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ISSUE BRIEF

Medicaid Community Engagement Interim Final Rule

Operational Readiness for States, Plans, and Partners

June 2026

INTRODUCTION

On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an Interim Final Rule with Comment Period (IFC) on implementing the Medicaid community engagement requirements enacted in Public Law 119-21, which CMS now refers to as the Working Families Tax Cut (WFTC) Act. CMS estimates that 43 states and the District of Columbia will be subject to the new requirements. The rule establishes federal standards for compliance, exemptions, verification, enrollee notifications, and reporting, with most states being required to implement the mandates by January 1, 2027. This timeline leaves states with a relatively short period to translate federal policy requirements into operational processes and systems.

The IFC largely tracks the statutory requirements, but it also provides important new operational direction that will shape state implementation efforts. The rule includes specific requirements related to medical frailty determinations, caregiver exemptions, hardship reviews, enrollee notices, and reporting, creating new administrative responsibilities that extend beyond traditional eligibility processes. At the same time, CMS allows states to leverage existing income and eligibility data, including Modified Adjusted Gross Income (MAGI)-based methodologies, which may mitigate the need to build entirely new compliance determination systems.

Taken together, the rule suggests that implementation challenges will stem less from policy interpretation and more from operational execution. States may be able to build on their existing eligibility infrastructure but will need to rapidly develop verification workflows, exemption review processes, notice procedures, and oversight mechanisms to meet federal requirements.

Importantly, community engagement requirements represent just one of several concurrent policy and operational changes affecting Medicaid programs. Implementation will require coordination not only across Medicaid agencies and managed care partners, but also with workforce agencies, social services programs, community-based organizations, and other governmental and interest-holder entities that states may have historically omitted from Medicaid eligibility and compliance processes. Building these partnerships—and aligning data, processes, and communication strategies across them—will be a critical and time-sensitive component of successful implementation.

Given the compressed timeline and the breadth of operational change required, states and stakeholders are expected to make immediate decisions that will shape both compliance outcomes and enrollee impacts. Health Management Associates, Inc. (HMA), is supporting Medicaid agencies, health plans, and stakeholder organizations to address urgent needs, including rapid policy and operational analysis, implementation planning, interagency coordination strategies, stakeholder engagement approaches, and development of federal comments on key areas of ambiguity.

Comments on the rule are due by July 31, 2026, creating a near-term opportunity for states and stakeholders to inform final policy decisions while simultaneously preparing for implementation.

OVERVIEW

The new requirements apply primarily to adults in the Affordable Care Act (ACA) Medicaid expansion group—low-income adults who qualify for coverage under the ACA but do not otherwise meet traditional eligibility criteria based on disability, pregnancy, age, or caregiving status. The IFC establishes the federal framework for administering community engagement requirements for this population, as well as certain Section 1115 waiver populations (i.e., demonstrations in Wisconsin and Georgia). Individuals subject to the policy[1] generally must demonstrate at least 80 hours per month of qualifying work, education, community service, or related activities, or meet an income-based compliance standard established in statute.

Proposed Rule Changes Discussed in this Brief

- Flexible compliance policies
- Exemptions tied to ability to work
- Highly structured verification framework
- Moderate systems impacts
- Questions remain regarding role of managed care organizations (MCOs)

[1] Medicaid community engagement requirements apply in the 50 states and the District of Columbia, but not in U.S. territories.

FLEXIBLE COMPLIANCE POLICIES INCREASE OPPORTUNITIES TO RETAIN COVERAGE

P.L. 119-21 established a series of activities enrollees could perform—individually or in combination—to meet the community engagement requirements. The law also gives states and enrollees additional flexibility by allowing income equal to the federal minimum wage for 80 hours ($580/month) to meet the community engagement requirement. This policy allows states to leverage existing income data to verify compliance and bypass the need to count hours, improving the administrative process for both the state and enrollees. However, not all enrollees subject to the community engagement requirement earn enough to meet the minimum threshold and therefore must find other ways to meet the requirements. Broader definitions of compliance activities in the IFC clarify and introduce new (albeit, more administratively burdensome) ways to meet the requirement.

Summary of IFC

The IFC retains the core compliance activities of work, community service, work programs, and participation in education programs; however, it goes into greater detail to define those activities. Some key flexibilities addressed in the IFC include:

- **Education program:** The IFC clarified that if an enrollee participated in an educational program at least half-time, they would comply with the community engagement requirement without counting hours. Although current state systems may lack ready access to means of electronically verifying this activity, the ability to avoid tallying hours might improve administrative efficiency.
- **Work:** The IFC broadened the definition of work to include not only paid work, but also in-kind work and unpaid work.
- **Leveraging the federal minimum wage again:** The IFC also allows states to permit individuals earning less than $580 per month divide their income by the federal minimum wage to estimate hours worked. They can then combine those estimated hours with other qualifying activities to meet the requirement. Although this approach may increase administrative burdens, it gives enrollees more flexibility to satisfy the community engagement requirement.
- **Community service:** The IFC placed an unexpected parameter around the community service—the activity must not serve a partisan purpose. This condition creates a new layer of oversight for states.

Key Considerations and Implications

- States may be able to leverage existing income verification infrastructure and integrate compliance determinations into current eligibility workflows, reducing reliance on manual activity reporting.
- Enrollees with variable work schedules, seasonal employment, or multiple sources of household income may also have additional avenues to maintain compliance without navigating separate reporting requirements.
- States, however, need to consider how they verify certain activities like in-kind and other unpaid work—information that is less readily available in electronic databases.

EXEMPTIONS TIED TO ABILITY TO WORK

States have a mechanism to exempt medically frail individuals from being enrolled in alternative benefit packages and ensuring individuals with complex medical needs retain access to the most comprehensive Medicaid benefit package for which they are eligible. Approximately 22 states now use this process, with eligibility and exemption decisions being made without consideration of how those complex medical conditions affect the individual's ability to work. The IFC, however, creates a new definition of medically frail and adds a new short-hardship exception option that states may elect, both based on short or long-term situations that may impact an individual's capacity to work 80 hours each month.

Summary of IFC

The IFC elaborates on the known mandatory and optional exceptions to the community engagement requirement established in P.L. 119-21 and ties several of them to the individual's ability to otherwise meet the community engagement requirement through the prescribed activities as follows.

- **Medically frail:** The definition of medically frail retains the key conditions highlighted in P.L. 119-21, but puts them within a framework of "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement, requiring a determination previously based on health status to include an additional dimension for functional status."
- **Short-term hardships:** States have the option to adopt four short-term hardship exceptions: (1) the enrollee is receiving inpatient care; (2) a county has a high unemployment rate; (3) a county experiences an emergency or disaster as declared by the president; or (4) an enrollee or their dependent must travel for medical care because it is unavailable in their community. Although these exemptions are identified in P.L. 119-21 with minimal qualification, the IFC added stipulations that link the

hardships directly to work and community engagement activities. For example, for the short-term hardship exception based on a declared emergency is contingent on whether the state can support the argument to CMS that the emergency affects the ability of applicable individuals to demonstrate community engagement. Similarly, for instances in which an enrollee's dependent needs to travel outside the community for medical care, the enrollee "must demonstrate having taken leave from employment or having absented themselves from other community engagement activities for reasons related to the dependent's condition or travel." Also, the IFC clarifies that states must adopt all or none of these exceptions. They may not adopt only a subset.

Key Considerations and Implications

- The 22 states with existing medically frail definitions and processes will effectively need to maintain two different definitions for the two different purposes. To align the definitions would further limit the current alternative benefit plan definition to consider the ability of the enrollee to participate in community engagement activities, which could restrict the definition beyond what the law allows.
- The preamble of the IFC indicates that states cannot rely on several diagnosis-based approaches to determine functional status, but it offers limited direction on which methods would be acceptable instead. For example, the rule provides a list of diagnoses[2] that may indicate medical frailty in some cases, but a citation from an Institute of Medicine report qualifies that, "while some conditions may be serious and complex at some points during the course of the disease or disability…the conditions will not necessarily be serious and complex for all patients at all times."[3] Because some people may have these conditions and still be able to work 80 hours a month, the conditions themselves may be unsatisfactory as evidence of medical frailty. The IFC also provided a list of diagnoses[4] that are unlikely to indicate medical frailty.
    - States will need to maintain lists of diagnoses and code sets, but the rule simultaneously seems to caution against simple, rule-based use of these lists. More complex algorithms involving multiple domains, including condition, utilization of services, and level of impairment, are encouraged.
    - The verification section of the preamble indicates that CMS has "reviewed examples of state processes for identifying individuals who are medically

[2] Includes cancer, end-stage renal disease, viral hepatitis, sickle cell disease, chronic obstructive pulmonary disease, HIV/AIDS, sarcoidosis, cognitive impairment, heart disease, amyotrophic lateral sclerosis, Parkinson's disease, Huntington's disease, cystic fibrosis, multiple sclerosis, spinocerebellar ataxias, muscular dystrophy, hemophilia, trauma disorders, and Thalassemia major.

[3] Centers for Medicare & Medicaid Services. Medicaid Program; Community Engagement Requirement for Certain Individuals. June 3, 2026. Federal Register. Available at: https://www.federalregister.gov/d/2026-11094/p-327.

[4] Includes asthma, hypertension, anemia, generalized pain, prediabetes, type I or II diabetes, obesity, psoriasis, headaches, and attention deficit/hyperactivity disorder.

frail or otherwise have special medical needs through algorithms using administrative claims data that assign acuity scores to individuals, which potentially could be used to make a determination of medical frailty or otherwise having special medical needs (for example, a score over a specified threshold could be used to determine an individual is medically frail."[5]) It is unclear whether each such algorithm will need to undergo federal review to ensure that it meets the federal definition to consider functional, along with health-based, status. Furthermore, these same algorithms may not be used conclusively as evidence that a person does NOT meet the medical frailty definition.

- These determinations cannot be fully automated and will require consideration of how the state standardizes reviews and thresholds to ensure consistent and accurate assessments of eligibility. Operationalizing these exceptions will require new workflows, provider education, and oversight mechanisms to ensure eligible individuals are appropriately exempted while minimizing administrative burden and coverage disruptions.

VERIFICATION FRAMEWORK AS A CENTRAL IMPLEMENTATION CHALLENGE

States already have policies and processes to verify Medicaid eligibility. When Congress established the new community engagement requirement, it did not provide specific requirements regarding how states would need to conduct verifications, including the extent to which states could accept self-attestation or require documentation as proof of compliance if they were unable to verify using available data sources. The IFC's requirement to tie many exemptions to enrollees' ability to complete the community engagement activities shifted some opportunities for states to use automated verifications to a more individualized review process that may demand significant administrative resources.

Summary of IFC

Although the rule provides multiple avenues for individuals to demonstrate compliance, it establishes a high evidentiary standard for exemptions, hardship exceptions, and ongoing eligibility determinations. Enrollees may still use self-attestation to a certain extent for exceptions like medical frailty when no other documentation is available, but the IFC requires states to move away from attestation by January 1, 2028. This provision gives states a little additional time to improve enrollee awareness of the requirements and fortify the states' ability to identify and consume verification documents.

[5] Centers for Medicare & Medicaid Services. Medicaid Program; Community Engagement Requirement for Certain Individuals. June 3, 2026. Federal Register. https://www.federalregister.gov/d/2026-11094/p-546.

States will also need to establish documentation standards that satisfy federal oversight expectations without creating excessive burden for families. In addition to the complexity of assessing whether certain health conditions truly prevent someone from participating in the community engagement requirements, enrollees relying on other exemptions like caregiving could experience difficulty navigating complex verification requirements. The rule requires states to verify both the existence of a qualifying caregiving relationship and the level of care being provided, creating a verification challenge that is inherently more subjective than traditional eligibility determinations. Assessing and verifying eligibility will require new workflows, documentation protocols, and caseworker training.

Key Considerations and Implications

- The rule encourages automated compliance verifications by leveraging existing data sources, but many cases will likely require individualized review.
- In practice, the challenge of determining who is exempt may prove more complex than determining who is compliant. Many states lack standardized processes for making these types of determinations at scale, creating potential implementation challenges related to documentation standards, provider involvement, and consistency across cases. Because hardship circumstances are often dynamic and difficult to verify through existing data sources, these reviews may become another significant driver of manual casework and administrative complexity.
- The rule introduces a range of administrative responsibilities that extend beyond traditional eligibility and enrollment functions. Eligibility workers, call center staff, supervisors, policy teams, managed care oversight staff, and legal personnel may all have valuable input regarding how to meet the new federal verification requirements effectively and consistently. Those same types of staff also will likely require training and support to administer the new requirements consistently—advising enrollees and stakeholders and conducting verifications, depending on their role.

SYSTEMS IMPACTS WILL BE SUBSTANTIAL, BUT LOWER THAN EXPECTED

States will need to modify eligibility systems to identify individuals who are subject to the requirements, track compliance status, manage exemptions and hardship determinations, generate notices, support reporting requirements, and monitor outcomes. These changes are largely additive to existing infrastructure, however, rather than anything that would require entirely new eligibility platforms. For most states, implementation will resemble a major eligibility enhancement initiative rather than a large-scale system replacement effort.

Summary of IFC

Although systems updates were not explicitly called out in the IFC, policy modifications throughout the rule have inherent systems impacts. In addition, the IFC requires state reporting on specific community engagement metrics. Most of these metrics are captured in existing state reporting requirements; however, the IFC also requires states to capture and report the number of individuals subject to the community engagement requirement, their compliance status with the requirement, and their manner of compliance. Arkansas reported these types of metrics as part of its 1115 demonstration in 2018–2019, but most other Medicaid expansion states will need to create a way to capture and report this new level of detail. Some other anticipated systems changes related to additions and clarifications in the IFC include:

- New data elements to incorporate in notices (e.g., lookback period months, short-term hardship exceptions) and reports (e.g., activity and compliance reports for CMS)
- Ability to distinguish between a new application and a renewal to apply policies appropriately
- Capacity to apply exemptions and short-term hardship exceptions to enrollee records
- Ability to verify compliance on a more frequent cadence
- Integration with reliable data sources for more efficient data exchange and compliance verification

Key Considerations and Implications

- The most successful states will focus on automation and electronic data verification whenever possible. The rule highlights existing requirements and opportunities to leverage existing data sources.
- States will likely weigh the costs and benefits of leveraging different shared data sources, as well as whether they consider those data sources to be reliable.
- Experience from prior Medicaid eligibility initiatives, including the post-pandemic unwinding process, demonstrates that coverage losses often are driven by administrative barriers rather than underlying eligibility status. States can improve continuity of coverage and program integrity by making thoughtful decisions about how they can update their existing systems to accommodate the new requirements.

OUTSTANDING QUESTIONS AROUND ROLES AND LIMITATIONS FOR MANAGED CARE ORGANIZATIONS

States have leaned on their managed care contractors for support with outreach and engagement during periods of substantial policy change, such as the implementation of the ACA and the recent "unwinding" of the continuous Medicaid eligibility provisions from the COVID-19 public health emergency. MCOs can support members to retain their coverage, but they cannot verify eligibility. However, the extent to which MCOs can be involved with community engagement continues to be a topic of debate. States and MCOs alike have been asking CMS for greater clarity on which support activities states may delegate to MCOs and which constitute a true conflict of interest.

Summary of IFC

The IFC reiterated the same parameters for MCOs that were highlighted in P.L. 119-21. It highlighted that the state must have safeguards in place against conflicts of interest but did not provide enhanced detail to address some of the critical questions from states and MCOs. The IFC also highlighted the option for states to coordinate with MCOs on notices.

Key Considerations and Implications

- Anticipate supplemental guidance from CMS related to MCO opportunities and parameters.
- Although states already have processes in place to provide preferred language and review and approve MCO communications before they are released to enrollees, further alignment of communications plans and efforts could be one way for states to enhance their outreach and engagement efforts.
- Health plans will need to prepare for increased outreach responsibilities, potential enrollment churn, and new demands related to identifying and supporting exempt populations. Providers, particularly safety net organizations, may experience increased administrative workload associated with documentation requests while also facing potential increases in uncompensated care if eligible individuals lose coverage for procedural reasons. The rule's effects will, therefore, be felt across the broader healthcare delivery system, not solely within Medicaid eligibility operations.

IMPLICATIONS FOR STATES, PLANS, AND PROVIDERS

The implications for states, plans, and providers differ and reflect their respective roles in administering requirements, supporting compliance, and engaging enrollees.

State Medicaid Agencies

Implementation will require significant operational redesign. For state Medicaid agencies, the primary challenge will be translating federal requirements into operational processes that can be administered consistently, efficiently, and at scale. Although many states can leverage their existing eligibility infrastructure, the rule introduces administrative responsibilities that extend beyond traditional eligibility and enrollment functions. States will need to develop processes that can be used to identify individuals who are subject to the requirement, verify compliance, adjudicate exemptions and hardship requests, issue notices, manage cure periods, conduct redeterminations, and respond to appeals. Collectively, these requirements create a new layer of program administration that will require coordination across policy, eligibility operations, technology, legal, program integrity, and enrollee support functions.

Automation opportunities may be concentrated in compliance, not exemptions. A central implementation question will be the extent to which states can automate compliance determinations and minimize reliance on manual case review. The rule's income-based compliance pathway creates opportunities to leverage existing eligibility data and verification services, potentially reducing administrative burden for both states and enrollees. However, many of the most operationally complex elements of the rule—including medical frailty determinations, caregiver exemptions, and hardship exceptions—cannot be fully automated and will require individualized review processes supported by clear policies, documentation standards, and staff training.

Enrollee communications will play a critical role in implementation success. States will need to develop robust outreach and communication strategies. Experience from prior eligibility and enrollment initiatives, including Medicaid unwinding activities, demonstrates that enrollees often lose coverage not because they are ineligible, but because they are unaware of reporting requirements, fail to respond to notices, or encounter barriers navigating administrative processes. Community engagement requirements introduce multiple new points of interaction between enrollees and eligibility agencies, increasing the importance of clear communications, targeted outreach, and enrollee support mechanisms.

Administrative complexity may present a greater risk than noncompliance. The greatest implementation risk may not be widespread failure to meet community engagement requirements, but rather the challenges associated with documenting compliance and exemption status. States that effectively leverage existing data sources, maximize automation, and simplify enrollee-facing processes will be better positioned to meet federal requirements while minimizing unnecessary coverage disruptions.

The rule represents a significant expansion of program integrity expectations that will require deliberate design and investment to align with the administration's focus on fraud, waste, and abuse. Specifically, states will need to strengthen frontend eligibility controls by building robust, data-driven verification processes that minimize reliance on self-attestation. Examples include integrating claims, eligibility, SNAP/TANF, incarceration, and education data sources and ensuring determinations are fully auditable and defensible under federal review. The introduction of nuanced exclusions (e.g., medical frailty, caregiver status) and multi-month compliance assessments will require clearly defined, consistently applied criteria and supporting documentation standards to avoid improper approvals, denials, or disenrollments.

Managed Care Organizations

Health plans will serve as a critical bridge between enrollees and state eligibility systems. Although MCOs are prohibited from making determinations of compliance with continuous eligibility requirements, they will likely play an important supporting role in implementation. Plans often maintain the most frequent and direct contact with Medicaid members and will likely become a key source of education, outreach, and navigation support as new requirements take effect.

States may look to plans to help identify members who are potentially subject to community engagement requirements, assist with member communications, and connect members to resources that support compliance or exemption eligibility. These activities, however, occur outside the traditional managed care financing framework. CMS explicitly distinguishes them from Medicaid-covered services and prohibits their inclusion in capitation rate development or classification as value-added services. As a result, states and plans will need to carefully define expectations, funding approaches, and accountability mechanisms to ensure these activities meaningfully support compliance while remaining consistent with federal rate-setting and medical loss ratio requirements.

Identifying and supporting exempt populations may become a core plan function. Plans are uniquely positioned to identify members who may qualify for exemptions, particularly medically frail individuals and members receiving intensive care management or behavioral health services. As states develop exemption processes, plans may play an increasingly important role in helping members understand documentation requirements, facilitating provider attestations, and supporting the collection of information needed to establish exemption status. Early identification of at-risk populations could help reduce inappropriate disenrollments and minimize disruptions in care.

Member outreach strategies will require significant investment. Community engagement requirements introduce a new set of enrollee communications challenges. Plans may need to develop targeted outreach campaigns, member education materials, call center protocols, and care management workflows to support affected populations. Lessons learned from Medicaid unwinding efforts suggest that proactive and tailored communications can play a significant role in reducing procedural coverage losses. Plans that invest early in member engagement strategies may be better positioned to help members maintain coverage and avoid gaps in care.

Enrollment volatility could create financial and operational uncertainty. Community engagement requirements may contribute to increased enrollment churn, particularly during the early stages of implementation when enrollees and administrators are adapting to new processes. Even among individuals who meet compliance requirements or qualify for exemptions, delays in documentation, notice response, or case processing could result in temporary coverage losses or disruptions. For plans, increased churn can create challenges related to capitation rate adequacy, financial and membership forecasting, risk adjustment, care management continuity, quality performance, and provider network stability.

Plans should begin preparing for implementation now. As states move toward implementation, plans should assess the size and characteristics of potentially affected populations, evaluate members who may qualify for exemptions, develop outreach and communication strategies, and establish operational playbooks for supporting compliance and coverage retention. Plans that proactively coordinate with state Medicaid agencies, providers, and community-based organizations will be better positioned to navigate implementation and support member continuity of coverage.

Providers

Providers will play a central role in exemption determinations and enrollee support. Providers are likely to encounter the policy first through increased documentation requests. Physicians, behavioral health providers, care managers, and other clinicians may increasingly be asked to support medical frailty determinations, document functional limitations, verify participation in treatment programs, or provide evidence related to other exemption categories. As states operationalize these requirements, providers may become a critical source of information to determine whether patients remain eligible for coverage.

Clinical and administrative workflows may need to evolve. Unlike traditional Medicaid eligibility processes, community engagement requirements introduce new points of interaction between providers and eligibility administration. Health systems, physician practices, behavioral health providers, and community health centers may need to develop workflows for responding to documentation requests, completing attestation forms, and coordinating with health plans and state agencies. Organizations that serve large Medicaid populations could experience increased administrative burden, particularly during the initial implementation period as policies, forms, and documentation standards continue to evolve.

Coverage losses may affect access to care and continuity of treatment. Although many individuals subject to the requirements may remain eligible through compliance pathways or exemptions, some enrollees will likely lose coverage because of incomplete documentation, failure to respond to notices, or barriers to navigating administrative processes. As a result, providers may experience disruptions in patient coverage and continuity of care, particularly among populations with complex medical, behavioral health, or social needs. Interruptions in coverage may lead to delayed care, increased reliance on emergency services, and challenges to maintaining ongoing treatment relationships.

Financial impacts could extend beyond Medicaid reimbursement. To the extent that community engagement requirements contribute to reductions in Medicaid enrollment, providers may see corresponding increases in uninsured patients. Hospitals, community health centers, behavioral health providers, and safety net organizations may experience higher levels of uncompensated care and bad debt, particularly in states with large Medicaid expansion populations. In some states, existing uncompensated care pools or supplemental funding mechanisms may partially offset these impacts, but the availability and adequacy of those resources vary significantly across states. Providers operating in markets with limited safety net funding could face greater financial exposure if coverage losses exceed expectations.

Safety net providers may be disproportionately affected. Organizations serving low-income populations are likely to experience the greatest impact from enrollment churn and procedural disenrollments. Community health centers, public hospitals, behavioral health providers, rural providers, and other safety net organizations often provide services to individuals who are most likely to face challenges in navigating eligibility requirements and documentation processes. These providers may increasingly find themselves supporting patients with both clinical needs and eligibility-related issues as community engagement requirements take effect.

Provider engagement may become an important implementation strategy for states and plans. Given their direct relationships with enrollees, providers are well positioned to identify individuals who may qualify for exemptions, to educate patients about new requirements, and to connect them with available supports. States and health plans may increasingly rely on provider organizations as partners in outreach and continuity of coverage efforts, particularly for medically frail individuals and other high need populations. As implementation approaches, providers should assess potential operational, financial, and patient care impacts and prepare for a more active role in supporting Medicaid enrollees.

Across stakeholders, the rule shifts the primary implementation challenge from system design to operational execution, increasing reliance on coordination, documentation, and enrollee engagement.

HOW HMA CAN HELP

The Medicaid community engagement requirements introduce a new set of policy, operational, technology, and stakeholder engagement challenges for states, plans, and providers. Although CMS has provided flexibility in several key areas, successful implementation will depend on an organization's ability to translate federal requirements into practical, scalable processes that minimize administrative burden and reduce the risk of unnecessary coverage loss.

Across these areas, implementation challenges will be driven more by operational complexity than by system design, requiring coordinated approaches that integrate policy, technology, and frontline workflows. HMA can help in the following ways:

- Supporting state implementation. HMA and HealthTech Solutions (HealthTech), an HMA Company, actively support states as they prepare to implement community engagement requirements. HMA helps agencies evaluate policy options, design verification and exemption processes, assess operational readiness, and align technology and business processes with federal requirements.
- Helping health plans prepare. Community engagement requirements create new risks related to member churn, outreach, and compliance monitoring. HMA works with plans to identify populations at risk of losing coverage, develop implementation playbooks, design member communication strategies, and establish approaches for supporting members who may qualify for exemptions or require additional assistance navigating new requirements.
- Preparing providers for operational impacts. Providers are likely to play an instrumental role in documenting medical frailty and other exemption categories. HMA helps providers assess operational impacts, develop documentation and workflow strategies, and understand how community engagement requirements may affect patient coverage, access to care, and care management activities.
- Combining policy and implementation expertise. HMA, Wakely, and HealthTech bring together Medicaid policy, eligibility and enrollment, managed care, operational transformation, financial modeling, and technology expertise to help organizations move from regulatory requirements to practical implementation strategies. As states move toward implementation, early planning will be critical to balancing compliance requirements, administrative burden, and continuity of coverage goals.

ABOUT THE AUTHORS

Lora Saunders
Associate Principal
lsaunders@healthmanagement.com

Rob Buchanan
Senior Principal
rbuchanan@healthmanagement.com

Aany Tazmin-Ewing
Senior Consulting Actuary II
aany.tazminewing@wakely.com

Chris Underwood
Senior Consultant
chris.underwood@healthtechsolutions.com

ABOUT HMA

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