CMS Medicaid Community Engagement Requirement

Top 10 Changes Likely to Reduce Medicaid Enrollment or Negatively Affect Coverage

Source: Medicaid Program; Community Engagement Requirement for Certain Individuals, CMS-2454-IFC, published June 3, 2026.

Executive Summary

The proposed/interim final CMS rule would make Medicaid eligibility for many adult-group beneficiaries conditional on demonstrating qualifying community engagement, generally 80 hours per month or an equivalent income threshold.

The most immediate provider-facing concern is that hospital presumptive eligibility and related point-of-care enrollment pathways become more complex. Hospitals and qualified entities would need to account for the community engagement requirement when screening affected adults, increasing the risk that otherwise eligible uninsured patients are delayed, diverted, or not enrolled.

The largest coverage risk is not limited to individuals who fail to work or engage in qualifying activities. It also includes procedural losses among people who work, attend school, qualify for an exception, or should be excluded but cannot successfully navigate documentation, notices, and verification requirements.

Lead Issue: Hospital Presumptive Eligibility Impact

The rule's treatment of presumptive eligibility, including hospital presumptive eligibility, is the most direct operational issue for hospitals. Under the rule, the community engagement requirement would have to be considered in existing enrollment pathways for affected adult-group applicants. That means hospitals and qualified entities may have to evaluate whether a patient appears to be excluded, excepted, deemed compliant, or otherwise able to satisfy the requirement before presumptive coverage can be approved.

This is likely to make point-of-care enrollment more difficult. Hospital presumptive eligibility is designed to be fast, simple, and available when an uninsured patient presents for care. Adding a community engagement screen creates new friction at precisely the moment when hospitals are trying to connect eligible patients to coverage and reduce uncompensated care.

For hospitals, the risk is practical rather than merely technical: eligible adults may leave the hospital without coverage because they lack documentation, do not understand the requirement, cannot demonstrate recent qualifying activity, or fall into an exception category that is not easily verified at the bedside. This could increase self-pay balances, bad debt, charity care, and delayed Medicaid eligibility determinations.

Key hospital implications

- **Operational change:** Community engagement screening would be added to presumptive eligibility workflows.
- **Coverage risk:** Eligible patients may fail or delay screening because compliance, exclusion, or exception status is not immediately verifiable.

- **Hospital business impact:** Hospitals may see more uninsured/self-pay encounters, delayed Medicaid billing, higher denial risk, and more follow-up work for eligibility teams.
- **Compliance risk:** Different hospitals and qualified entities may interpret evidence, exceptions, or exclusions differently, creating uneven patient access to coverage.

Top 10 Changes Likely to Reduce Enrollment or Negatively Affect Coverage

1. Hospital presumptive eligibility and point-of-care enrollment become more complicated

The rule applies the community engagement requirement to enrollment pathways that include presumptive eligibility and hospital presumptive eligibility. Hospitals and qualified entities would need to assess whether affected adult applicants appear excluded, excepted, deemed compliant, or otherwise compliant. This could slow enrollment when patients are presenting for care and may increase uncompensated care exposure.

2. Adult-group Medicaid coverage becomes conditional on an 80-hour monthly activity test

Applicable individuals generally must demonstrate at least 80 hours per month of qualifying work, community service, participation in a work program, half-time education, a combination of qualifying activities, or income equal to at least 80 hours at the federal minimum wage. Failure to satisfy or prove compliance can lead to denial or disenrollment.

3. The affected population is broad

The requirement generally applies to many non-pregnant adults ages 19 through 64 who are enrolled through the Medicaid adult group or certain section 1115 demonstration coverage, are not enrolled in Medicare Part A or B, and are not otherwise eligible under another Medicaid category. Because the adult group is large in expansion states, the potential enrollment impact is significant.

4. New applicants may need to prove compliance before enrollment

States must require applicable applicants to demonstrate compliance for at least one month, and at state option two or three consecutive months, immediately before the month of application. This creates a pre-enrollment barrier for people seeking coverage after a job loss, health crisis, housing instability, or other disruption.

5. Current beneficiaries must prove compliance at renewal, with states permitted to verify more often

The rule requires compliance assessment at renewal and permits states to verify compliance more frequently. Each additional verification point increases the chance of missed notices, incomplete responses, data mismatches, and procedural disenrollment.

6. Procedural disenrollment is an expected coverage-loss pathway

CMS acknowledges that people who may be working, in school, otherwise meeting the requirement, or qualifying for an exception can still lose coverage for administrative reasons. This is a major concern because the coverage loss may result from process failure rather than actual noncompliance.

7. A 30-calendar-day response period precedes denial or disenrollment

When the state cannot verify compliance, deemed compliance, exception, or exclusion status, the individual receives a notice of noncompliance and has 30 calendar days to make a satisfactory

showing. If the individual fails to do so, the state must deny the application or disenroll the beneficiary after considering other eligibility bases.

8. Loss of excluded status becomes a new eligibility risk point

Individuals who were previously outside the requirement can become subject to it if they lose excluded status. These transitions create new moments when people may fail to receive, understand, or respond to notices, even if they could meet the requirement or qualify for an exception.

9. Verification gaps shift burden back to beneficiaries

States must first attempt to verify compliance or exception status using reliable information available to the state. But when reliable data are unavailable, incomplete, or not reasonably compatible, the burden shifts to the individual to provide additional information. Workers with variable hours, self-employment, multiple jobs, caregiving responsibilities, unstable addresses, or limited documentation face heightened risk.

10. Implementation timing and outreach requirements create near-term operational pressure

States must implement the requirement no later than January 1, 2027, unless a good-faith effort exemption applies. The rule also requires targeted outreach before implementation. Short timelines for eligibility-system changes, notices, data interfaces, staff training, and beneficiary education increase the risk of confusion and erroneous coverage loss.

Hospital and Health System Takeaways

- Hospitals should treat presumptive eligibility workflow changes as an immediate operational risk area, not a downstream policy issue.
- Eligibility, revenue cycle, patient access, community health, and Medicaid managed care teams should be aligned before state implementation begins.
- Hospitals should monitor state decisions on whether to require one, two, or three months of pre-application compliance and whether to verify compliance more frequently than annual renewal.
- Coverage losses may translate quickly into higher uncompensated care, more delayed authorizations, greater patient financial assistance need, and added patient access staffing burden.

Source Notes

Federal Register, Medicaid Program; Community Engagement Requirement for Certain Individuals, CMS-2454-IFC, published June 3, 2026.

CMS fact sheet, Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period.

Key Federal Register provisions reviewed include: scope and applicability; demonstrating community engagement; mandatory and optional exceptions; assessing and verifying compliance; noncompliance notice and response procedures; implementation timing; state outreach; monitoring and reporting; and presumptive eligibility implications.