Medicaid member engagement and support. Unlike generic outsourcing providers, Epiphany brings deep program knowledge, compliance-ready processes, and the ability to scale rapidly to meet urgent deadlines.

All service agents are carefully selected for their high levels of empathy and consultative, problem-solving mindset, and are trained further on program policy and your processes.



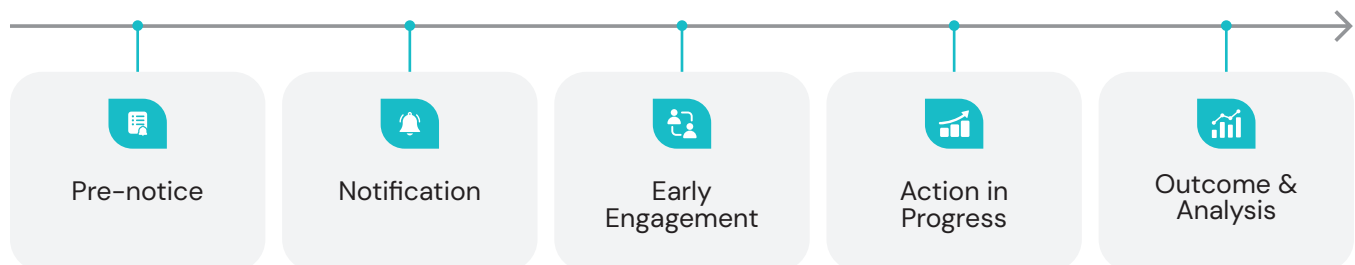
When compliance, funding and public trust are at stake, every interaction becomes a moment that matters. That's why the human touch with members is so critical to success.

Jim Talley

Our proprietary solution is called **REACH (Retention Engagement Actions for Coverage & Healthcare)**. Built around four integrated service streams, REACH is designed to cover every stage of the redetermination lifecycle.



The Retention Sprint Desk addresses the core challenge of doubled outreach volume. Working from pre-notice through to outcome and analysis, Epiphany's agents prioritize members by risk tier, focusing the most intensive outreach on those hardest to reach: members who move frequently, have outdated contact details, or have historically disengaged. Inbound and outbound support runs in parallel, absorbing member questions as official notices land and converting awareness into action before deadlines approach.

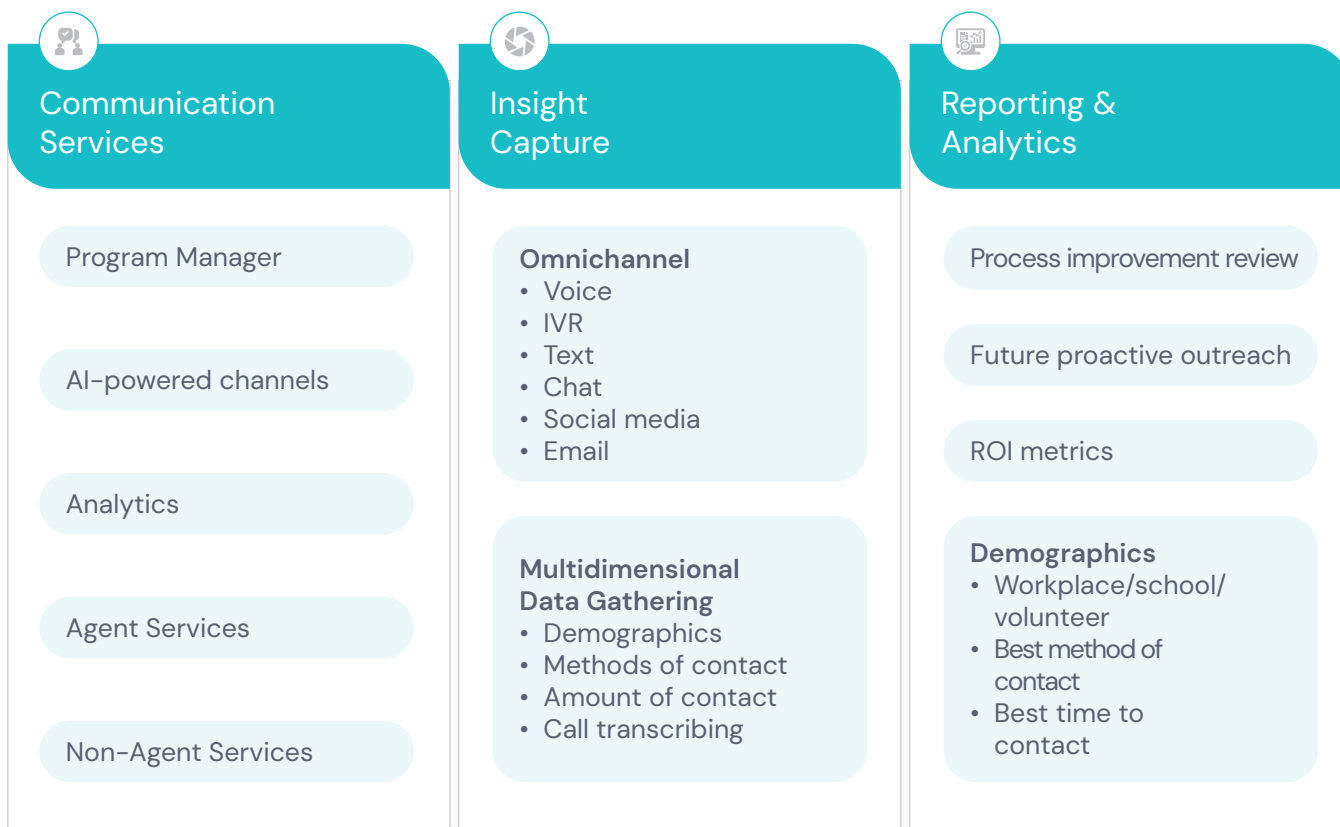




The Work Requirement and Advocacy Hub tackles the new complexity introduced by Section 71119. Dedicated Compliance Coaches contact members directly, walking them through the process of documenting their 80 hours of qualifying activity. The team also proactively identifies and records members who qualify for federal exemptions, reducing avoidable coverage loss before it happens.



Member Intelligence and Continuous Improvement ensures that every outreach cycle makes the next one smarter. Behavioral data, contact center insights, and engagement outcomes are analyzed to build campaign strategies that improve with each renewal cycle, delivering greater ROI over time and providing defensible compliance reporting if audit scrutiny increases.



The Member Engagement Platform is the technology backbone that ties it all together. Centralized member data, predictive risk scoring, and an integrated multi-channel communication engine enable Epiphany to operate at scale without operational fragmentation, and without proportional cost increases as volume grows.

Together, the four streams cover the redetermination challenge end to end: finding members, supporting them through compliance, learning from every interaction, and scaling efficiently to meet whatever volume the new six-month cycle demands.

Why Now, and Why Epiphany

The January 2027 deadline is fixed. But the window to act is considerably shorter than it appears.

States are required to begin enrollee outreach ahead of January, so MCOs cannot afford to wait for state direction before preparing their own outreach capacity. Procurement decisions, onboarding, and agent training all take time. The organizations that will be best positioned in January 2027 are the ones making decisions now.

The cost of not taking proactive action could be prohibitively high. If you remember the post-Pandemic unwinding, we saw that 25.2 million members were disenrolled, and 69% of those were due to procedural issues, according to KFF.

Every MCO will know the cost of losing a member already, and this will vary according to state and services provided. But according to an ASPE paper, we could be looking at \$400–600 per churn event. Do the math to scale this up to a membership base.

Doing nothing is not an option. And building internal capacity at the speed and scale required is not realistic for most MCOs either. It means hiring, training, and managing a significantly expanded workforce, developing new compliance-ready scripts and processes, and absorbing an increased workload.

The case for outsourcing is clear, and the reason for Epiphany's existence.

Epiphany deploys fast, flexes with demand, and integrates cleanly with existing workflows, without the long-term overhead of a permanently expanded internal function.

Not every contact center partner can deliver this. Epiphany's differentiation is rooted in nearly a decade of focus on Medicaid member engagement and technology implementations, reaching people who are hard to contact, navigating complex conversations with empathy, and achieving outcomes in an environment where failure has real human consequences. That specialization shows up in several ways that matter to MCOs evaluating partners under time pressure:

What sets Epiphany apart

- **Purpose-built for Medicaid.** Not one service line among many — Medicaid member engagement and support is the entirety of what Epiphany does, across more than 20 states and nearly a decade of operation.
- **H.R.1 domain knowledge.** Teams activated to support six-month redetermination cycles, work requirement verification, exemption identification, and documentation support.
- **Compliance coaching expertise.** Agents are specifically trained to help coach members navigating eligibility requirements, documentation needs, exemptions, and renewal processes, reducing confusion and improving successful program participation.
- **Member engagement intelligence.** Interaction data is analyzed to identify the outreach methods, timing, and messaging that drive the best outcomes, with actionable insights shared to strengthen future member engagement strategies.
- **Rapid scale-up.** Deployable at any scale, from small pilot engagements to hundreds of service agents, with in-flight process improvement built into every engagement.
- **Flexible commercial model.** Pay-as-needed scenarios available for unplanned support needs, reducing financial commitment risk.
- **Low implementation burden.** Integrates with existing MCO workflows and data systems without adding management overhead.
- **Proven track record.** 97% member satisfaction rate. 100% US-based workforce. MBE certified in multiple states.

The shared outcome: more covered members, better health outcomes, and stronger MCO performance.

Let's Get Started

Epiphany's approach to onboarding new clients is structured, proven and repeatable — whether that means deploying 50 service agents or 500. Here is a brief summary of what you can expect from us, and where we will need your support.



Onboarding, Technical Integration and Readiness

- Data Integration and Population Ingestion
- Omnichannel Platform Configuration
- Staffing & Training



Active Redetermination Sprint Operations

- Pre-Notice Awareness
- Notification Management
- Early Engagement Outreach
- Action in Progress and Retention Engine



Work Requirement Coaching and Exemption Management

- Active Member Engagement and Coaching
- Exemption Submission Support



Cycle Completion, ROI Analysis and Continuous Improvement

- Final Reconciliation and Reporting
- Program ROI and Audit Support
- End of Project Review

Before starting work, we'll outline the specific requirements for completing the project to your specification. These will include data access, workflows, org charts, script support, compliance and reporting needs.

The objective is to ensure that we have the information and access to key people to ensure efficiency and compliance, without becoming a burden. We are here to make the job easier, and give you peace of mind that it is being addressed in a timely, professional manner. Our role is to add capacity and capability, not complexity and burden.

How can we help you?

Book a discovery call to discuss how we can support you, whether it's a short term engagement or longer term project.



(888) 364-4512



info@epiphanymgmt.com



Suranjan Shome, CEO, Epiphany

Suranjan Shome is the Founder and CEO of Epiphany Management Group, where he leads a mission-driven effort to elevate Medicaid programs through strategic technology investments, world-class customer experience, and comprehensive support services. He is an active board member and community leader through the Greater Akron Chamber, contributing his expertise to regional growth and civic initiatives.



Jim Talley, President, COO, Epiphany

Jim started his working life as a contact center agent more than 30 years ago, advancing through leadership roles across customer experience, operations and service delivery. Today, he leads Epiphany's contact center operations, bringing a unique frontline perspective to every engagement. He understands, better than most, the challenges that agents face, as well as the critical role they play in shaping customer and member experiences, operational excellence and exceptional service.



Joe Moser, Special Advisor

Joe Moser is a nationally recognized healthcare leader with extensive experience in Medicaid policy, managed care, and program innovation. He has served as Medicaid Director for the State of Indiana, Managing Principal at Health Management Associates, and Vice President of Development at CareSource, where he helped shape strategy for one of the nation's largest government-sponsored health plans.