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Understanding Medicaid Community Engagement Requirements and New Section 1115 Guidance

July 15, 2026

Summer Webinar Series

Coming Up August 12:
How New Program Integrity Expectations Affect Medicaid Payments

Previous recording available on healthmanagement.com/insights

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A Changing Healthcare Landscape

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Federal legal and regulatory changes are driving seismic changes across healthcare, with significant implications for Medicaid

The combination of statutory changes enacted through OBBBA and subsequent federal guidance is reshaping Medicaid financing, eligibility, oversight, and waiver policy, creating simultaneous strategic, operational, and financial implications across the healthcare system.

KEY DRIVERS OF CHANGE

Eligibility & Coverage

- Community engagement
- Redeterminations and retention
- Eligibility operations

Medicaid Financing & Reimbursement

- State directed payments
- Provider financing
- Managed care payment policy

Program Integrity & Oversight

- Fraud, waste, and abuse requirements
- Compliance and reporting expectations
- Federal oversight

Waiver Policy & Innovation

- Section 1115 guidance
- Budget neutrality expectations
- Demonstration strategy

TODAY'S FOCUS

Medicaid Community Engagement and 1115 waivers

Community engagement requirements and new Section 1115 guidance are only part of a broader federal policy agenda, but both require near-term decisions regarding eligibility, beneficiary outreach, waiver strategy, financing, and operational readiness.

Community Engagement Requirements

- New federal eligibility requirements effective January 2027
- New compliance, verification, exemption, and outreach obligations
- Significant policy, operational, and technology decisions

1115 Waiver & Budget Neutrality Guidance

- New CMS expectations regarding waiver design and financing
- Potential implications for future waiver approvals and renewals
- Strategic considerations for long-term Medicaid financing

Changes to Medicaid for ACA Expansion Adults

Community Engagement Requirements

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Community engagement requirements will reshape Medicaid eligibility

The 2025 federal budget (Public Law 119-21[1]) establishes Medicaid Community Engagement (CE) requirements for ACA expansion adults, creating new compliance, operational, and retention challenges.

KEY FEATURES

- States must implement community engagement requirements by January 1, 2027.
- Affected adults generally must demonstrate 80 hours per month of work, education, community service, or other qualifying activities.
- The requirements primarily apply to ACA expansion adults ages 19–64 who are not entitled to Medicare.
- Numerous exclusions and exceptions apply, including for pregnant individuals, caregivers, people with disabilities or medical frailty, and certain other populations.

[1] Public Law 119-21 (the One Big Beautiful Bill Act [OBBBA], now referred to by CMS as the Working Families Tax Cut [WFTC] Act).

Community engagement requirements include multiple compliance pathways and protections

The statute and implementing rule establish the populations subject to community engagement requirements, the activities that satisfy those requirements, and the exclusions, exceptions, and hardship protections that may apply.

Multiple pathways satisfy community engagement requirements

- **80-hour monthly standard:** Applicable individuals generally must demonstrate 80 hours of qualifying activity each month.
- **Multiple qualifying activities:** Qualifying activities include employment, community service, approved work programs, and half-time educational enrollment.
- **Flexible compliance pathways:** Individuals may combine multiple activities to meet monthly requirements.
- **Income-based alternative:** Monthly earnings equal to at least 80 hours at the federal minimum wage satisfy the requirement.

Requirements apply primarily to ACA expansion adults

- **Applicable population:** Applies primarily to ACA expansion adults ages 19–64 who are not pregnant or enrolled in Medicare.
- **Additional populations:** Certain Section 1115 demonstration populations are also subject to the requirements.
- **Non-expansion states** generally are affected only through qualifying Section 1115 programs.
- **Timeline:** Implementation is required by January 1, 2027.

The law establishes broad exclusions, exceptions, and hardship protections

- **Excluded populations** include certain caregivers, American Indians and Alaska Natives, former foster youth, pregnant and postpartum individuals, and certain veterans.
- **Medical frailty exclusion:** Individuals who are medically frail or have significant physical, behavioral health, developmental, or functional limitations may qualify for exclusions.
- **Deemed compliant populations:** Certain individuals meeting SNAP or TANF work requirements may be deemed compliant.
- **Optional hardship exceptions:** States may offer hardship exceptions subject to CMS requirements.

Enrollment impacts could be substantial

“Medicaid expansion enrollment could decline by 27% to 55% among adults subject to work requirements, depending on implementation and mitigation strategies.”

- Urban Institute, Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements, March 2026.

The law establishes CE implementation framework, but states retain substantial operational discretion

Federal law establishes baseline requirements, but CMS guidance and state implementation choices will shape how community engagement operates in practice.

Federal Requirements	State Policy Decisions	Operational Implications	Systems and Data Implications
Applicable population	Number of look back months and frequency of compliance review	Documentation/ verification requirements (incl. provider documentation)	Application logic, workflow rules
Exempt populations	Short-term hardship exceptions	Application processing complexity (automated vs. manual review)	Case routing and document management
Qualifying activities	Medically frail criteria	Staffing and workload	Data matching and automation
6-month compliance review	Verification methodology	Call center demand	Notice generation and member portals
Required notices and appeals	Outreach and engagement strategy	Training	Reporting
		Appeals	

States must establish look-back and verification frequency policies within federal parameters

Federal law requires both look-back periods and ongoing compliance verification, but states must decide how many months of prior compliance beneficiaries must demonstrate (1, 2, or 3 months) and whether compliance will be assessed more frequently than the required six-month renewal cycle.

Policy Choice	Potential Advantages	Potential Tradeoffs
Shorter look back period (e.g., 1 month)	Simpler documentation; faster decisions; less documentation	Less historical verification
Longer look back period (e.g., 3 month)	Greater confidence in sustained compliance	More documentation, processing time, and administrative burden
Six-month verification	Lower administrative workload	Less frequent monitoring
More frequent verification	Earlier identification of noncompliance	Increased demand for staff, notices, and systems activity; increased enrollment churn

States may opt to adopt short-term hardship exceptions

Federal law allows states to offer short-term hardship exceptions, but states must decide whether to adopt the policy; if adopted, all four federally-defined hardship categories must be available.

- **Hardship Exceptions:** (1) Receives **inpatient** services (e.g. hospital, nursing facility, intermediate care facility) for intellectual disabilities, inpatient psychiatric hospital services, or similar; (2) Lives in county with **emergency/disaster declaration**; (3) Lives in county with **unemployment rate** at/above 8% or 1.5 times the national unemployment rate; (4) **Must travel** (or dependent must travel) outside the community for extended period of time to receive necessary medical services for serious/complex medical condition not available in their community

State Medicaid Agencies

- Adopt hardship exception policies
- Review and approve requests
- Verify supporting documentation
- Notify affected beneficiaries
- Track and monitor approved exceptions

Medicaid Health Plans

- Identify members who may qualify for exceptions
- Educate members about available hardship protections
- Assist members with exception requests
- Track affected members and outreach activities

Providers

- Identify patients who may qualify for exceptions
- Document qualifying medical circumstances
- Submit supporting clinical information
- Respond to state verification requests

States must establish community engagement verification policies

Federal rules require states to maintain a verification strategy, but states must determine how compliance will be verified, which data sources will be used, and how to balance administrative burden with program integrity.

State Medicaid Agencies

- Implement data interfaces with other state and federal data sources
- Revise notices
- Train eligibility staff
- Monitor revised timely processing standards for affected populations

Medicaid Health Plans

- Increased spending on outreach, call centers, and coordination with community partners
- Support members with compliance tracking, reporting, and systems integration

Providers

- Provide documentation of inpatient services, medical acuity for exemption criteria
- Support patients with application and renewal processes where possible

States must establish self-attestation policies

Federal rules permit broader use of self-attestation during initial implementation, but states must determine when self-attestation may be used to document compliance or exemptions and prepare for more limited use beginning in 2028.

State Medicaid Agencies

- Train eligibility workers to process self-attestations, including any changes between 2027 and 2028
- Outreach and notices to reflect self-attestation policy
- Develop a self-attestation form and distribute

Medicaid Health Plans

- Leverage reporting to identify members with conditions that could qualify for exception and conduct outreach
- Reach out and educate member on potential exception and how to request

Providers

- Identify patients with conditions that could qualify for exception at point of service
- Educate patient on potential exception and how to request
- Complete provider forms for medically-related exceptions, if available

States must establish medical frailty determination policies

Federal law exempts medically frail individuals, but states must define how functional limitations and special medical needs affect an individual's ability to comply with community engagement requirements and how eligibility for the exemption will be documented and verified.

State Medicaid Agencies

- Medically frail are "Specified Excluded Individuals" from Community Engagement requirement.
- Interpret and apply the federal medical frailty definition and categories.
- Consider functional impairment and ability to comply with work requirements.

Medicaid Health Plans

- Medical frailty determination requires both qualifying condition and functional impairment.
- Claims-based identification alone may not capture eligibility for exclusion.
- Health plans can support identification of potentially medically frail members.

Providers

- Individual must meet one of five federally defined medical frailty categories.
- Diagnosis alone does not qualify an individual as medically frail.
- Condition must significantly impair ability to meet community engagement requirements.

Medical frailty exemptions will require significant operational readiness

Implementing medical frailty exemptions will require new data sources, documentation standards, verification processes, systems capabilities, and oversight functions across Medicaid eligibility operations.

State Medicaid Agencies

- Develop and maintain auditable diagnosis-based identification methodologies.
- Establish verification and exception processes.
- Modify systems, contracts, staffing, and workflows to assess functional impairment and support CMS oversight requirements.

Medicaid Health Plans

- Expand member identification methods beyond diagnosis codes alone.
- Support outreach and education regarding medical frailty exclusions.
- Coordinate documentation exchange among providers, members, and Medicaid agencies.

Providers

- Expect increased requests for provider attestations and supporting documentation.
- Clinical documentation should describe functional limitations, not just diagnosis.
- Timely provider response may be critical to preventing beneficiary coverage loss.

Implementation requires coordinated action across agencies and community partners

Community engagement requirements create implementation responsibilities across multiple stakeholders, prompting some states to engage providers, community organizations, employers, and other partners through workgroups, town halls, and provider communications.

Partner	Potential Responsibilities
Department of Labor	Employment verification; Workforce programs; Referral partner
SNAP/TANF Agencies	Data sharing; Eligibility coordination
Managed Care Organizations	Beneficiary outreach and navigation assistance; Identify potentially exempt beneficiaries
Providers	Clinical documentation; exemption support/verification
Educational Institutions	Enrollment verification; Referral partner
Community-based organizations	Volunteer opportunities; Beneficiary outreach and navigation assistance
Employers	Employment verification; Workforce engagement

Beneficiary outreach strategies may help reduce unnecessary coverage loss

States must develop and execute beneficiary communication strategies, and many are leveraging multiple outreach channels and lessons learned from Medicaid unwinding to improve awareness, compliance, and retention.

Direct Beneficiary Outreach	Public Education and Awareness	Community-based Engagement	Leverage Medicaid Unwinding Lessons
› Notices and policy letters › Emails, texts, and phone outreach	› Informational videos › Social media and paid media campaigns › News releases	› Town halls and public events › Flyers, posters, and local office signage	› Multilingual communications › Text messaging campaigns › Call center support › Managed care outreach › Trusted community partners

Stakeholders can help beneficiaries understand and comply with requirements

Health plans, providers, community organizations, and other partners can support beneficiary education and navigation, but only the state Medicaid agency can make final compliance and exception determinations.

Determine whether the requirements apply

- Whether they are in the applicable population
- Whether they may qualify for an exemption

Understand key deadlines

- When renewal or compliance reviews occur
- When action is needed to maintain coverage

Document and report compliance

- What activities satisfy the requirement
- What documentation is accepted
- Where documentation can be obtained

Request exemptions when appropriate

- How to claim an exemption
- What information may be required to support a request

Health plans, providers, and community partners may support beneficiaries, but only state Medicaid agencies can determine compliance or exception eligibility.

States must align systems, operations, and reporting capabilities

Community engagement requirements will require states to update eligibility systems, workflows, data exchanges, member communications, and reporting processes, while preparing for additional CMS guidance on system demonstrations, outcomes, and performance metrics.

Eligibility Workflow Configuration	Data and Automation	Member Communications	Reporting and Oversight
› Application logic and eligibility rules › Compliance and exemption workflows › Case routing and task management	› Data matching and verification processes › Automated compliance determinations › Integration of new data sources	› Notice generation and tracking › Member portals and self-service tools › Communication preferences and outreach	› Compliance monitoring and reporting › Performance metrics and audit support › CMS-required outcomes and reporting

- Future CMS guidance is expected to address system demonstrations and reporting requirements for CMS-defined outcomes and performance metrics.

What States will need to successfully implement CE

States will need to clearly define and operationalize their role in CE compliance determinations while coordinating with key stakeholders to support beneficiary education, strengthen awareness of requirements, and reduce avoidable coverage disruptions during implementation.

Core Readiness Areas for State Medicaid Agencies

Domain	What States Need to Do
Systems Enhancements	**Upgrade eligibility and data systems** to incorporate CE reporting, automation of work hour calculations, and integration with wage or workforce data sources
Staffing and Training	**Increase capacity for case management and eligibility staff**, since many CE determinations (e.g., exemption reviews, appeals) will require manual processing and new skills
Cross-Sector Partnerships	**Collaborate with managed care plans, workforce agencies, and community organizations** to share data, coordinate outreach, and support beneficiaries in fulfilling CE requirements
Member Outreach and Communication	**Implement robust, multi-channel communication strategies** to reduce beneficiary confusion—leveraging lessons from PHE unwinding to educate enrollees about CE rules, deadlines, and how to report activities
Data and Reporting	**Track CE compliance, churn, exemptions, and reinstatements.** in order to monitor coverage continuity, identify drivers of disenrollment, and support timely interventions that minimize avoidable coverage loss and ensure program integrity

Health plans will play a key role in member engagement, education, and coverage retention

Although states are responsible for CE compliance determinations, plans will play a key role in educating and engaging members, supporting awareness of requirements, and helping reduce avoidable coverage disruptions as implementation rolls out across managed care markets.

Core Readiness Areas for Medicaid Health Plans

Domain	What Plans Need to Do
Identification of At-Risk Members	**Identify members subject to CE requirements**. Use clinical, utilization, and social data to flag individuals who may be eligible for exclusions (medically frail, caregivers) or hardship exceptions; stratify high-risk subgroups likely to experience churn or challenges reporting compliance with CE requirements
Member Engagement & Navigation Support	**Develop multichannel, culturally responsive outreach and education strategies** to explain CE requirements, deadlines, exemptions, and reporting processes; assist members in gathering required documentation
Clinical & Care Management Support	**Leverage care management programs** to identify members who may qualify for exceptions or face challenges meeting requirements and connect them with appropriate resources and support.
Data & Systems Alignment	**Build capabilities to track member CE status**, outreach triggers, exemptions, cure periods, reinstatements, and coverage transitions while supporting data exchange with state systems and vendors.
Provider & Community Partnerships	**Coordinate with providers, workforce boards and community colleges, employers, and community-based organizations** to support member engagement and documentation completion
Monitoring	**Monitor CE-related churn, call center volume, outreach effectiveness, reinstatement trends, and financial impacts**

Providers will play a key role in member engagement, education, and coverage retention

Although states are responsible for CE compliance determinations, providers will be a key source of information and support for beneficiaries subject to community engagement requirements. Supporting awareness of requirements and helping patients enroll in coverage quickly and efficiently will reduce the risk of coverage gaps.

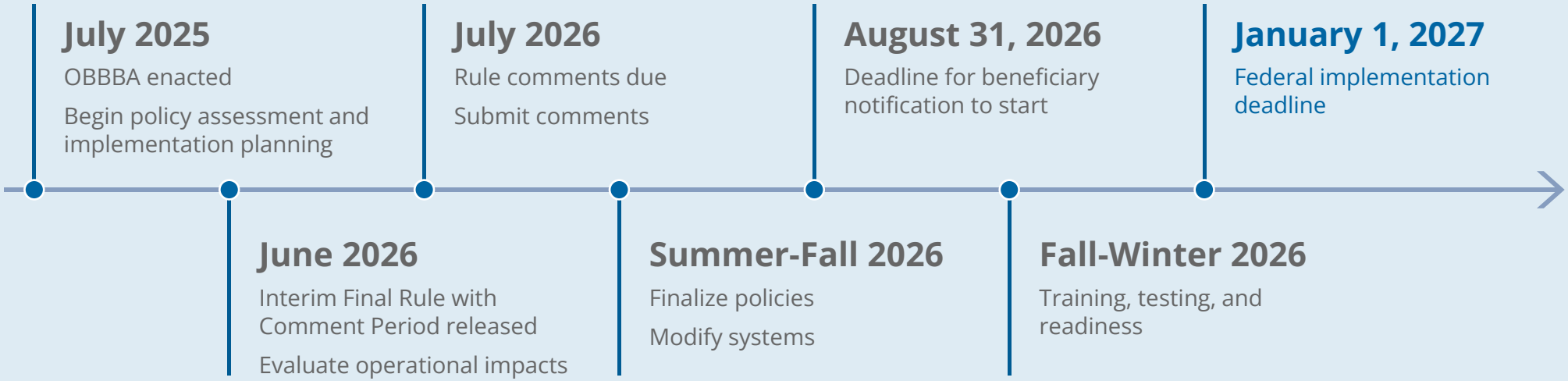
Core Readiness Areas for Medicaid Providers

Domain	What Providers Need to Do
Staffing and Training	**Increase capacity for financial assistance and social work staff** to support patients that need help navigating the new requirements—including applications, verification, and referrals to qualifying activities and supports.
Identification of At-Risk Members	**Identify members subject to CE requirements**. Use real-time patient visits to flag individuals who may be eligible for exclusions (medically frail) or hardship exceptions.
Member Engagement & Navigation Support	**Develop or leverage talking points from the State Medicaid agency or managed care plans** to explain CE requirements, deadlines, exemptions, and reporting processes; assist members in gathering required documentation
Community Partnerships and Referrals	**Leverage existing social worker and patient navigator expertise** to support member engagement and documentation completion. Also collaborate with health plans to align efforts and engagement strategies.
Monitoring	**Monitor patient support efforts and financial impacts.**

Implementation timelines are compressed as states plan amid ongoing uncertainty

States must continue advancing policy, operational, technology, and outreach activities despite a compressed implementation timeline, pending CMS guidance, and ongoing litigation.

- **Implementation activities are underway.** States are advancing policy, systems, operations, and outreach planning.
- **Additional guidance is expected.** CMS plans to issue future guidance on systems demonstrations, outcomes, metrics, and reporting expectations.
- **Litigation may affect implementation.** A coalition of states has challenged portions of CMS implementation guidance, including aspects of the medical frailty exemption framework, creating uncertainty as implementation activities continue.



Changes to Budget Neutrality for Section 1115 Medicaid Demonstration Projects

New Section 1115 Guidance

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SMDL 26-003 fundamentally changes how Section 1115 budget neutrality is evaluated

Beginning January 1, 2027, states must obtain CMS Chief Actuary certification and demonstrate prospective budget neutrality for new Section 1115 demonstrations, amendments, and renewals.

Topic	Change Description
Budget Neutrality Determination	CMS Chief Actuary certifies budget neutrality of a demonstration prior to approval and actuarial analysis of projected financial impacts of individual demonstration activities must occur.
Budget Neutrality Expenditure Limit	Demonstrations cannot be approved if they are expected to result in an increase in federal Medicaid expenditures and so the concept of an expenditure limit or budget neutrality cap is no longer applicable.
Expenditures in Absence of the Project	Medicaid Authorizable Populations and Services (MAPS) are defined as populations and services that the state could have otherwise covered, subject to guardrails.
Budget Neutrality Monitoring	CMS will employ new special terms and conditions related to expenditure monitoring and states must complete corrective action if expenditures substantially deviate from projections.
Demonstration Savings and Rollover into Subsequent Renewal Period	Current demonstration period savings plus limited rollover of previous demonstration period savings can be used to offset current demonstration period costs.

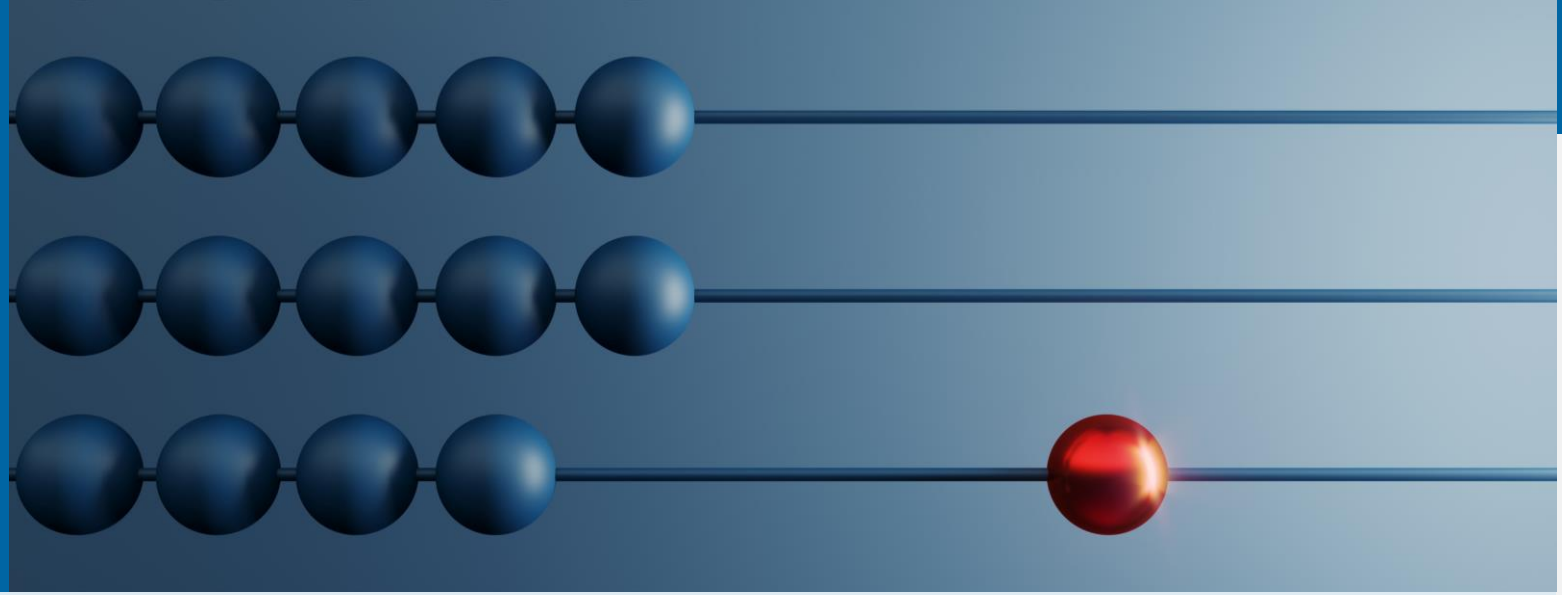
State Medicaid Director Letter (SMDL) #26-003 | Issued 6/11/26 | Effective 1/1/27

Implications for States and Stakeholders

States should begin preparing now for a more rigorous 1115 waiver environment that may affect demonstration design, financing strategies, analytical requirements, and approval timelines.

- **Analytic Capacity.** The budget neutrality framework is changing to become more detailed, strict, and subject to enhanced review—requiring states to have stronger data infrastructure and modeling capabilities earlier in the process.
- **Demonstration Design.** Certain benefits and services may be treated differently—meaning that states may need to narrow their focus, phase in initiatives, or identify offsetting savings within the demonstration.
- **Financing.** Savings will become more difficult to accumulate and carry forward , so states that have historically relied on demonstration savings as a key financing mechanism will need to engage in significant strategic and financial planning.
- **Different Authorities.** States and Medicaid-focused organizations should begin to identify alternative approaches, authorities, and partnerships to continue to advance policy goals.
- **Scenario Planning.** States and Medicaid-focused organizations can begin scenario planning and assessments now and monitor additional guidance and clarifications critical to operational issues.
- **Early and Longer Planning.** States should build additional time into future section 1115 demonstration planning.

Actuarial Implications



- **Prospective Approval versus Retrospective Review.** An actuary's role evolves from primarily estimating budget neutrality to helping establish confidence that budget neutrality will be achieved before a demonstration is approved.

- **More Robust Budget Neutrality Support.** The standard of evidence is increasing. The actuarial methods themselves may not fundamentally change, but the expectations for rigor, transparency, and prospective justification do.

- **Separate Treatment of MAPS and 1115 Expenditures.** MAPS will require federal budget impact calculation while each 1115 activity will require it show detailed financial analysis.

- **Greater CMS Involvement.** Rather than building a model and defending it later, the state and their actuary should expect more iterative discussions with CMS as methodologies and assumptions are developed.

Potential CMS actuarial review process for Section 1115 demonstrations

Although CMS has not yet described its review process, states may wish to prepare for an iterative actuarial review model with substantial upfront documentation, technical review, and revision cycles before approval.

Potential Actuarial Review Process (Illustrative)

Demonstration Design

State develops proposal and preliminary budget neutrality methodology.

Pre-submission Engagement

State, actuaries, and CMS discuss assumptions, data sources, and analytical approach.

Submission and Technical Review

State submits waiver, amendment, or renewal with detailed financial analysis.

CMS Office of the Actuary reviews assumptions, methods, and projected impacts.

Iterative Refinement

CMS requests additional information, documentation, or revised analyses.

State and actuaries respond and update models.

Certification and Approval

CMS Chief Actuary certifies prospective budget neutrality.

Demonstration proceeds through final CMS approval.

Questions?

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How HMA Can Help

For more than 40 years, HMA has helped Medicaid stakeholders navigate complex policy and operational change. Our team includes former Medicaid and CHIP directors, senior agency leaders, health plan executives, and policy specialists with experience across federal and state programs. **Ready to talk? Email: medicaid@healthmanagement.com**

Future Medicaid Related HMA Events:

August 12 Webinar: How New Program Integrity Expectations Affect Medicaid Payments

October 5-7 HMA Conference: US Healthcare 2026: Signals, Signs & Flashing Lights

Contact us.
We can help.

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