

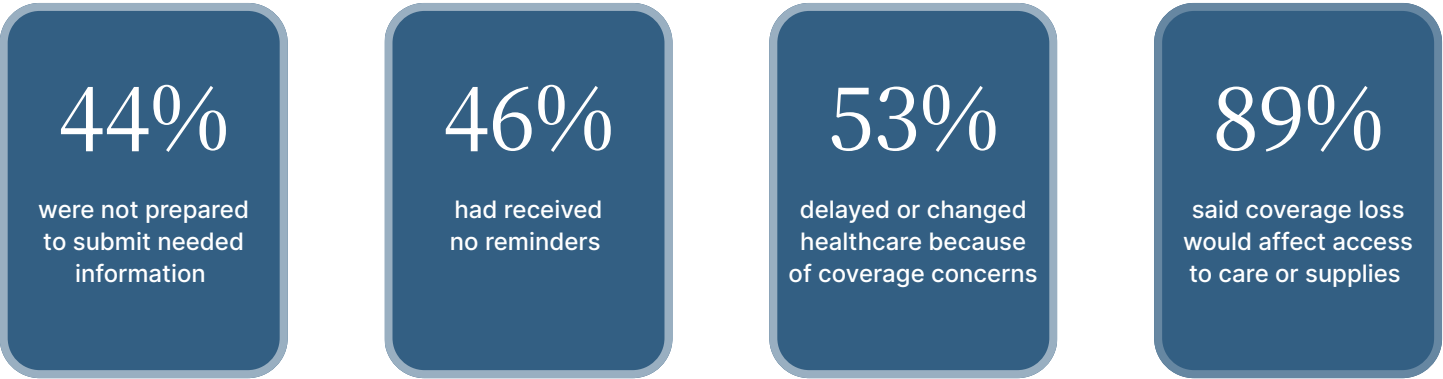
The Path to Prepared

How Health Plans Can Prepare Members, Reduce Confusion and Protect Continuity of Care

Based on Aeroflow Health's independent survey of more than 1,000 Medicaid respondents.



Aeroflow Health recently conducted an independent survey of more than 1,000 Medicaid-covered respondents and learned that **the immediate risk is not awareness of the upcoming change**. It is whether members understand if they are affected, what documentation they need, and how and when to report their details.



Executive Summary

Federal Medicaid community engagement requirements must be implemented by 43 states and the District of Columbia no later than January 1, 2027. At the same time, most adults in the Medicaid expansion group will move to six-month eligibility renewals. ^{[2][3][8]}

Aeroflow's survey found a clear readiness gap: **63% knew requirements were coming, yet 44% were not prepared to submit the needed information** and nearly half had received no reminders. ^[1]

For health plans, the core operational challenge is preventing avoidable coverage loss caused by confusion, missed reporting, and overlapping administrative processes. The response should pair precise, state-specific guidance with repeated multichannel outreach and trusted partner touchpoints.

What Health Plan Leaders Should Take Away

Findings	Implications for health plans
Awareness exceeds readiness	Members need process guidance, not another general announcement.
The main fear is uncertainty	Clarify who may be affected, what qualifies, where to report, and what happens next.
Mail alone will miss members	Layer email, text, phone, portals, and partner outreach onto required notices.
Work reporting and renewal will overlap	Coordinate the two message streams so members do not confuse separate actions.
Partners can add reach	Use compliant, plan-approved vendors and providers to repeat accurate state guidance.

What Is Changing?

Community Engagement Requirements

The One Big Beautiful Bill Act (Public Law 119-21) and the 2026 CMS interim final rule require 43 states and the District of Columbia to implement Medicaid community engagement requirements for certain adults no later than January 1, 2027. The rule generally requires affected adults to document qualifying work, community service, work-program participation, half-time education, qualifying income, or an applicable exclusion or exception. ^{[3][8]}

Who is Subject to the Requirement?

Generally subject to the requirement	Examples of exclusions or exceptions
Adults ages 19 through 64 in the Medicaid adult expansion group or certain section 1115 demonstrations, unless another exclusion or exception applies	Pregnant and postpartum people; former foster youth; certain American Indians and Alaska Natives; parents or caregivers of a child age 13 or younger or a disabled person
Applicants and current beneficiaries whose compliance must be assessed at application, renewal, and any additional interval selected by the state	People who are medically frail; veterans with a total disability rating; certain SNAP or TANF participants; people in drug or alcohol treatment; inmates and certain recently incarcerated people
People who must demonstrate 80 hours of qualifying activity, at least half-time education, qualifying income, or a combination allowed by the rule	State-selected short-term hardship circumstances, including certain medical care, qualifying emergencies or disasters, and high-unemployment areas

[3]

The examples above are not an eligibility determination or a complete legal list. State implementation choices and documentation rules will vary. **Member communications should direct people to the applicable state Medicaid agency or plan resource for an official determination.**

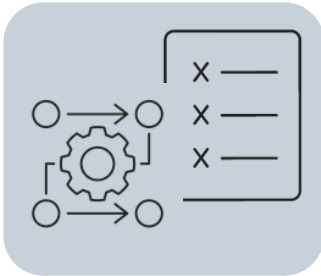
A Narrow Outreach Window

CMS requires states to begin outreach 4 to 6 months before implementation, depending on how many prior months of compliance applicants must demonstrate. For a January 1, 2027, start date, initial notices could arrive in July, August, or September 2026. States must communicate by regular mail or the member's elected electronic format, plus at least one additional channel, such as text, telephone, an online account, or another commonly used electronic method. ^[8]



Two Ways Members Can Fall Through the Cracks

Real-world implementations show that confusion can cause coverage loss in two distinct ways and the 2027 requirements create exposure to both.



The back-door failure: Arkansas, 2018. Arkansas became the first state to implement a Medicaid work requirement in 2018. Nearly 17,000 already-enrolled adults lost coverage within the first six months—not because they failed to work, but because they failed to report. More than 95% of the targeted population was already meeting the requirement or qualified for an exemption.^[11] **This is an attrition failure: people who belong in the program are pushed out by the reporting process itself.**



The front-door failure: Georgia, 2023–2025. Georgia launched Pathways to Coverage in July 2023. Because applicants must document qualifying activity before enrolling, participation fell far below projections. Full-year-equivalent enrollment during the first 15 months was fewer than 3,500 people, compared with an original first-year estimate of more than 25,000. During the same period, GAO reported \$54.2 million in administrative spending and \$26.1 million in medical assistance spending.^[12] **This is a suppression failure: eligible people struggle to enroll in the first place, while substantial resources are spent administering the process.**

Why this distinction matters for 2027: The federal requirements create verification points at application and at six-month renewals. A campaign focused only on current members may help address the Arkansas-style attrition risk but miss the Georgia-style enrollment barrier. A campaign focused only on applicants creates the opposite gap. **Plans need coordinated outreach for both populations, delivered at the appropriate points in the eligibility journey.**

What Aeroflow's Survey Shows

Awareness Did Not Translate Into Readiness

Aeroflow's survey reveals a readiness gap with direct implications for enrollment and retention. Although 63% of respondents were aware of the upcoming requirements, 44% were not prepared to submit the necessary information. Awareness alone did not answer the practical questions members face.^[1]

Uncertainty Is the Dominant Concern

Combined, uncertainty-related responses accounted for 71% of respondents' primary concerns, including knowing whether they qualify, understanding exemptions, losing coverage by mistake, and general uncertainty. Only 10% said they had no concerns.^[1]

Additionally, 37% identified themselves as exempt because of pregnancy, disability, caregiving responsibilities, or another program status. However, a survey response does not establish whether someone meets the rule's legal exclusion criteria.



Members are most concerned about applicability and avoidable loss



Coverage Concerns Are Already Affecting Care

53% said concerns about Medicaid coverage had caused them to delay or change healthcare needs. If coverage were lost, 67% expected a significant effect on their health or access to care and supplies, and another 22% expected a moderate effect. ^[1]

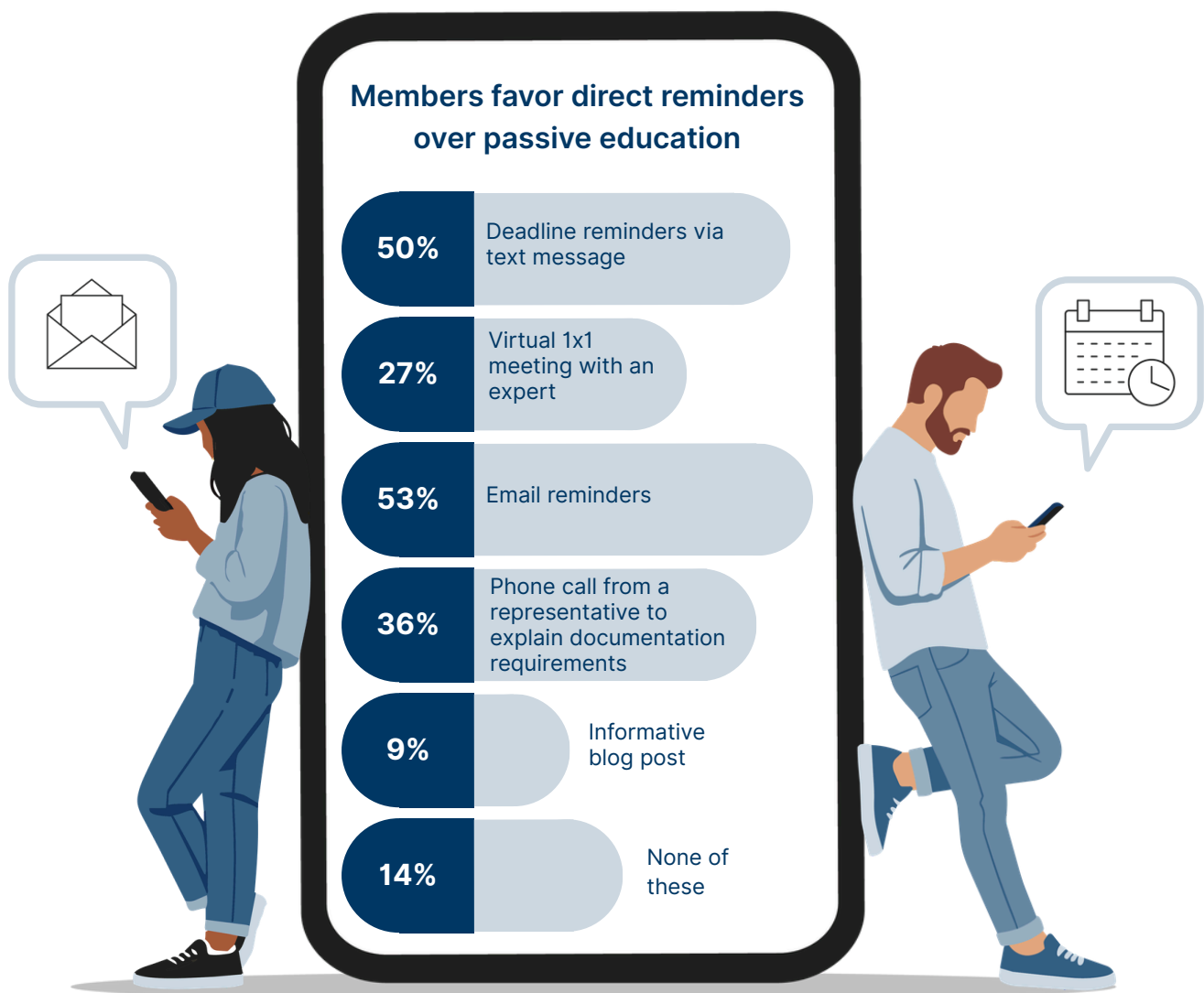
For a health plan, avoidable attrition can quickly become a continuity-of-care problem. A member who loses coverage may interrupt medication and other recurring supply use even when the underlying clinical need has not changed.



The Channel Problem

Knowing what members need to hear is only part of the equation. Health plans must also deliver that information proactively through the channels members are most likely to notice and use. Survey findings indicate that direct, timely reminders are more valuable to members than relying on them to independently find educational resources.

According to the survey, nearly half of respondents had received no reminders since the requirements were announced, and 37% said they had previously missed an important healthcare notice because it arrived by regular mail. ^[1] CMS still requires written outreach, but the member data support a layered strategy rather than reliance on a single notice.



Direct Reminders Outperform Passive Content

Email reminders were selected by 53% of respondents and text reminders by 50%. Phone support was selected by 36% and one-to-one virtual help by 27%. Only 9% selected an informative blog post. ^[1] Blogs remain useful as a detailed destination, but they are unlikely to create sufficient reach by themselves.

Viewed alongside the two failure points above, these findings answer a more specific question than simply which communication channels members prefer. They indicate which channels may be most effective for reaching an enrolled member approaching renewal—a Track 1, Arkansas-style attrition risk. They do not address how to reach someone who has not yet applied—a Track 2, Georgia-style enrollment barrier. Because the survey did not measure that population, plans would need to examine their own application-funnel data to identify the most effective outreach strategies.

The survey also did not ask about another potentially valuable channel: members' recurring contact with trusted healthcare providers or suppliers. For members who regularly receive a DME refill call, home health visit, or another clinical or supply-related touchpoint, that interaction may be more frequent and trusted than the five channels included in the survey. However, it falls outside both plan-controlled outreach and the scope of this research. See "Two Tracks, Not One Campaign" below for how plans can incorporate these existing relationships into their outreach strategy.

National Estimates Point to Procedural Loss

CBO estimates that the work requirement provision will increase the number of uninsured people by 5.3 million in 2034. Its analysis separates people who do not meet the requirement from an additional 2.8 million people expected to lose Medicaid because the requirement adds steps to the application process. ^[4]

CBO also projects that 10% of the adult expansion group will lose coverage after the first six-month redetermination. Of that group, 70% are expected to lose coverage for procedural reasons, communication problems, or difficulty navigating re-enrollment rather than because they are ineligible at the time of review. ^[4] This estimate relates to the new renewal cadence, not directly to work requirement compliance, but it illustrates the risk created by overlapping administrative processes.

The Operational Lesson

Clear eligibility rules remain important, but they do not prevent avoidable loss unless the member can recognize the notice, understand the action, reach the correct reporting destination, and respond before the deadline. **Plans need a process communication strategy as much as a policy communication strategy.**

What Health Plans Are Preparing For

Recent Aeroflow conversations with health plan sales contacts show a consistent concern across markets: **plans expect the reporting process to create more confusion than the underlying activity standard.** The feedback is qualitative and should not be treated as a representative payer survey, but the themes align closely with the member data and published evidence.



Concern heard from plans	What it requires operationally
Member attrition after missed or incomplete reporting	Identify likely at-risk members early and repeat the action before the deadline.
Member confusion and frustration	Use plain language and separate work reporting, renewal, and exemption instructions.
Uncertainty about state implementation	Maintain state-specific content and update it as official guidance changes.
Compliance limits on partner outreach	Preapprove content, audiences, channels, data fields, and escalation paths.
Limited visibility into individual readiness	Add short readiness questions to existing social-needs and clinical-compliance surveys.

Public Plan Responses Show Two Complementary Approaches

Health Net committed \$1 million to its Get Informed Stay Covered campaign for Medi-Cal members. Its plan includes multilingual education, targeted outreach to vulnerable members, and collaboration with providers and community organizations. ^[5]

Managed Health Services in Indiana launched the MHS Serves Workforce Support Program to fund community organizations that provide employment services, training, and regional workforce coordination. Together, these examples show the breadth of the response available to plans. **Education helps members navigate the administrative process. Workforce and community partnerships help members address practical barriers.** Plans can combine both approaches and use trusted healthcare touchpoints to reinforce them.

The strongest campaign begins before the member deadline and repeats one clear action at a time. The timeline below can be adapted to a state implementation date, eligibility renewal, or plan-specified reporting window.

Extend Plan Guidance through Existing Member Touch Points

Timing	Primary objective	Recommended activity	Measures
60 to 90 days before	Build the audience and message rules	Confirm state policy, official destinations, suppression logic, language needs, approvals, and escalation contacts.	Eligible audience logic approved; contact data completeness
60 to 90 days before	Establish relevance	Email and mail a plain-language overview; ask the readiness screen; prompt contact-information updates.	Delivery; opens; survey completion; uncertainty rate
30 to 60 days before	Explain the process	Send state-specific email and text with qualifying activity, exclusion information, and direct official links.	Clicks to official resources; phone questions; readiness improvement
7 to 30 days before	Prompt action	Use deadline reminders and phone outreach for members who remain uncertain or have not engaged, as permitted.	Engagement by channel; escalation rate; completed contact updates
At renewal and after	Protect continuity	Separate renewal instructions from work reporting; monitor aggregate retention, claims interruption, and re-enrollment trends.	Renewal completion; procedural closure; coverage continuity



A 90-Day Activation Framework

Health plans hold the eligibility, timing, and reporting information needed to make member outreach precise. By working with strategic vendor partners, health plans can combine their guidance with established patient relationships and multichannel touchpoints to extend the reach of accurate, plan-approved communications.

The most effective partnership model preserves the health plan's role as the authoritative source while enabling trusted partners to reinforce its guidance at existing points of care. This coordinated approach can include the following actions:

- Segmented outreach by state, effective date, and known age or coverage factors. Pediatric patients, adults age 65 or older, and known Medicare members should not receive generic messages implying that they are subject to the requirement.
- Use plan-approved email, text, direct mail, and web content to explain the process and direct members to official reporting resources.
- Add a short readiness screening to existing member surveys to identify people who do not know whether the requirement applies, where to report, or whether they are ready.
- Reinforce renewal and re-enrollment messages when plan data indicate that a member is approaching the end of an eligibility period.
- Share aggregate campaign reach, engagement, readiness, and escalation trends with the plan, subject to the agreed data-use framework.

Two Tracks, Not One Campaign

The two failure points above call for two separate workstreams, aimed at different members and measured by different outcomes.

Track 1 — Renewal Protection (the Arkansas fix)

Targets: currently enrolled members approaching a renewal or reporting deadline. Goal: reduce procedural termination among people who are already eligible.

- Time reminders to each member's individual renewal date, not a single blanket notice.
 - Add a reporting-status check to outreach touchpoints members already expect.
 - Escalate to phone follow-up for members who haven't confirmed status inside a defined pre-deadline window.
- Success metric: lower procedural closures at renewal.

Track 2 — Application Navigation (the Georgia fix)

Targets: members and prospective members not yet enrolled, including new applicants. Goal: reduce front-door suppression among people who would qualify for an exclusion or exception but don't know how to claim it.

- Surface exemption categories (medically frail, caregiver, etc.) before submission, not after denial.
- Provide a pre-application checklist so eligible members don't self-select out or stall in a documentation loop.
- Track where in the application process members abandon or get stuck.
- Success metric: higher exemption-claim accuracy at first application.

A successful program will not be measured by message volume alone. Plans should look for fewer members who say they are unsure, higher click-through to official resources, more current contact information, fewer procedural closures, faster re-enrollment after a closure, and fewer interruptions in clinically necessary care or supplies.



Conclusion

Many members are aware that change is coming but are not prepared, have received no reminders, or do not know whether they qualify. Arkansas and Georgia already demonstrate what that operational risk can look like: one state pushed otherwise eligible members out of coverage through reporting burdens, while the other prevented eligible members from enrolling in the first place. Together with national projections, these examples show how administrative complexity can lead to coverage loss even when people work or qualify for an exclusion.

Health plans have an opportunity to reduce that risk before January 1. Clear state-specific guidance, coordinated work requirement and renewal messaging, repeated digital reminders, phone support, and trusted partners can help members complete the right action at the right time.

Aeroflow is prepared to support that work with existing Medicaid patient touchpoints and a growing set of state-specific communications. Plan data and approved resources are the bridge from generic education to targeted member support. With that information, Aeroflow can help plans extend their reach, identify readiness gaps, and protect continuity for members who rely on recurring medical supplies.

About Aeroflow Health

Aeroflow Health is a leading provider of durable medical equipment and health services, headquartered in Asheville, North Carolina, and consists of an extensive catalog of solutions, including [Aeroflow Breastpumps](#), [Aeroflow Diabetes](#), [Aeroflow Sleep](#) and [Aeroflow Urology](#). Committed to improving quality of life through innovative solutions, Aeroflow Health partners with healthcare providers and communities to offer comprehensive medical equipment and supplies, ensuring patients receive the care they need when they need it most. For more information, visit www.aeroflowhealth.com.

About This Research

Aeroflow Health conducted a national survey in 2026 to assess awareness and readiness for work requirements among Medicaid adults ages 19–64 with a dual household income at or below \$75,000. Of the 2,525 people screened, 1,265 reported current Medicaid coverage, and 1,225 completed the readiness questions. The survey included adults across major U.S. regions and collected information on awareness, preparedness, the perceived effects of coverage loss, process concerns, reminder history, trusted sources, and preferred support.

The survey was not limited to people who will be legally subject to community engagement requirements. Results should therefore be interpreted as a measure of broad member communication needs rather than a population estimate of legal applicability. Percentages may not total 100% because of rounding, and the question about helpful interventions allowed respondents to select multiple answers.

This paper is for informational purposes only and does not constitute legal advice. State implementation, verification, exclusions, exceptions, and reporting methods may change. Health plans and members should rely on current guidance from CMS and their state Medicaid agencies.



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