Medicaid Community Engagement Requirements

Challenges Facing Providers, States

July 31, 2026

1. The medically frail exclusion is narrower and more difficult to establish than many stakeholders expected.

A medical diagnosis alone is insufficient. An individual must have a qualifying condition and demonstrate that the condition significantly impairs the ability to satisfy the community-engagement requirement. This creates a much higher evidentiary standard than simply showing the presence of a serious or chronic condition.

2. CMS has left states to make some of the most consequential eligibility decisions.

CMS did not provide a definitive list of diagnoses qualifying someone as medically frail or a uniform standard for measuring functional impairment. States must create diagnosis-code lists, documentation requirements, attestation forms, and verification standards. Lists that are too narrow could produce inappropriate coverage losses; lists that are too broad could face CMS objections.

3. The verification structure may itself generate coverage losses and gaps in care.

States must first determine whether an individual qualifies for a durable exclusion before evaluating compliance with the work requirement. Lookback periods, data-matching failures, delayed verification, and requests for additional documentation could produce temporary denials, retroactive reinstatements, payment reconciliation problems, and gaps in treatment.

4. Managed-care organizations face simultaneous revenue losses, higher administrative expenses, and uncertain changes in enrollee acuity.

Capitation payments stop when members disenroll, but plans cannot immediately eliminate fixed costs. Plans may also be expected to conduct outreach, educate members, exchange eligibility data, and help beneficiaries document compliance. Members who later reenroll may return with greater medical needs because of missed medications, delayed preventive care, and untreated conditions.

5. Some medically frail expansion enrollees may migrate into the Aged, Blind, and Disabled Medicaid category.

The report describes a potential long-term phenomenon of "eligibility category migration." Individuals who might otherwise remain in the expansion population may pursue formal disability determinations because maintaining a medically frail exclusion requires recurring documentation. This could shift high-acuity beneficiaries between Medicaid categories without reducing their health needs or overall program costs.

6. Hospitals and other providers may bear substantial financial consequences through increased uncompensated care.

Individuals terminated from Medicaid for noncompliance may be unable to receive subsidized Marketplace coverage, creating a coverage cliff. Safety-net hospitals, rural hospitals, community health centers, and other providers could see increased emergency-department use, more uncompensated care, and worsening financial pressure.

7. Providers will assume new eligibility and medical-documentation responsibilities.

Physicians and other clinicians may be asked to attest not only that a patient has a diagnosis, but also that the condition functionally prevents the patient from meeting the requirement. Hospitals

will also need to modify presumptive-eligibility procedures. The report recommends standardized forms, provider education, and close coordination among states, health plans, and providers.

8. States carry the heaviest implementation burden and must begin preparing immediately.

States must modify eligibility systems, update Medicaid Management Information Systems, hire and train staff, establish medically frail criteria, conduct beneficiary outreach, process new enrollment transactions, and meet extensive reporting requirements. Previous state work-requirement initiatives reportedly cost from less than $10 million to more than $250 million, and the new federal requirements could be even more expensive.

9. The rule could cause substantial Medicaid coverage losses, many resulting from administrative barriers rather than failure to work.

The report cites estimates that approximately 5.7 million people could lose Medicaid coverage by 2034, with about 5.3 million becoming uninsured. A significant portion of these losses may result from documentation, verification, and reporting burdens rather than a failure to participate in qualifying activities.

10. Most affected individuals must document at least 80 hours of qualifying activity each month.

Applicable expansion adults generally must demonstrate at least 80 hours per month of employment, education, job training, or community service. Monthly income of at least $580 may serve as an alternative safe harbor.

Bottom Line

The report's most important insight is that the community-engagement requirement is not merely a work requirement. It creates a complex eligibility, documentation, financing, and operational system that could shift costs and responsibilities throughout the Medicaid program. States, managed-care plans, hospitals, physicians, and beneficiaries could all be affected by inconsistent medical-frailty standards, data failures, coverage disruptions, administrative expenses, and increased uncompensated care.