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Medicaid Program; Community Engagement Requirement for Certain Individuals

June 17, 2026

Background & Key Takeaways

On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an Interim Final Rule with Comment Period on the Medicaid Program; Community Engagement Requirement for Certain Individuals (hereinafter, "IFC"). The IFC finalizes and implements statutory changes from Section 71119 of the One Big Beautiful Bill Act (OBBBA), enacted into law on July 4, 2025.[1] Section 71119 requires states to implement community engagement requirements (also known as work requirements) as a condition of Medicaid eligibility for certain adults between the ages of 19-64, no later than January 1, 2027 (or earlier through a Section 1115 demonstration).[2] The IFC outlines how states will need to comply with Section 71119, community engagement verification processes, documentation requirements and key communications.

In addition, CMS discusses the impact of Section 71119 on hospital presumptive eligibility determinations. As of May 2026, CMS reports 43 states and the District of Columbia (44 jurisdictions) cover populations subject to the community engagement requirements. CMS anticipates the policies in the IFC will decrease Medicaid enrollment by about 3.1 to 3.3 million individuals between Fiscal Years (FY) 2027-2036.

A CMS fact sheet on the IFC is available here. Despite CMS accepting comments on the IFC until **July 31, 2026**, the regulations are final and go into effect July 31, 2026. Vizient looks forward to working with our provider clients to help inform our letter to CMS.

Assessing Individual Compliance with the Community Engagement Requirement

Per Section 71119 of the OBBBA, states must require applicable individuals to demonstrate community engagement as a condition of eligibility for medical assistance at application and renewal. In addition, the law provides states with the option to conduct more frequent verifications of compliance with the community engagement requirement.

Also, CMS indicates states must require applicable individuals to demonstrate community engagement one month prior to the month of application. However, states have the option to extend this review period to two or three consecutive months prior to the month of application.

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[1] Section 71119 of OBBBA (Requirement for States to Establish Community Engagement Requirements for Certain Individuals) amended Section 1902 of the Social Security Act (the Act) to add new subsection (xx) that requires "applicable individuals" demonstrate, as a condition of their Medicaid eligibility, "community engagement" (e.g., that they work at least 80 hours a month, complete 80 hours of community service a month, participate in a work program for 80 hours a month, is enrolled in an educational program at least half time, engages is a combination of these activities for at least 80 hours a month, is a seasonal worker, or earns at least the equivalent of 80 hours of minimum-wage work in a month) for a minimum period of time preceding their Medicaid application and during their Medicaid enrollment, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm and https://www.congress.gov/bill/119th-congress/house-bill/1/text

[2] Presently, states are not required to provide coverage to the adult group. States that have elected to provide coverage to the adult group have primarily done so using state plan authority. The adult group consists of low-income individuals (up to 133 percent of the Federal poverty level) who are age 19 to 64, not pregnant, not entitled to or enrolled in Medicare Part A or B, or described in any other mandatory eligibility groups (for example, parent and caretaker relatives, children, or individuals eligible based on their receipt of SSI). However, some states have applied such requirements through a section 1115 demonstration. The community engagement requirement will apply in states that have elected the adult group through the state plan or that have a section 1115 demonstration that covers a similar population to which the requirement applies.

Consistent with OBBBA, CMS finalizes that a state must first determine whether a person is an "applicable individual" or a "specified excluded individual" when an individual first applies for Medicaid and then during regular eligibility renewals. After this step, for applicable individuals, the state must assess whether the individual meets the community engagement requirement or qualifies for an exception.

CMS clarifies that states must make decisions on applications based on the rules in place at the time the application was submitted, even if the decision is made after the community engagement requirement begins. For current beneficiaries, at minimum, states must verify community engagement at renewal. However, states may opt for more frequent verification. States must also inform affected individuals about the requirement before it takes effect. These rules apply to both new applicants and current beneficiaries.

Additional information regarding when states may assess compliance (e.g., when the state conducts more frequent verifications of compliance with the community engagement requirement; prohibition on assessing compliance for specified excluded individuals; processing certain changes; eligibility decision notifications) is included in the IFC (pg. 132-144).

Applicable Individuals

Section 71119 of the OBBBA requires that certain Medicaid beneficiaries, called "applicable individuals," must participate in community engagement activities (such as work, education or community service) as a condition of eligibility, both before applying and while enrolled. This statutory requirement only applies to Medicaid beneficiaries covered under the Affordable Care Act (ACA) expansion or certain section 1115 demonstration populations. In the IFC, consistent with the law, CMS defines "applicable individuals" as individuals enrolled in the Medicaid state plan adult group ages 19–64with a household income at or below 133% of the federal poverty level (FPL), who are not pregnant and are not enrolled in Medicare Parts A or B.[3] This definition also includes certain adults covered under section 1115 demonstrations that provide minimum essential coverage (MEC). For example, low-income adults ages 19–64 who receive full Medicaid coverage through the waiver, are not pregnant or on Medicare and do not otherwise qualify under the regular state plan.

In addition, CMS indicates that if an individual becomes an applicable individual at a later date (e.g., by moving into the adult group or a Section 1115 demonstration that includes applicable individuals), the state must reassess eligibility and determine whether the person is an "applicable individual." For this mid-year change, CMS provides policy detailing additional state requirements.

Mandatory Exceptions for Certain Individuals

Section 71119 includes a mandatory exceptions requirement which requires that the state deem an applicable individual as having demonstrated community engagement for a month if certain hardship circumstances exist for all or part of a month.[4] Because of this deeming, CMS indicates

[3] In Medicaid, the "adult group" (often referred to as the expansion group) is an eligibility category created by the Affordable Care Act (ACA). If a state does not cover this group of adults through Medicaid (or a similar program), then there is no one subject to the IFC in that state. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-adult-group.pdf

[4] Regarding mandatory exceptions, Section 71119 provides the following:
(3) EXCEPTIONS.

that in most cases, a person will continue to be eligible for Medicaid at the time they lose their status as a specified excluded individual. Additionally, the law gives states the option of requiring the individual to verify information related to such deeming. Consistent with the circumstances outlined in the law, CMS finalizes mandatory exceptions to the community engagement requirement for individuals under age 19, entitled to or enrolled in Medicare, eligible under another mandatory Medicaid eligibility group or previously excluded from the requirement to be treated as meeting the community engagement requirement. CMS also finalized a mandatory exception for people who were recently incarcerated. CMS indicates that if someone was in jail or prison at any point in the 3 months before the month being reviewed, the state must treat them as meeting the community engagement requirement for that month.

CMS also indicates that mandatory exceptions can apply to individuals who were previously excluded from the requirement to demonstrate community engagement but whose exclusion ends. Alternatively, mandatory exceptions can apply to those who were enrolled in another eligibility group and, following a redetermination, transition to an eligibility group consisting of applicable individuals.[5] In addition, CMS explains that states must count individuals as compliant for any month in which they meet an exception, which aims to help individuals whose circumstances have changed adjust to the community engagement requirement.

Short-Term Hardship Exceptions

As noted in the OBBBA, states have the option to include in their State plans a short-term hardship exception to the community engagement requirement for applicable individuals. States are not permitted to select one or only some of the short-term hardship exceptions specified in statute. For an applicable individual to be eligible for the short-term hardship exception, a "short-term hardship event" must occur. Consistent with the OBBBA, the following categories qualify as short-term hardship events:

- Individuals receiving inpatient hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), inpatient psychiatric services and home and community-based services that substitute for an institutional stay.
    - Further, CMS clarifies that the short-term hardship exception should apply not only to people in hospitals or other institutions but also to people receiving services of similar acuity in the community. If a community service is effectively substituting for inpatient hospital, nursing facility, ICF/IID or inpatient psychiatric care, so that without it the person would likely need institutional care, the state can treat that month as a hardship for that individual.

(A) MANDATORY EXCEPTION FOR CERTAIN INDIVIDUALS.—The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month, and may elect to not require an individual to verify information resulting in such deeming, if—
(i) for part or all of such month, the individual—
(I) was a specified excluded individual (as defined in paragraph (9)(A)(ii)); or
(II) was—
(aa) under the age of 19;
(bb) entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII; or
(cc) described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); or
(ii) at any point during the 3-month period ending on the first day of such month, the individual was an inmate of a public institution.

[5] For example, a beneficiary enrolled in the adult group has been excluded from the community engagement requirement because they have a dependent child who is age 13, but their child turns 14 during the individual's eligibility period. During the beneficiary's renewal, the State determines the individual is now an applicable individual subject to the community engagement requirement. The State requires beneficiaries to demonstrate 1 month of community engagement activity at renewal. Because the beneficiary was a specified excluded individual as a result of having a dependent child under the age of 14 for part or all of at least 1 month during the review period, which aligns with the eligibility period in this scenario, they meet the mandatory exception criteria for at least 1 month during the review period

    - CMS also indicates that states may set up clear categories of services that always qualify for short-term hardship exceptions (e.g., prescribed home care after hospital discharge) or decide on a case-by-case basis, but each state must show the community service directly replaces the institutional care.[6]
- Individuals residing in areas subject to a federally declared disaster or national emergency.[7]
- Individuals residing in counties where the unemployment rate is at or above the lesser of 8% or 1.5 times the national rate (to implement a short-term hardship exception in this circumstance, a state first must receive CMS approval).[8]
- Individuals, or their dependents, who must travel outside their community for an extended period to receive medical care for a serious or complex medical condition that is not available within their community of residence.[9]

In addition, CMS clarifies that the short-term hardship will generally have an end date (e.g., until the last day of the month in which the applicable individual's inpatient hospitalization ends). CMS also outlines communication requirements related to short-term hardship exceptions.

Specified Excluded Individuals

The OBBBA provides nine categories of individuals, referred to as "specified excluded individuals,"[10] who do not need to demonstrate community engagement (i.e. they are not "applicable" individuals). In the IFC, CMS provides additional information regarding each category of specified excluded individuals, including "individuals who are medically frail or otherwise has special needs." CMS details how states must verify status as a specified excluded individual in the IFC (pg. 174-185).

Also, CMS clarifies that states may not reverify a specified excluded individual's status between regularly scheduled renewals, even if the state opts for a more frequent verification process for other beneficiaries. However, the state may reverify a specified excluded individual's status if the state has information indicating the individual's status has changed.

Definition of Medically Frail

In the IFC, CMS details the exclusion category of "individuals who are medically frail or otherwise has special medical needs" (hereinafter, "medically frail") from the community engagement requirement. CMS indicates an individual is medically frail if they fall into one of five diagnostic

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[6] CMS explains the agency did not publish a fixed list of types of services that may apply because many services vary in intensity depending on the person.
[7] This includes living in a county (or equivalent) affected by a Presidential emergency declared under the National Emergencies Act (NEA). Because NEA declarations can be broad, open-ended, and nationwide or regionally vague, CMS will treat an NEA-based hardship as applying only where the emergency actually impairs an individual's ability to meet community engagement—for a county, multiple counties, or statewide—rather than automatically covering entire border states or other large areas. States must show how the NEA-declared emergency creates barriers to community engagement (for example, impacts on businesses or other local disruptions), notify CMS promptly when they plan to use an NEA-based hardship, and CMS will review the State's use and implementation of these exceptions.
[8] CMS will use Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics (LAUS) as the default standard to determine whether a county (or equivalent) meets the unemployment thresholds. States may submit other reliable or preliminary data (for example, from a state labor department) if BLS figures are unavailable and CMS will review to see if this data is acceptable.
[9] CMS proposes definitions for this requirement, including "dependent," "serious or complex medical condition," "community," and "Period of time" in the IFC (pg. 126-131)
[10] CMS defines and explains these categories further in the IFC (pg. 55-101) which include: former foster care children under age 26; American Indians and Alaska Natives; parents, guardians, caretaker relatives, and family caregivers of a child age 13 or under of a disabled individual; veterans with a 100% VA disability rating (VA assigns disability ratings based on the severity of a veteran's service-connected condition(s), which is stated as a percentage); individuals who are medically frail or otherwise has special medical needs; individuals in SNAP households who are subject to SNAP work requirements; individuals participating in a drug or alcohol treatment and rehabilitation program; current inmates of a public institution; and pregnant and postpartum women.

categories including blindness or disability; substance use disorder (SUD); a disabling mental disorder; a physical or developmental disability that impairs activities of daily living; or a serious or complex medical condition. In the IFC, CMS declines to further define in regulation these categories. However, CMS explains states must use lists of diseases, diagnoses, disorders or other health conditions to help define these categories and identify individuals who might potentially qualify as medically frail. States must create auditable, justifiable lists of diseases, diagnoses, disorders or other health conditions, using health-care code sets such as ICD-10, to identify people who may qualify as medically frail and these lists must be updated regularly to add or remove conditions based on implementation experience. CMS states that the agency has not identified any other populations that it believes could reasonably be considered medically frail outside of the five categories.

Notably, the IFC requires the individual to prove the health condition significantly impairs their ability to comply with the community engagement requirement.[11] This additional requirement was not explicitly included in the OBBBA or in the December 2025 guidance CMS released.[12]

In addition, CMS directs states to verify medical frailty after initially accepting an individual's self-attestation, such as through a screening tool, using available data (e.g., adjudicated claims or encounter data, as relevant to the individual, from the preceding 12 months) or, beginning January 1, 2028, additional documentation if needed. CMS also indicates that states may require documentation to verify medical frailty when reliable data is unavailable, but states have flexibility to rely on other information through December 31, 2027 to allow time for system updates. States must reverify medical frailty at least every 12 months (or more frequently). Beginning January 1, 2028, individuals initially approved based only on self-attestation must be reverified at their next renewal using available data before requesting documentation.

Outreach

In the IFC, CMS requires states to notify Medicaid enrollees who are subject to community engagement requirements before the requirement takes effect on January 1, 2027. CMS provides in the IFC that for states with community engagement requirement effective dates of January 1, 2027, initial outreach notices must be sent between July and September 2026, depending on whether the state requires 1, 2 or 3 months of prior community engagement. States must provide outreach notices through at least two modalities including by regular mail (or, if elected by the individual, in an electronic format) and in one or more additional modalities (e.g., telephone, text message, an internet website). States must post clear information about the community engagement requirements on their websites.

CMS also explains that states can work with managed care plans to support implementation of the community engagement requirement, including outreach, education, data sharing and referrals to qualifying programs. However, the state remains responsible for administering the requirement. Plans cannot determine compliance, collect certain eligibility information or issue official notices, and must follow federal funding and conflict-of-interest rules.

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[11] If a person can demonstrate community engagement by performing 80 hours per month of qualifying community engagement activities, notwithstanding their physical, mental, or other behavioral health condition, they would not qualify as medically frail. CMS explains the agency will not add or allow states to add extra categories because it has not identified other populations that reasonably fit the term and because permitting additions could invite inappropriate expansions (e.g., treating homelessness as medical frailty).

[12] https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf

Demonstrating Community Engagement

To implement Section 71119 of the OBBBA, CMS provides additional information regarding how states are to ensure an applicable individual demonstrates community engagement. Specifically, CMS finalizes that an applicable individual meets the community engagement requirement by completing at least 80 hours per month through work, community service, a work program, being enrolled at least half-time in an educational program or any combination of these activities. CMS indicates states must calculate each activity separately, convert education hours, then add the figures together. If the total reaches 80 hours, no further verification of other activities is needed. In the IFC (pg. 23-52) and outlined in Table 1 below, CMS proposes definitions for each of the options for demonstrating community engagement.

An individual can also meet the community engagement requirement if they have a monthly income of at least the federal minimum wage multiplied by 80 hours or, if a seasonal worker, the individual has an average monthly income over the past six months that is at least the federal minimum wage multiplied by 80 hours. States must allow all of these options and cannot limit individuals to only certain methods of meeting the requirement.

Table 1. Definitions for Community Engagement Requirement

Community Engagement Type and Characteristics	Key Details & Statutory or Regulatory Alignment
Work: Work in exchange for money, work in exchange for goods or services ("in-kind" work), and unpaid work[13] other than community service	• Includes self-employment, independent contracting, internships, unpaid trial periods, and unpaid family caregiving. • In-kind and unpaid work generally aligns with the Food and Nutrition Service's (FNS) regulatory definition of working for SNAP.[14]
Community Service: Unpaid work in a structured program under public or nonprofit organizations	• Service must directly benefit the community; embedded training that is integral to the service counts; partisan activity and purely individual or recreational activities do not count. • Aligns with Temporary Assistance for Needy Families (TANF) definition of community service.[15]
Work Program: Includes programs defined at section 6(o)(1) of the 2008 Food and Nutrition Act[16]	• Limited supervised unemployment job search may be allowed as a subsidiary activity if it is < 50% of required hours; Medicaid employment services under Section 1915 waivers do not independently qualify. • CMS will permit a program of employment and training that meets the definition of work program

[13] CMS explains that the proposed definition of work does not require that an individual receive payment for duties or activities performed for the benefit of another individual or entity, accommodates situations where individuals engage in unpaid work, including, but not limited to, unpaid work as part of a trial period when applying for a job, or unpaid work, such as an internship, to gain experience for a job or industry. Unpaid work can benefit an individual or private entity and does not need to benefit the community.

[14] https://www.ecfr.gov/current/title-7/subtitle-B/chapter-II/subchapter-C/part-273/subpart-G/section-273.24

[15] https://www.ecfr.gov/current/title-45/subtitle-B/chapter-II/part-261/section-261.2

[16] CMS defines work program to align with the definition from Section 6(o)(1)of the Food and Nutrition Act of 2008 which defines work program as: 1) a program under title I of the Workforce Innovation and Opportunity Act (WIOA); 2) a program under section 236 of the Trade Act of 1974; 3) a program of employment and training operated or supervised by a state or political subdivision of a state that meets standards approved by the Governor of the state, including an employment and training program under subsection (d)(4) of section 6 of the Food and Nutrition Act of 2008, other than a supervised job search program or job search training program; 4) a program of employment and training for veterans operated by the U.S. Department of Labor or the U.S. Department of Veterans Affairs (VA), and approved by the Secretary of the U.S. Department of Agriculture (USDA); and 5) a workforce partnership under subsection (d)(4)(N) of section 6 of the Food and Nutrition Act of 2008. In the IFC, CMS incorporate this definition with one modification that programs outside of these aforementioned work programs, such as those operated by health providers that do not qualify under the part of the definition related to programs operated or supervised by a state, are not included in this definition. COMPS-10331.pdf

Educational Program enrollment at least half time: Institution of higher education; career & technical education; high school; state approved high-school equivalency programs	• Meets requirement if enrolled at least half time[17] • Institution determines half-time status; enrollment counts through normal attendance, recess, and vacations per institution status. • The Higher Education Act of 1965[18]; and the Carl D. Perkins Career and Technical Education Act of 2006.[19]
Educational Program Enrollment Less than Half-Time	• Education hours accrued by an individual enrolled in an educational program less than half-time may be combined with hours performed for other community engagement activities to count towards 80 hours • If credit based: 1 credit hour counts as 3 education hours per week during the individual's enrollment. Then multiply by 4.33 to get monthly hours (e.g., 6 credits = 77.94 hours/month). Non-credit programs count actual class/training hours.[20,21] • SNAP and TANF

Notifying Individuals About Eligibility Decisions and Changes in Eligibility Requirements

While not included in the OBBBA, current regulations require states to provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, which includes eligibility approvals, denials and terminations.[22] In the IFC, CMS clarifies that if a person loses their status as an excluded individual and becomes subject to the community engagement requirement, this change in status could affect their Medicaid eligibility. Should this occur, states must provide at least a ten-day advance notice and offer the individual the right to a fair hearing to challenge this change. The notice must also include clear information about the community engagement requirement, so the individual understands their new responsibilities before the change takes effect.

Verification of Compliance Related to the Community Engagement Requirement

In the IFC, CMS finalizes requirements for states to verify whether an applicable individual meets the monthly requirement, whether the individual is "deemed compliant" during months they fall into certain exception statuses and whether the person qualifies as a specified excluded individual who is not subject to the Medicaid community engagement requirement. For these circumstances, CMS requires states to use an "ex parte" process by first attempting to verify whether an individual meets the community engagement requirement, or qualifies for an exception or exclusion, using reliable

[17] The U.S. Department of Education's (ED) definition of half-time status defers to the institution to make its own determination as to whether an enrolled student is carrying a half-time academic workload (see definition of "half-time student" in 34 CFR 668.2(b)). Additionally, in SNAP regulations related to student eligibility, the institution of higher education determines enrollment status (see 7 CFR 273.5(b)(10) specifying the enrollment status of a single parent "as determined by the institution"). For consistency with existing standards in SNAP and those of ED, CMS provides that the state will use the enrollment status determined by the school or institution (that is, full-time, half-time, less than half-time).

[18] https://www.govinfo.gov/content/pkg/COMPS-765/pdf/COMPS-765.pdf

[19] https://www.ed.gov/adult-programs/adult-education-laws-and-policy/perkins-v

[20] CMS finalizes that 1 credit hour equals 1 hour of instruction, the agency expects students to spend 2 hours on out-of-class work for a total of 3 hours of time spent in the educational program for the week. To calculate the time spent in the educational program for a 1 credit hour course during a 1-month period, this would be 3 hours a week multiplied by 4.33 weeks (in a month) for a total of 12.99 hours in a month. This new standard is based on the Carnegie Unit, which defines 1 unit of credit as equal to 3 hours of student work per week (1 hour of lecture plus 2 hours of homework). The Carnegie Unit is used in the credit hour definition at 34 CFR 600.2. CMS gives examples of credit hour standards in the IFC (pg. 37-40).

[21] To calculate the time spent in the educational program for a 1 credit hour course during a 1-month period, this would be 3 hours a week multiplied by 4.33 weeks (in a month). CMS states that on average, there are 4.33 weeks in a month. This is calculated by dividing the total number of weeks in a year (52), by the total number of months (12).

[22] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR0717d3fdf4a090c/section-435.917

information already available to the state, without requesting additional information from the applicant or beneficiary until December 31, 2027.[23,24] As new data sources become available to verify compliance related to the community engagement requirement, CMS may require states to use additional data sources in the future.

Beginning January 1, 2028, CMS finalized additional verification requirements for states. Specifically, when documentation is not reasonably available, states must require additional documentation to verify that the individual met or is deemed to have met the community engagement requirement or qualifies as a specified excluded individual.[25] In these cases, states have discretion to determine what types of information are sufficient to substantiate eligibility based on the circumstances, provided that such information reasonably supports the individual's status when neither reliable data nor documentation can be obtained.

Noncompliance Procedures

Consistent with requirements in the OBBBA, CMS indicates that if a state cannot verify that an individual met the community engagement requirement or qualifies for an exclusion during the review period, the state must issue a notice of noncompliance.[26] The state must give the individual 30 calendar days from receipt of the notice to demonstrate that they met the requirement or that the notice of noncompliance does not apply.[27] CMS clarifies that the state must continue coverage during this period and cannot terminate coverage until a final ineligibility determination is made.

In the IFC, CMS provides that states may not restrict an individual's ability to reapply for Medicaid after losing coverage for noncompliance with community engagement requirements and cannot impose waiting or lock-out periods. States are required to process applications and provide benefits promptly if the individual is found eligible, regardless of prior noncompliance.

Implications of Community Engagement on Presumptive Eligibility (PE) and Presumptive Eligibility Determined by Hospitals

Under the Affordable Care Act (ACA), states may designate "qualified entities," such as hospitals, to grant presumptive eligibility determinations for pregnant women, children, certain breast and cervical cancer patients and individuals eligible for family planning services in case these groups need immediate, temporary Medicaid coverage while their full application is being processed. In

[23] Ex parte verification applies to three determinations: (1) the person met the community engagement requirement, (2) the person is deemed compliant due to an exception, or (3) the person is a specified excluded individual not subject to the requirement. It is not limited to renewals; it applies any time the state verifies compliance.
[24] In the IFC, CMS indicates that reliable information includes effective electronic data sources documented in the state's verification plan, other state and local agency records, Federal data via the Federal Data Services Hub, the State eligibility system and case file, payroll records, adjudicated claims and encounter data from the prior 12 months. States are required to collect relevant data from SNAP/TANF agencies, correctional facilities, and, where permitted, education institutions to verify exclusions or half-time enrollment, and to connect to or establish procedures to access any other State or local data needed to verify compliance or exclusion status.
[25] Examples of reasonably available documentation include paystubs to verify work hours or income, a document from a community service organization that demonstrates the number of hours an individual volunteered, transcripts or class schedules as proof of half-time enrollment in an educational program, a document from VA showing disability status and approval notices from SNAP or TANF.
[26] CMS interprets the term "review period" to reference the time period under consideration, during which an applicable individual must demonstrate the required number of months of community engagement (or be deemed to being doing so through an exception) to fulfill the requirement.
[27] A state is considered unable to verify compliance when after reviewing the information provided on the application and any reliable information available to the state, the state still lacks sufficient information to determine whether the individual has demonstrated or is deemed to have demonstrated community engagement for the number of months required under the state plan. A state is considered to have insufficient information at application if: 1) the information provided by the applicant is not reasonably compatible with the reliable information available to the State , or 2) the individual did not provide the additional information or documentation requested by the state to verify that they met or are deemed to have met the community engagement requirement.

addition, states must provide certain hospitals with the option to become a qualified entity that makes Medicaid PE determinations.[28] This option, called hospital presumptive eligibility (HPE), is available even if a state has not designated other qualified entities to make these determinations. States that cover the adult Medicaid expansion group must allow hospitals to make HPE decisions for the adult group. CMS also allows states the choice to let hospitals make PE determinations for other Medicaid groups covered under Medicaid or groups covered through Section 1115 demonstrations. CMS explains that an individual applying for PE or HPE must confirm that they met the community engagement requirement for at least the month before applying, and for up to three prior consecutive months if required by the state, or that they qualify for an exclusion that counts as meeting the requirement for those months.

To implement this process, CMS acknowledges states will need to update PE and HPE training materials, train qualified entities on the requirement and update PE and HPE application materials, including eligibility determination notices, to capture this information. These updates should include information on how providers can assess who is an applicable individual, who is a specified excluded individual and how providers can determine if an applicable individual meets exception criteria.

In addition, hospitals are required to screen individuals who appear eligible for the adult group or certain Section 1115 demonstration programs to determine if they are subject to the community engagement requirement and identify how they may have met it. The PE and HPE determinations must continue to rely on the applicant's own statements, including whether they are excluded or meet the community engagement requirement.

State Systems Changes Needed to Implement the Community Engagement Requirement

States are required to update their Medicaid systems to support the community engagement requirement, including by expanding the use of electronic data sources to verify qualifying activities, exceptions and exclusions, and automating formerly manual processes. CMS will monitor states' progress through status reports, milestone tracking and technical support to ensure states are prepared and making good-faith efforts to comply with all requirements and will issue additional guidance on required system features, testing and performance metrics as needed.[29]

Under current regulations, after CMS approves a state's Medicaid system, the state can receive 75% federal financial participation (FFP) for operations if it demonstrates the system supports reporting, performance tracking and accountability. After the state receives this funding, CMS conducts ongoing, periodic oversight of state Medicaid systems to ensure they continue meeting federal requirements and qualify for enhanced federal funding.[30] Under the IFC, these requirements also apply to community engagement systems. CMS clarifies that states can receive up to 90% federal funding for system upgrades if they get prior CMS approval through an Advance Planning Document (APD). States must continue showing their systems meet federal standards through

[28] https://www.medicaid.gov/faq/2020-04-09/91721

[29] Additionally, CMS will focus on whether states are making meaningful progress towards systems readiness, identifying and escalating implementation risks in a timely manner, and seeking technical assistance to ensure operational readiness. CMS plans to use information obtained through these oversight activities to inform our understanding of state progress, implementation challenges, and whether a state is making continued good-faith efforts toward compliance.

[30] This involves routine monitoring through performance reports, metrics, and other data rather than requiring reapproval for every system update or enhancement. Formal review or reapproval is only triggered when CMS identifies concerns, such as declining system performance, compliance issues, or risks revealed through oversight, at which point CMS may evaluate the entire system, a specific module, or a particular component. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-C/section-433.119

reporting and performance measures.

Good Faith Effort Exemption

Consistent with the OBBBA, CMS explains that states may receive a temporary good faith effort exemption if they are making strong progress but cannot meet the deadline. CMS will review requests case-by-case and could grant short-term exemptions of up to 6 months, with possible extensions through December 31, 2028, for states that continue to show progress in implementing the requirements. To qualify, states must demonstrate a detailed plan, ongoing efforts, significant barriers and provide regular progress reports. Failure to comply can result in the exemption being revoked and potential corrective action.

Monitoring

CMS finalizes that states must provide timely and complete data that is of sufficient quality to monitor enrollment, retention and eligibility processes for community engagement activities that begin January 1, 2027, or an earlier date specified by the state.[31] Failure to properly report data, or data indicating compliance problems, may result in corrective actions, additional reporting requirements or increased outreach to beneficiaries. CMS will review trends within a state and compare results to other states to identify potential issues, such as unusually high rates of exclusions or terminations. If issues are identified, CMS may take further action but must first provide notice and an opportunity for a hearing before imposing any financial penalties.

Regulatory Impact Analysis

CMS projects that Medicaid enrollment would be reduced by 2.3 million individuals beginning in FY 2027, accounting for implementation occurring in the second quarter of the fiscal year, and by between 3.1 to 3.3 million individuals in each subsequent year until 2036. CMS also projects that federal Medicaid spending will be reduced by $350.3 billion over the next 10 years and state Medicaid spending would be reduced by $41.6 billion over the same time period. The full ten-year impact of the community engagement requirement on Medicaid enrollment and expenditures between FY 2027 and FY 2036 is shown in Table 41 of the IFC (pg. 321-322).

CMS estimates total system upgrade and maintenance costs of $1.52 billion (2026–2036), with $1.289 billion expected to be borne by the federal government and $231 million by the states, based partly on planning data from 21 states. CMS expects states may have additional costs to upgrade state Medicaid eligibility systems but there is limited information on how much states will invest in these systems and actual costs remain uncertain. CMS also reminds states that Section 71119 of the OBBBA provides $200 million in Government Efficiency Grants to states and Washington, D.C to establish systems to implement the community engagement requirement and eligibility determinations, and to support system upgrades. CMS indicates that half of the funds will be divided equally among all 51 eligible recipients, and the other half will be allocated based on each state's proportion of individuals subject to the work requirement.

[31] CMS requires that states submit data elements for applicants and beneficiaries applying for and receiving medical assistance, through five specified categories: (1) enrollment totals of individuals applying for and receiving medical assistance; (2) application and renewal processing, timeliness, and backlogs; (3) outcomes of determinations and redeterminations eligibility; (4) populations subject to and their compliance with the requirements of section 1902(xx) of the Act; and (5) other such data specified by CMS in regulation, guidance, or technical specifications to monitor implementation and the impact of community engagement.

What's Next?

The IFC goes into effect July 31, 2026, with key compliances dates of January 1, 2027 and January 1, 2028. Although comments are also due on July 31, 2026, the IFC is a final rule and it is unclear whether CMS will make additional changes based on stakeholder feedback. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued client feedback on this IFC. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this IFC – both positive reactions and provisions that cause you concern. Please direct your feedback to Randi Gold, Director, Hospital Payment Policy and Regulatory Affairs in Vizient's Washington, D.C. office.