Policy Brief

Medicaid Community Engagement Requirements Interim Final Rule

On June 3, 2026, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule with comment period (CMS-2454-IFC) implementing the Medicaid community engagement requirement established by the 2025 Working Families Tax Cut (WFTC) legislation. The rule requires certain non-elderly, non-pregnant adults — referred to as "applicable individuals" — to demonstrate qualifying community engagement activities as a condition of Medicaid eligibility.

Unlike a standard proposed rule, this IFC takes effect without a prior notice-and-comment period. Comments are accepted through July 31, 2026, but the rule is already operative on that same date. States must implement no later than January 1, 2027.

The rule arrives against a layered regulatory backdrop. Section 71102 of the WFTC legislation imposed a moratorium — effective through September 30, 2034 — on the 2024 Eligibility and Enrollment final rule, which had updated Medicaid application, renewal, and redetermination processes. Because those suspended provisions underpin the community engagement verification framework, CMS is simultaneously restoring prior CFR language (pre-2024) for enrollment and renewal regulations, creating a dual-track regulatory environment that adds complexity for states and their technology partners.

Why This Rule Matters to Civitas Members

This rule creates a new federal verification infrastructure requirement touching the same data flows, eligibility systems, and community data assets that HIEs, HDUs, and RHICs operate and support every day. The rule's silence on interoperability standards, data exchange mechanisms, and the role of community data infrastructure is a gap — and an opportunity to ensure member organizations are recognized as essential partners in implementation.

What the Rule Requires

Community Engagement Requirement

Applicable individuals must demonstrate 80 hours per month of qualifying activities, which may include employment, participation in certain work programs, community service, or enrollment in an educational program at least half-time. Activities may be combined to reach the threshold. Alternatively, individuals may meet the requirement by earning at least 80 times the federal hourly minimum wage — $580 per month at the 2026 federal minimum — without regard to hours worked.

Who Is Subject to the Requirement

The community engagement requirement applies to non-pregnant adults ages 19 to 64 who are eligible for or enrolled in the Medicaid adult group or in certain section 1115 demonstrations

providing minimum essential coverage. Forty-three states and the District of Columbia cover this population and are therefore subject to the requirement. Territories are excluded.

A broad set of individuals are statutorily excluded, including former foster care youth, American Indians and Alaska Natives, parents and caretaker relatives of children age 13 and under or of disabled individuals, veterans with a total disability rating, individuals who are medically frail or have special medical needs that significantly impair compliance, those compliant with TANF or SNAP work requirements, participants in drug or alcohol rehabilitation programs, inmates of public institutions, and individuals who are pregnant or in a postpartum period.

States may elect to offer short-term hardship exceptions for individuals who are:

- Receiving inpatient hospital, nursing facility, or certain outpatient services
- Residing in a county with a declared federal emergency or disaster
- Residing in a county with an unemployment rate at or above 8% or 1.5 times the national average
- Traveling outside their community for extended medical care for a serious or complex condition

Verification Framework and Data Exchange Requirements

CMS requires states to conduct ex parte verification — drawing on available data sources before requesting information from individuals — at application, at renewal, and optionally at more frequent intervals between renewals. States must attempt to verify both community engagement compliance and exclusion status through available sources before placing the burden on applicants or enrollees. The Federal Data Services Hub is referenced as one conduit, but the rule does not enumerate or limit the external data sources states may use.

When a state cannot verify compliance through available data, it must issue a notice of noncompliance and provide the individual with 30 calendar days to demonstrate compliance or that the requirement does not apply. Failure to do so may result in application denial or disenrollment. Individuals who are disenrolled may reapply at any time and will be assessed at the point of reapplication. States may also delegate certain verification functions to managed care organizations (MCOs). The rule does not specify how MCOs must access external data sources to fulfill delegated verification responsibilities.

States must submit performance indicator and eligibility processing data to CMS to support ongoing monitoring and program integrity. States that fail to meet reporting requirements or demonstrate compliance issues may be subject to corrective action. States unable to meet the January 1, 2027 implementation deadline may apply for a good faith effort exemption, subject to criteria, quarterly reporting, and duration limits established by CMS.

Strategic Implications for Civitas and Members

1. **The verification gap is both an opportunity and a risk.** The rule's ex parte verification mandate requires states to draw on available data sources before burdening individuals, but does not define which sources qualify, what exchange mechanisms are acceptable, or what technical standards apply. Health data intermediaries – HIEs, HDUs, CIEs, etc – hold real-time clinical data directly relevant to the most consequential exclusion determinations —

medically frail status, pregnancy, postpartum eligibility, disability, and substance use treatment participation. These are exactly the determinations where incorrect outcomes carry the highest health consequence, and where incomplete data is most likely to result in wrongful disenrollment. Health data intermediaries in expansion states are already connected to the hospitals, clinics, behavioral health providers, and long-term care facilities whose patient data would document these exclusions. Without a defined role in the verification framework, states may default to less complete sources or to member self-attestation workflows that increase both administrative burden and disenrollment risk for medically vulnerable populations.

2. **The rule is silent on interoperability.** CMS has an active, explicit interoperability agenda — TEFCA, the CMS-0057-F interoperability rule, and the recently proposed CMS-0062-P prior authorization rule all emphasize FHIR-based, standards-driven data exchange. The absence of any interoperability standard or data exchange specification in this rule's verification framework is inconsistent with that posture. It also creates a real risk that states build point-to-point, non-standardized verification workflows that are difficult to audit, scale, or extend. Civitas members are the connective tissue between the clinical data states need and the eligibility systems they are required to operate, and the absence of standards guidance makes that role harder to fulfill systematically.

3. **Health data intermediaries, including APCDs, hold underutilized assets for income and employment verification.** The rule allows individuals to meet the community engagement requirement by demonstrating earnings of at least $580 per month, with income verified through IRS and SSA wage data sources. Health Data Intermediaries — including HIEs and HDUs — that maintain claims, encounter, and clinical data offer a complementary verification pathway, one that can corroborate employment-related coverage history, worker compensation status, and utilization patterns that may be consistent with active employment. State APCDs similarly hold longitudinal, post-adjudication claims data submitted by payers on a periodic basis, which can support retrospective corroboration of coverage transitions, employment status over time, and patterns of utilization consistent with disability or serious illness — though their value in this context is analytical and historical rather than real-time. Neither health data intermediaries nor APCDs are recognized in the rule as data sources for verification, which is a gap Civitas is well-positioned to raise with CMS.

4. **Managed care delegation creates data access problems.** When states delegate verification to MCOs, those MCOs need access to clinical data to make accurate determinations, particularly for medically frail and disability exclusions. The rule does not establish any mechanism by which MCOs would access HIE or HDU data to fulfill delegated verification functions. In states where MCO contracts cover large portions of the Medicaid adult population, this gap could result in either poor data quality in verification decisions or redundant, manual outreach to providers that health data exchange infrastructure could otherwise support electronically.

5. **RHICs are positioned to support rural communities disproportionately affected by this rule.** RHICs operating in rural and underserved geographies will see disproportionate

impact on the populations they serve. The optional state hardship exceptions — particularly those tied to high unemployment counties and emergency or disaster declarations — are most relevant in the rural communities where RHICs work. RHICs that hold community-level social determinants data or that coordinate between safety net providers and Medicaid agencies are positioned to support both hardship exception documentation and the state outreach requirements the rule establishes, which are notably underspecified in terms of modality, targeting, or community partnership expectations.

6. **The January 2027 timeline is aggressive and creates systemic risk.** States have approximately six months from rule publication to implement a requirement that touches eligibility systems, renewal workflows, MCO contracts, outreach infrastructure, and data reporting. This timeline is compounded by the regulatory complexity introduced by the simultaneous restoration of pre-2024 CFR provisions under the WFTC section 71102 moratorium. States must build community engagement verification on top of an eligibility framework that is itself in transition. States with existing HIE and HDU infrastructure are better positioned to demonstrate readiness; those without it face higher risk of errors at the eligibility determination level, with direct consequences for beneficiaries and care continuity. Health data intermediaries that surface coverage changes and enable provider notification when a patient is disenrolled serve a care continuity function the rule does not acknowledge but that is directly relevant to the populations most affected.

Next Steps

Civitas is monitoring this rule and tracking how CMS and states address the data infrastructure and interoperability gaps identified in this brief, including any sub-regulatory guidance, State Health Official letters, or informational bulletins that follow. Civitas will also coordinate with federal advocacy partners on data source recognition and verification standards, downstream provider impacts, and the role of community data infrastructure.

Members with operational experience relevant to this rule are encouraged to share that perspective with Civitas. Particularly useful would be experience with:

- State HIE or HDU data source agreements that support Medicaid eligibility or enrollment functions
- Clinical documentation workflows for medically frail, disability, or pregnancy exclusion determinations
- MCO data access challenges when seeking clinical data for coverage or care management decisions
- APCD or claims data use in eligibility or income verification contexts
- Rural outreach or hardship documentation workflows in counties with high unemployment or declared emergencies

Member input will inform how Civitas engages on this rule as implementation guidance develops. Please send feedback or questions to Karen Ostrowski.