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Community Engagement Requirements

Implications of the Interim Final Rule for MCOs, Providers, and States

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EXECUTIVE SUMMARY

The Community Engagement IFR: A Compounding Risk Event

On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid Community Engagement Interim Final Rule (IFR)[1], implementing the work reporting requirements established under H.R. 1[2]. With a comment period open through July 31 and initial implementation effective January 1, 2027, the rule creates immediate operational and financial pressures for every major stakeholder in the Medicaid ecosystem.

The scale of the requirement is substantial. CBO's original estimate of the House-passed legislation projected that approximately 18.5 million people nationally would be subject to the requirement each year[3]. In its supplemental estimate scoring the law as enacted, CBO projects approximately 5.7 million people will lose Medicaid coverage nationally by 2034 as a result of the community engagement requirement — roughly half due to not meeting the requirement or qualifying for an exception, and half due to the added administrative burden of the application and verification process alone — with 5.3 million of that loss resulting in becoming uninsured[4].

The IFR deviates from what most stakeholders anticipated from minimal guidance received from CMS leading up to the IFR. The medically frail exclusion is substantially narrower than prior state pilot definitions suggested but doesn't provide states a list of conditions which qualify as medically frail. The verification hierarchy is operationally complex. Timelines are compressed. And the downstream consequences — enrollment losses, coverage cliffs, uncompensated care, and acuity shifts — extend well beyond any single stakeholder.

This paper analyzes the implications of the IFR across three stakeholder groups: Managed Care Organizations (MCOs), provider organizations, and state Medicaid agencies. Each faces a distinct but interconnected set of risks. Understanding those risks — and acting on them before the comment period closes and implementation begins — is critical.

> *This paper's central finding: the Community Engagement IFR compounds risk across MCOs, providers, and states simultaneously, rather than affecting each in isolation. The driver is a medically frail exclusion that is narrower and more procedurally demanding than CMS's preliminary signals suggested, paired with verification infrastructure that each state must build from scratch under a compressed timeline. The comment period closing July 31 is the last substantial opportunity to influence these parameters before implementation begins.*

This report was authored by Colby Schaeffer, ASA, MAAA and Shelley Moss, FSA, MAAA at Incline Actuarial Group. The purpose is to help readers understand the implications of the new Medicaid Community Engagement Interim Final Rule. This information may not be appropriate, and should not be used for other purposes, including as legal advice on the validity of the IFR. The authors were not engaged nor compensated by any organization to prepare this paper. Incline Actuarial Group does not endorse any specific policy, regulatory, or operational action on matters discussed in this report.

The authors are credentialed actuaries — Fellows and Associates of the Society of Actuaries and Members of the American Academy of Actuaries — with professional experience in Medicaid managed care capitation rate development and certification. This paper has been prepared in accordance with the applicable Actuarial Standards of Practice ("ASOPs") promulgated by the Actuarial Standards Board, including ASOP No. 41, Actuarial Communications, governing the disclosures required in an actuarial document of this kind.

This paper does not involve the development or application of actuarial models, the use of client-provided or proprietary data, or the selection of quantitative actuarial assumptions. Its analysis and conclusions reflect the professional judgment of the undersigned actuaries, applied to publicly available sources cited throughout the report — including the text of CMS's Medicaid Community Engagement IFR and H.R. 1— and rely on no data, analysis, or other input from any other party. It reflects these authorities as of its date, and the authors undertake no obligation to update it for subsequent developments, including changes CMS may make in finalizing the rule or additional sub-regulatory guidance.

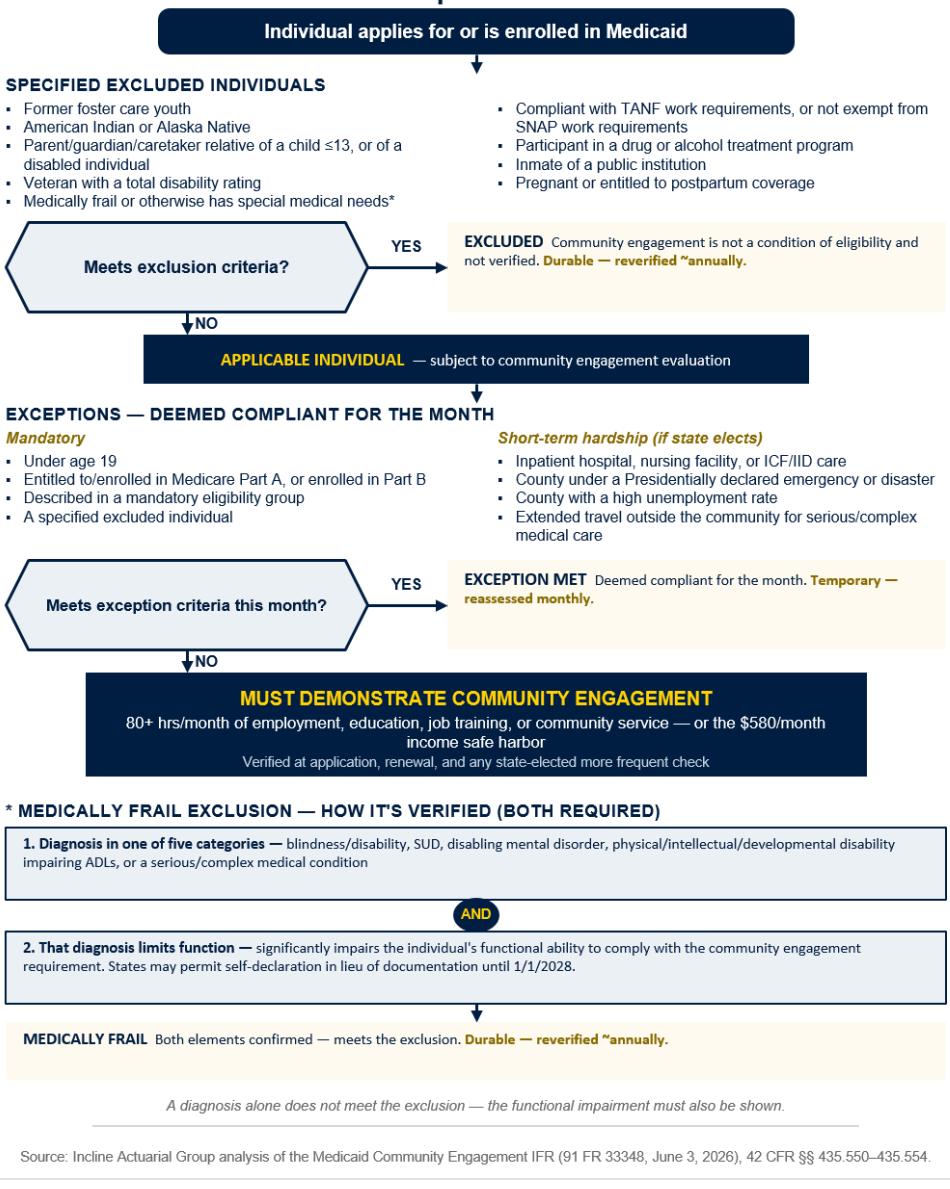
What the IFR Establishes

Who Is Subject to the Requirement

Exhibit 1 shows a flow chart illustrating how states determine who is subject to the community engagement requirement. More details regarding the determination process are shared below.

EXHIBIT 1

Determining Who Is Subject to the Community Engagement Requirement



Source: Incline Actuarial Group analysis of the Medicaid Community Engagement IFR (91 FR 33348, June 3, 2026), 42 CFR §§ 435.550–435.554.

In determining "applicable individuals" that must meet community engagement requirements, states must first evaluate **exclusion** status. If an individual is excluded, community engagement is not a condition of Medicaid eligibility and is not verified.

Exclusions are durable – that is, once granted they typically remain in effect until they are required to be reverified, roughly annually.

The IFR specifies the following categories of specified excluded individuals:

- Former foster care youth
- American Indian or Alaska Native
- Parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age and under, or of a disabled individual
- Veteran with a disability rated as total
- Medically frail or otherwise has special medical needs that significantly impair the ability to comply with the requirement
- Compliant with TANF work requirements, or not exempt from SNAP work requirements
- Participant in a drug or alcohol rehabilitation or treatment program
- Inmate of a public institution
- Pregnant or entitled to postpartum coverage

Medically frail is an exclusion, not an exception.

- All individuals who don't meet an exclusion are considered "applicable individuals" and states must evaluate if any exceptions apply or if the individual is compliant with community engagement requirements.
- **Exceptions** are temporary — month-by-month status that must be regularly reassessed. If an applicable individual meets exception criteria, states must deem them compliant for a month. The IFR includes mandatory exceptions and optional short-term hardship exceptions.
- **Mandatory exceptions** include children under the age of 19, individuals entitled to or enrolled for benefits under Medicare Part A or enrolled for benefits under Medicare Part B, individuals described in any of the mandatory eligibility groups, or a specified excluded individual.
- **Optional short-term hardship exceptions** include those receiving certain medical services such as inpatient hospital, nursing facility services, or an intermediate care facility for individuals with intellectual disabilities; residing in a county in which there is an emergency or disaster declared by the President; residing in a county with high unemployment rate; or

traveling outside of their community for an extended period of time for medical services for a serious or complex medical condition for themselves or their dependent. States can elect to offer these short-term hardship exceptions, but if they elect to offer, they must offer all.

Applicable individuals — those subject to the requirement — must demonstrate 80 or more hours per month of a combination of qualifying activities: employment, education, job training, or community service. A safe harbor of $580 per month (Federal minimum wage of $7.25 multiplied by 80 hours per month) in income may be used in lieu of hour tracking.

The Medically Frail Exclusion

CMS created a separate medically frail definition for community engagement purposes, distinct from the Alternative Benefit Plan (ABP) medically frail definition[5]. This is not a modification of the ABP standard — it is a similar yet separate construct. The IFR limits the exclusion to five categories:

- Blindness or disability
- Substance use disorder (SUD) — *distinct from the standalone exclusion for program participants above; a SUD diagnosis alone must still meet the functional limitation standard to qualify here, and applies only to individuals in recovery for fewer than five years (active treatment participation is not required)*
- Disabling mental disorder
- Physical, intellectual, or developmental disability that significantly impairs the ability to perform one or more activities of daily living (ADLs)
- Serious or complex medical condition

A diagnosis alone is insufficient. The condition must also significantly impair the individual's functional ability to comply with the community engagement requirement. The IFR did not prescribe or suggest specific verification procedures for demonstrating impairment. States must develop their own diagnosis code lists within the five categories but cannot add new categories. Prior state benchmarks — including the Nebraska list[6] and those used for ABP — are not reliable guides to the IFR standard.

Expansion to ABD Eligibility Category Migration

Some individuals currently enrolled through the expansion eligibility category may, if they applied, qualify for Medicaid through the Aged, Blind, and Disabled (ABD) pathway via a formal Social Security Administration (SSA) disability determination. Historically, many such individuals have not

pursued that route: income-based expansion eligibility is faster to obtain and requires substantially less documentation than a disability determination, and SSA processing times — already running months to years — provide little incentive to apply when expansion coverage is readily available[7]. States also receive higher federal match for expansion beneficiaries than ABD. Consistent with this pattern, an analysis of Arkansas's 2018 work requirement pilot found that only 45% of the state's disabled Medicaid enrollees were eligible through the SSI-linked disability category; the majority qualified through other pathways, including expansion[8].

The community engagement requirement may alter that calculus for a subset of this population. One category within the medically frail exclusion — blind or disabled, as defined in Section 1614 of the Social Security Act[9] — draws on the same statutory standard applied in SSA disability determinations, meaning some medically frail expansion members plausibly could qualify for ABD eligibility today. What the IFR changes is not the availability of that route, but the relative burden of remaining in the expansion category: the medically frail exclusion requires a qualifying diagnosis **and documented impairment** of the ability to meet the community engagement requirement, verified under standards each state must build without CMS specification, and reverified approximately annually. By contrast, an SSA disability determination is not a lower bar: the medically frail "blind or disabled" prong uses the Section 1614 standard, but requires an additional, separate showing that the condition significantly impairs the individual's ability to comply with the community engagement requirement[10]. Additionally, once an SSA determination is granted, it is reviewed far less frequently: roughly every three years where medical improvement is possible, or five to seven years where it is not, with the substantial majority of reviews resulting in continued benefits[11,12]. And critically, ABD eligibility sits entirely outside the community engagement framework, which applies only to the ACA expansion adult group[13]: a member who transitions to ABD is not merely excluded from the requirement within the expansion category but is no longer subject to it at all.

For medically frail expansion members who could plausibly clear the SSA standard, the recurring, procedurally undefined burden of the medically frail exclusion may now approach or exceed the burden of pursuing a one-time SSA disability determination — creating an incentive to apply for SSA disability status that did not meaningfully exist before the IFR. We refer to this dynamic throughout this paper as **eligibility category migration**: members shifting from expansion to ABD eligibility not because their underlying health status has changed, but because the relative burden of maintaining each status has changed. This is not a near-term operational alternative, however: SSA disability determinations typically take months to years to adjudicate, and federal workforce reductions have lengthened this further[7]. The practical relevance of eligibility category migration is a longer-horizon eligibility dynamic, not a substitute for near-term medically frail verification.

TERMINOLOGY NOTE

Throughout this paper, we use 'exclusion' and 'exception' precisely as defined by the IFR. Medically frail, pregnancy, caretaker status, etc. are exclusions (durable, annually reverified). Mandatory exceptions (under the age of 19, entitled or enrolled under Medicare Part A and/or Part B) and optional short-term hardships (inpatient/nursing facility care, states of emergency, high unemployment, and medical travel) are exceptions (temporary, reverified monthly). The distinction matters operationally and actuarially.

Implementation Timeline

The IFR phases in requirements and verification standards across three milestones:

- **January 1, 2027:** Initial requirement effective. States may allow self-declaration of medically frail exclusion status in lieu of documentation.
- **January 1, 2028:** Full documentation required. Provider attestations or equivalent verification must support medically frail exclusions.
- **December 31, 2028:** Good-faith compliance extension period ends.

Additionally, starting for redeterminations scheduled on or after January 1, 2027, states are required to redetermine Medicaid eligibility (and community engagement verification) every six months rather than annually. States can elect a minimum of one month, but up to three months for their lookback period to establish that community engagement requirements are met. States have two options to shift to a six-month redetermination timeline:

- Reschedule early - members must have at least six months of coverage
- Roll forward – wait until their first annual renewal date post January 1, 2027 effective date.

Given the flexibility and phased in implementation, this will produce significant state-by-state variation in how enrollment impacts materialize. National enrollment and impact data will be unreliable; state-specific modeling is essential.

Coverage Gaps

Lookback period mechanics create coverage gaps. A member hospitalized in the month of application may be evaluated against the prior month's compliance record — and denied if that prior month shows neither hospitalization nor qualifying activity. Plans and states should model the coverage gap patterns these lookback windows produce.

Section 1: Managed Care Organization (MCO) Impacts

MCOs face a uniquely compounded set of risks: simultaneous revenue exposure, acuity shifts, operational burden, and actuarial uncertainty — all on a compressed timeline. Understanding and quantifying these risks early is critical to rate adequacy advocacy, contract positioning, and operational planning.

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Revenue Loss and Enrollment Volatility	Immediate premium reduction as members disenroll; claim cost offsets may not completely offset if there are shifts in acuity; may take time to right size economies of scale and fixed admin	Quantify premium-at-risk and fixed admin by member segment before the notice wave
Acuity Shifts	**Acuity Increases**: Narrower medically frail exclusion concentrates sicker members remaining; member churn can increase acuity due to missed preventive care and pent-up demand; additional utilization if additional provider documentation is required to verify medical frailty **Acuity Decreases:** acuity increases could be partially offset by members that are well enough to work remaining enrolled, and, over a longer horizon, by eligibility category migration to ABD among the highest-acuity medically frail members	Model acuity shift scenarios with consideration to reasons a person is staying or leaving Medicaid eligibility, including eligibility category migration; advocate for risk corridors or mid-year rate adjustments
Operational Burden and Administrative Cost Exposure	New outreach, eligibility, and administrative functions — often unfunded in capitation rates	Engage states during comment period on MCO role definition and rate impact

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Actuarial Uncertainty and Modeling Challenges	Phased verification, state variation, and enrollment churn create modeling instability, and eligibility category migration	Build scenario ranges; flag assumptions explicitly in rate filings

1.1 Revenue Loss and Enrollment Volatility

Revenue exposure begins the moment disenrollment occurs. When a member loses coverage for failing to meet community engagement requirements, capitation payments stop immediately. Unlike other revenue downturns, plans cannot offset this through near-term administrative cost reduction — new rules, new administrative processes, and technology investments all require simultaneous spending precisely when enrollment is declining.

The churn dynamic compounds the financial risk. Evidence from prior work requirement pilots and the Public Health Emergency (PHE) unwinding shows that members who lose coverage and later re-enroll return with higher acuity[14,15,16], driven by lack of access to prescription drugs, deferred preventive care, and pent-up demand.

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Enrollment declines also carry economies-of-scale implications for plan fixed and variable administrative costs. Administrative cost ratios rise as the denominator shrinks. Plans operating in states with high community engagement non-compliance rates should model administrative MLR pressure separately from benefit cost trends.

1.2 Risk Pool Acuity Shifts

There are a number of different drivers that will shift acuity either upwards or downwards. The magnitude of the acuity shifts likely differ depending on the reason someone is staying (exclusion/exception category or meeting community engagement requirements) or leaving (failure to produce verification, failing to meet community engagement requirements). Plans would be advised to model these acuity shifts under different scenarios.

Upward Acuity Drivers:

The narrower-than-expected medically frail exclusion has a direct actuarial consequence: sicker members with often high-cost conditions, but technically still able to work, who would have been

excluded under broader state definitions will instead be classified as applicable individuals. Some will comply and remain enrolled; others will disenroll. Those who remain enrolled likely skew higher acuity than the base period population.

Onerous and frequent verification requirements may lead to higher member churn in and out of Medicaid eligibility. Member churn disrupts access to care and continuity of care. This discontinuity of coverage and care can result in increased utilization due to missed preventive care (including lack of adherence to medication), and pent-up demand of services.

Additionally, since the medically frail exclusion requires a documented diagnosis (presumably captured in claims data) **and** additional documentation of impaired ability to meet community engagement requirements (possibly through provider documentation), additional utilization may occur to obtain the proper verification.

Downward Acuity Drivers:

There may be a partial offset: members healthy enough to sustain 80 hours per month of qualifying activity will remain enrolled and tend to be lower cost. However, this offset is unlikely to completely neutralize the acuity shift from the medically frail concentration effect and churn-driven re-enrollment patterns.

Plans should also note that the functional limitation standard — the requirement that a condition significantly impair the member's ability to comply — creates verification complexity that will produce inconsistent outcomes across similar clinical profiles. Members with conditions like cancer may meet the impairment standard during active chemotherapy but not in remission, creating month-to-month fluctuation in exclusion status that may not be reflected in the narrow lookback period.

A second, longer-horizon factor may partially mute the upward acuity concentration described above. **Eligibility category migration** — members shifting from expansion to ABD eligibility via SSA disability determination once the relative burden of that determination approaches or falls below the burden of maintaining the medically frail exclusion[17,7] — shifts some of the highest-acuity medically frail members out of the expansion pool entirely.

This is not a net reduction in acuity across the Medicaid population — these individuals remain Medicaid-eligible and, by definition, retain the same underlying health needs. Rather, it is a redistribution of acuity between eligibility categories: the expansion population loses some of its highest-acuity members to ABD, which would tend to mute (though not reverse) the concentration effect described above, while the impact on ABD risk pools is likely more muted still, since ABD populations already skew toward chronic, high-acuity profiles. Plans and states modeling

expansion and ABD acuity should treat eligibility category migration as a cross-category dynamic rather than an independent net driver and should note that it moves on a longer timeline than the other drivers discussed here — SSA determinations typically take months to years[7] — making it better suited to multi-year modeling.

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CMS has published preliminary estimates of the share of members expected to fall into excluded and excepted categories[18]. These are useful benchmarks but should be validated against plan-specific claims and demographic data before being used in rate or reserve analyses. The functional limitation standard makes top-down population estimates unreliable at the plan level.

1.3 Operational Burden and Administrative Cost Exposure

The IFR creates a series of new operational functions for plans — some required by the rule, others which could be at least partially delegated from state to the plan by state contract amendments or practical necessity. Over half of Medicaid enrollees are currently unaware of the upcoming requirements[19], making member education an urgent priority for plans regardless of whether states formally mandate it.

Outreach and Education

While the IFR does not permit plans to determine eligibility, plans should anticipate being required to conduct member outreach under state contracts. The IFR specifies states conduct initial outreach beginning three months prior to implementation (plus the number of months a state requires members to demonstrate prior compliance), which means initial outreach could be required as early as June 30, 2026. Additionally, outreach is required at enrollment, periodic outreach tied to exception status changes or hardship exception expirations, and ad hoc outreach. Plans that build this infrastructure proactively are better positioned to reduce churn (possibly mitigating increased acuity) and demonstrate stewardship to their state partners.

An example of this is where CalOptima has committed $19.8M through December 31, 2028, to expand outreach efforts to help members understand how to maintain their health coverage in light of new community engagement requirements[20]. Plans should understand their own additional administrative costs and understand how (if at all) they will be considered by the state in rate development — will they be considered part of regular activities, added to the admin portion of the capitation rate, or considered value-added benefits?

Exclusion and Exception Determination Support

States must exhaust available data sources before requesting member-provided documentation — a sequencing requirement that stretches the verification timeline and creates opportunities for plans to add value by providing claims-based identification of likely-excluded members. Plans may be asked formally through contract amendments to support this function. If so, plans should advocate for the additional administrative cost to be quantified, reported, and reflected in capitation rates.

The distinction between exclusions (annual reverification) and exceptions (monthly) also has operational implications for care management prioritization. Exclusion determinations, once made, reduce ongoing touchpoint burden. Exception management is a recurring workflow. Therefore, exclusion determinations should be prioritized to maximize efficiency.

Retroactive Coverage and IBNR Risk

Where coverage is ultimately restored retroactively after a verification delay, plans may have provided services during a period that did not initially appear covered. This creates potential IBNR distortion: claims may be suppressed during eligibility uncertainty and released upon coverage confirmation. Plans should stress-test IBNR development patterns under a scenario where eligibility gaps are followed by retroactive reinstatements, and flag this explicitly in reserve reviews.

The 820/834 transaction[21] lag and reconciliation patterns will also be affected. Plans should align with their state Medicaid Management Information System (MMIS) counterparts on eligibility file timing and reconciliation workflows ahead of implementation.

1.4 Actuarial Uncertainty and Modeling Challenges

The IFR creates significant modeling complexity driven by phased implementation, state-level variation, and enrollment dynamics that historical base period data cannot reliably project.

State-level variation extends to how household versus individual income is calculated (CMS requires only a "reasonable method"), how gig and self-employed workers demonstrate compliance, whether optional hardship exceptions are adopted, and how aggressively states enforce the lookback window. Plans operating across multiple states face a patchwork of rules that require separate modeling assumptions in each market.

The PHE unwinding is the closest historical analog for extensive enrollment operational changes. That experience produced enrollment changes that were materially more convoluted and protracted than pre-implementation projections — and that surfaced cost increases on a lag.

Plans should assume similar dynamics: early enrollment drops, churn-driven re-enrollment, and a lagged cost spike as re-enrollees return at elevated acuity.

Eligibility category migration adds to this modeling difficulty. Because the incentive to pursue SSA disability determination is a product of the IFR's verification burden, base period claims and enrollment data will not directly reflect it. Its magnitude is not yet observable in implementation, and plans should revisit these assumptions as SSA processing outcomes become observable over the next several years.

1.5 Strategic Positioning and State Engagement

The comment period — open through July 31, 2026 — is the most direct lever available. Key areas where MCO engagement is actionable:

- **Medically frail code lists:** States must develop diagnosis code lists and plans have the claims-based data to support evidence-driven selection. Engaging early can shape definitions in ways that reduce inappropriate exclusions and downstream administrative friction.
- **Verification standards:** Provider attestation formats, data exhaust sequencing, and documentation sufficiency standards are still being defined. Plans positioned as operational partners — not just contractors — can help design workable processes.
- **Rate adequacy:** The administrative cost, acuity shift, and churn dynamics described above should be quantified and presented to states as part of rate development. Historical base period data could systematically understate forward-looking costs under this rule. Rate development should also account for eligibility category migration as a multi-year dynamic affecting the size and composition of the expansion capitation base itself.
- **Outreach funding:** If states require plans to conduct member outreach and education, this function should be reflected in capitation rates or funded through separate program mechanisms. Plans should document scope and cost before contract amendments are finalized.

Plans that treat this as a compliance exercise will be reactive. Plans that engage as data-driven partners — contributing population analytics, operational modeling, and implementation recommendations — will be better positioned on rates, contracts, and state relationships heading into 2027.

Section 2: Provider Organization Impacts

Providers sit at the intersection of every downstream consequence of the IFR. Disenrollment and coverage gaps mean uncompensated care, deferred care, and higher-acuity patients when coverage is restored. The Medicaid coverage cliff means patients who lose Medicaid cannot fall back on subsidized exchange coverage and end up in the emergency department uninsured. For safety-net hospitals and rural providers already operating on thin margins, the compound effect is existential financial pressure.

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Uncompensated Care	New community engagement requirements will likely lead to a rise in uninsured rates which lead to uncompensated care which threaten financial viability and can lead to service reductions or facility closures. This is further compounded by the coverage cliff where those not meeting the community engagement requirements are not eligible for marketplace subsidies.	Work with states and MCOs to provide beneficiary outreach and education to support compliance verification
Hospital Presumptive Eligibility (HPE)	HPE workflows must now incorporate the ability to assess community engagement status, including assessing exclusions and exceptions. This represents a new administrative burden.	Providers should assess HPE workflows now and work with states on what community engagement documentation will be required and how quickly eligibility determinations will be processed.
Medically Frail Documentation	The functional limitation standard likely requires provider attestation with different assessment criteria than current disability or medical necessity certifications.	Train providers on attestation process and understanding of IFR framework; Work with states and MCOs now to develop medically frail condition code lists

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Deferred Care and Increase Acuity for Risk-Bearing Providers	Medicaid churn could result in shifts to higher acuity in patient cohorts	Providers in risk-bearing arrangements should model acuity shift scenarios and consider risk corridors and other acuity adjustments when negotiating with plan partners.

2.1 Uncompensated Care and the Coverage Cliff

The most immediate and quantifiable risk for providers is uncompensated care. Members who lose Medicaid coverage for failing community engagement requirements do not disappear — they continue to seek care, often in more costly settings (emergency departments, urgent care) rather than primary care. The financial burden of that care falls on health and provider systems.

The Medicaid coverage cliff amplifies this dynamic significantly. Under current law, and clarified in the IFR[22], a person who loses Medicaid for non-compliance with community engagement requirements is still treated as Medicaid-eligible — and therefore ineligible for Marketplace premium subsidies under section 36 B of the Internal Revenue Code. They cannot fall back into subsidized exchange coverage. The result is a population that is uninsured with no ACA subsidy pathway available.

For safety-net hospitals and rural providers, this creates a cascading risk: rising uncompensated care strains operating budgets, threatens financial viability, and in the most acute cases could lead to service reductions or facility closures — further restricting access to care even for members who retain coverage.

> *The coverage cliff is one of the most consequential and underappreciated features of the IFR. A person who loses Medicaid for non-compliance with community engagement requirements is not merely uninsured — they are ineligible for the Marketplace subsidy that would otherwise be available to them. Providers will bear the direct cost of this structural gap.*

2.2 Hospital Presumptive Eligibility: New Administrative Complexity

Hospital Presumptive Eligibility (HPE) allows hospitals to temporarily enroll uninsured individuals in Medicaid at the point of care. Under the IFR, HPE workflows must now incorporate community engagement screening, a meaningful addition to the admissions and eligibility

determination process.

This creates two distinct burdens for providers. First, clinical and administrative staff must be trained to assess community engagement status — including whether a patient meets an exclusion, an exception, or is subject to the work reporting requirement — in a time-pressured environment. Second, for patients who do not meet the requirement, providers must determine the coverage pathway (if any), which in the post-IFR environment may lead to no coverage at all.

Providers should assess HPE workflows now, before implementation, and engage with their state Medicaid agencies on what community engagement screening documentation will be required and how quickly eligibility determinations will be processed.

2.3 Documentation Burden for Medically Frail Determinations

Provider attestations will likely be a primary mechanism for establishing medically frail exclusion status, particularly once the self-declaration period ends on January 1, 2028. Physicians and other treating providers will be asked to attest not only to a diagnosis but to the functional limitation standard: that the condition significantly impairs the patient's ability to comply with the community engagement requirement.

This is a more demanding attestation than a standard disability or medical necessity certification. The functional limitation standard is condition-specific, may fluctuate over time (e.g., cancer patients in active treatment versus remission), and will require providers to understand the IFR's framework well enough to complete attestations accurately. Incorrect or incomplete attestations may result in members being denied exclusion status they legitimately qualify for.

Training providers on the attestation process — and ensuring documentation templates are aligned with state requirements — is a near-term priority. Plans, states, and provider organizations should collaborate on standardized attestation tools before the verification phase begins.

PRACTICAL NOTE

States must develop their own diagnosis code lists for the medically frail exclusion. Providers should engage with their state Medicaid agencies and plan partners during the comment period to ensure the code lists adequately capture the patient populations they serve. Omissions in the code list will result in patients being misclassified as applicable individuals.

2.4 Deferred Care and Acuity at Re-Enrollment

When members lose coverage and later regain it, they return with deferred care needs. Incline has cited this dynamic in prior work: MACPAC's analysis of churn in Medicaid and CHIP found that coverage interruptions are common and are associated with disrupted access and higher downstream utilization[23]. Preventive services missed, chronic conditions unmanaged, and acute episodes treated in emergency settings rather than primary care all contribute to elevated acuity at re-enrollment.

For providers, this means a patient cohort that is more resource-intensive when coverage is restored. For value-based arrangements — risk-sharing models, capitated provider organizations, ACOs — this acuity spike creates financial exposure that should be explicitly modeled and reflected in contract terms.

Providers in value-based arrangements should assess their exposure to the re-enrollment acuity dynamic now, before implementation, and consider whether risk corridors, acuity adjustments, or re-enrollment exclusion windows are appropriate protections to negotiate with plan partners.

2.5 Strategic Priorities for Providers

- **Engage in the comment period:** Providers have the most direct evidence of which patient populations will be adversely affected by narrow medically frail definitions. State code list development should incorporate provider input, particularly for complex chronic disease, behavioral health, and developmental disability populations.
- **Update HPE workflows:** Assess current Hospital Presumptive Eligibility processes and determine what community engagement screening requirements will be added under the IFR. Train admissions and eligibility staff before January 2027.
- **Develop attestation infrastructure:** Build or adopt standardized medically frail attestation templates aligned to the IFR's functional limitation standard. Coordinate with plan partners and state agencies on format and documentation requirements.
- **Assess uncompensated care exposure:** Model the financial impact of projected coverage losses in your service area. Safety-net and rural providers should quantify this exposure for financial planning, payer contract negotiations, and advocacy purposes.
- **Review value-based contract terms:** For providers in risk-sharing or capitated arrangements, assess whether current contract terms adequately protect against the acuity spike from community engagement-related churn.

Section 3: State Medicaid Agency Impacts

States bear the heaviest operational load under the IFR. They must develop diagnosis code lists, design verification hierarchies, update IT systems, conduct beneficiary outreach, train eligibility staff, and submit new data to CMS — all under compressed timelines and with budgets already under pressure from federal funding changes.

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Administrative Cost and Budget Pressure	Significant implementation and ongoing administration costs are expected. Any implementation and transition work done prior to release of the IFR will have to be reassessed.	States should estimate costs and budget appropriately. Partner with health plans and providers to not duplicate efforts.
Medically Frail Code Lists and Functional Limitation Verification Standards	IFR provided five medically frail categories, but no code lists. In addition to a beneficiary having a specified condition, they must demonstrate a functional limitation in their ability to meet community engagement requirements. The IFR did not specifically define a code list of conditions or a standard for verifying function limitations, but left it up to the states to determine	States should engage MCO partners, providers, and advocacy groups during the comment period to develop balanced code lists and verification standards.
IT System Updates and Eligibility Infrastructure	Substantial MMIS and eligibility system updates are required under tight timelines	States should work on implementation now, plan for delays, and build manual backup processes for early implementation period
Beneficiary Outreach	Initial beneficiary outreach required to begin as early as June 30, 2026 for some states.	States should consider coordinating with and contractually requiring MCOs to support outreach. States should consider if the support costs will be built into capitation rates.

RISK AREA	KEY EXPOSURE	STRATEGIC PRIORITY
Verification Hierarchy and Sequencing Complexity	Exclusion determination (probably the most data intensive verification) must happen before community engagement compliance is verified (probably the least data intensive verification). Additionally, states must exhaust available data sources before requesting member documentation.	Workflows should be evaluated to meet compliance while also minimizing redundancy.
Data Reporting to CMS	IFR requires new data reporting on information and outcomes regarding enrollment, renewal, determination, and compliance, among other things.	States should treat this reporting infrastructure as a design requirement, not an afterthought.

3.1 Administrative Cost and Budget Pressure

GAO analyses of states that implemented community engagement requirements via 1115 waivers found a wide range of administrative costs — less than $10 million in New Hampshire, over $250 million in Kentucky[24]. Those figures are likely understated for the IFR context, because they predate the requirement to verify functional limitation (not just diagnosis) for the medically frail exclusion. That standard requires a more individualized, documentation-intensive process than prior implementations.

The administrative burden lands at a particularly difficult moment. Federal budget pressures are already squeezing state Medicaid allocations, and the costs of community engagement implementation — IT system updates, hiring additional eligibility staff, revised training, updated beneficiary outreach, revised vendor contracts — are largely non-deferrable. States that underestimate these costs risk implementation failures that compound compliance exposure.

Additionally, the IFR guidance diverges significantly from anticipated rules based on preliminary CMS guidance, so any transition and implementation work that has already been done will need to be reassessed for compliance with the latest IFR guidance.

In a recent KFF survey[25], some states indicated that they plan to use AI tools to help with community engagement implementation. Use of AI ranged from analyzing claims data to conducting beneficiary outreach and upload of verification documents and data. This could help with workloads, but AI does not come without costs.

HISTORICAL REFERENCE

GAO found that New Hampshire spent under $10 million implementing community engagement requirements via 1115 waiver. Kentucky spent over $250 million. Both figures predate the functional limitation standard established by the IFR. States should budget conservatively and pursue federal administrative match funding where available.

3.2 Developing Medically Frail Code Lists and Verification Standards

States must develop diagnosis code lists for each of the five medically frail categories and establish documentation standards for how functional limitation will be verified once the self-declaration period ends. This is arguably the highest-stakes implementation decision states will make: code lists that are too narrow will generate inappropriate coverage losses and provider attestation disputes, creating additional uncompensated care and administration costs; lists that are too broad risk CMS challenge.

CMS has not provided an exhaustive list of qualifying conditions — only the five condition categories. States operate within those boundaries but have discretion over code-level specificity. Provider attestation standards — what documentation is sufficient, what forms are acceptable, how frequently reverification is required — must also be developed from scratch.

States should engage MCO partners, provider organizations, and advocacy groups during the comment period to build code lists that are clinically defensible and operationally workable. The comment period closes July 31, 2026. Decisions made now will shape implementation for years.

3.3 IT System Updates and Eligibility Infrastructure

The IFR requires substantial MMIS and eligibility system updates. States must implement the verification hierarchy (exclusion check before compliance check), track community engagement status separately from standard eligibility, generate and process new 834/820 transaction types[21] reflecting community engagement-related enrollment events, and build data submission infrastructure for the new CMS reporting requirements.

IT implementation timelines are notoriously difficult to manage under regulatory pressure. Vendor promises should be scrutinized; states should plan for delays and build manual backup processes for the early implementation period. The parallel ramp in eligibility staffing — new hires, revised training curricula, updated procedures — compounds the implementation complexity.

3.4 Beneficiary Outreach

CMS requires initial beneficiary outreach to begin as early as June 30, 2026[26] — before the IFR's own comment period has closed. This is an extraordinarily compressed timeline. Over half of current Medicaid enrollees are unaware of the upcoming requirements, which means outreach is not a supplementary function; it is a core implementation dependency.

States must conduct outreach across multiple channels and populations: at enrollment, periodically throughout coverage, when exception status changes, and upon loss of exclusion status.

States can and likely will require managed care plans to share this burden contractually. Depending on the level and nature of required support from plans, states should consider if additional costs will be considered part of regular activities, built into the admin portion of the capitation rates, or considered value-added benefits.

Several states are exploring AI-based tools to support outreach and eligibility screening. Arkansas, Missouri, and Oklahoma are exploring AI tools that interact directly with members to support document identification and upload[25]. These approaches hold promise for scale, but implementation risk should not be underestimated — and equity implications of AI-mediated eligibility processes deserve scrutiny.

3.5 The Verification Hierarchy and Sequencing Complexity

The IFR establishes a specific verification hierarchy that creates operational tension: states must evaluate exclusion status before checking compliance. Exclusion determination — particularly medically frail — is a very documentation-intensive part of the process, but it must happen first, because excluded members cannot be assessed for compliance.

The practical implication is that states cannot default to what might be the simplest verification path (e.g., confirm employment income via safe harbor) without first ruling out exclusion. For members who are clearly employed and meeting the 80-hour standard, this sequencing may add administrative overhead with no meaningful policy benefit. States should design their workflows to minimize redundant steps while respecting the required hierarchy.

States must also exhaust available data sources before requesting member documentation — a requirement that stretches timelines but protects members from unnecessary documentation burdens. Retroactive coverage restoration after delayed verification creates the IBNR and reconciliation issues described in the MCO section. State IT systems and plan payment systems

must be coordinated to handle retroactive eligibility accurately.

3.6 Data Reporting to CMS

The IFR establishes new data reporting requirements for states, including total Medicaid enrollment, application and renewal processing information, determination outcomes, the number of individuals subject to work reporting, compliance rates, and any additional data CMS specifies. CMS has not indicated whether this data will be released publicly.

States should treat this reporting infrastructure as a design requirement, not an afterthought. Data quality issues in community engagement reporting will create compliance exposure and may trigger federal oversight. Building the reporting architecture in parallel with the IT system updates — rather than as a Phase 2 deliverable — is the lower-risk path.

3.7 Strategic Priorities for States

- **Prioritize the comment period:** The July 31 deadline is not ceremonial; it is also the date the IFR goes into effect. States that submit substantive comments on medically frail definitions, verification standards, and operational timelines are more engaged in the process and could influence more implementation flexibility from CMS. Comments should be technically grounded and operationally specific.
- **Build diagnosis code lists with stakeholder input:** Engage MCO partners, provider organizations, and advocacy groups now. Code lists built in isolation are more likely to be clinically incomplete and more likely to generate disputes.
- **Sequence IT investments carefully:** MMIS updates, eligibility system changes, and reporting infrastructure should be planned as an integrated program, not independent workstreams. Identify the critical path dependency and protect it.
- **Engage MCO partners on outreach contracting:** States that require plans to conduct member outreach should formalize the scope, timeline, and funding mechanism in contract amendments before January 2027. Significant ad hoc outreach requirements without corresponding rate adjustments will create friction.
- **Model the fiscal impact now:** Administrative cost, enrollment loss, and uncompensated care shift should be modeled before implementation begins — not after the first enrollment reports come in. States that quantify expected impacts can make more informed decisions about code list design, hardship exception adoption, and lookback period length.

CONCLUSION

Acting Before the Window Closes

The Community Engagement IFR is not a distant policy development — it is an operational reality taking effect in seven months, with comment period obligations due in six weeks from IFR release. The stakeholders best positioned to navigate this environment are those who engage now: during the comment period, in state code list development conversations, in rate adequacy analysis, and in outreach and eligibility infrastructure build-out.

Three priorities cut across all stakeholder groups:

- **Engage the comment period substantively.** The July 31 deadline is the last formal opportunity to influence implementation parameters. Technical, operationally grounded comments — particularly on medically frail code lists and verification standards — are the highest-leverage input available.
- **Model financial impact with explicit assumptions.** The PHE unwinding demonstrated that enrollment and cost dynamics under complex eligibility changes are more protracted and convoluted than early projections suggest. Build scenario ranges, state explicit assumptions, and revisit them quarterly as implementation unfolds.
- **Coordinate across stakeholder lines.** The coverage cliff, churn dynamics, uncompensated care burden, and provider attestation infrastructure are all cross-stakeholder problems. Plans, providers, and states that coordinate early will design better processes than those that build in isolation.

WORK WITH INCLINE

Incline Actuarial Group works with state Medicaid agencies, managed care organizations, and risk-bearing providers on rate-setting, budget neutrality, and policy implementation. We are actively supporting clients on IFR planning and can assist with financial modeling, comment period analysis, and actuarial impact assessment.

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This paper was prepared by Incline Actuarial Group. All views represent the professional judgment of Incline's actuarial team based on analysis of the IFR and related source materials as of July 28, 2026.

This does not constitute legal advice. For questions, contact Incline Actuarial Group.

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