

WHITE PAPER

Meeting the Moment: Using Data to Drive Medicaid Community Engagement Implementation



State Medicaid agencies are preparing for a major operational effort

Medicaid, the public insurance program that provides comprehensive health coverage to millions of low-income individuals and families, is undergoing significant change. Public Law 119-21, also known as The Working Families Tax Cut Legislation or One Big Beautiful Bill, introduced provisions that reshape how states and the federal government administer and oversee Medicaid. The law's community engagement requirement represents one of the most significant shifts for Medicaid policy and operations, and its implementation will be strongly impacted by states' ability to weave together and glean insights from multiple data sources that are not always well-connected.

Under the community engagement requirement (section 71119) of the new law, to be eligible for Medicaid, people ages 19 to 64 that apply for or are enrolled in Medicaid through the Affordable Care Act adult expansion group or through a section 1115 demonstration must show that they are engaging in work or qualifying community activities¹ for at least 80 hours per month. The law also exempts certain adults, including parents of dependent children and those determined to be medically frail, from these requirements (Exhibit 1). These provisions take effect January 2027,² making it imperative that states begin planning towards implementation and preparing for program monitoring, even as they await further detailed guidance from the Centers for Medicare & Medicaid Services (CMS).

¹ Qualifying activities include work, community service, participation in a work or an education program, or some combination of these activities. People can satisfy the requirement if their average monthly income exceeds the minimum wage multiplied by 80 hours.

² The provisions of section 71119 cannot be waived, but the secretary of the U.S. Department of Health and Human Services may exempt a state from compliance up to December 31, 2028, if that state demonstrates a good faith effort to comply.

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Exhibit 1. Groups exempt from the community engagement requirement



Exemptions

- People younger than age 19
- Former foster care youth up to age 26
- Native Americans
- Disabled veterans
- Medically frail individuals or those who have special medical needs
- People in compliance with work requirements of other programs, such as the Supplemental Nutrition Assistance Program
- Parent, guardian, or caretaker relative of a dependent child age 13 or younger or a disabled individual
- People enrolled in Medicare Part A or Part B
- Inmates of public institutions
- People participating in a drug addiction or alcohol treatment and rehabilitation program
- Pregnant individuals and those entitled to postpartum medical assistance



Optional exemptions for short-term hardships:

- People receiving inpatient hospital services, nursing facility services, services in an intermediate care facility for people with intellectual disabilities, inpatient psychiatric hospital services, or similar services (including outpatient care relating to other services)
- People living in a county experiencing a national emergency or disaster
- People living in a county with an unemployment rate above eight percent or one and a half times the national unemployment rate
- People who must travel outside of their community for an extended period for medical treatment

Impact on states

Determining whether Medicaid recipients meet the community engagement requirement will be a complex process that involves reconciling data across multiple systems, programs, and agencies. Moreover, states must apply new and complex logic to the data to implement the policy, a task that is often challenging when there is no single data set designed for the programmatic purpose.

Technical challenge spotlight

Beneficiaries who are medically frail or have another disabling condition will be exempt from the community engagement requirement. This concept is not new—under the Affordable Care Act, states can provide alternative benefit plans for certain Medicaid beneficiaries. People who are medically frail can opt into one of these plans, when available, or the standard Medicaid package. States have considerable flexibility in defining medical frailty, and each state that offers an alternative benefit plan uses a different definition. Not all states provide alternative benefit plans, so many states will need to define medical frailty as a part of implementing the community engagement requirement. Further, to identify these beneficiaries, states will need to compile and analyze Medicaid enrollment records from eligibility and enrollment systems, as well as inpatient, outpatient, prescription drug, and long-term care claims and encounter records from Medicaid Management Information Systems.

To meet the implementation deadline, states are already working diligently on large-scale eligibility and enrollment (E&E) system enhancements to respond to the new requirements, ahead of the release of federal guidance. States will likely have to update their systems after federal guidance is released if the two do not align. This underscores the need for flexible technical solutions.

The scale of systems enhancements needed to meet the implementation deadline means that states must prioritize essential activities. But sometimes activities may not seem critical until it is too late. For example, while states are focused on implementing verification functionality, they may not be prioritizing their system design to support monitoring. However, these program changes will have important impacts on state budgets insofar as changes lead to 1) reduced enrollment, 2) shifts in eligibility pathways (e.g., moving from the adult expansion group to a disability group, which has a lower federal match rate), and 3) shifts in the overall health status of the remaining patient population.

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States should design community engagement solutions with compliance reporting and monitoring in mind. Anticipating future needs will ensure states are set up for success beyond community engagement implementation in January 2027.

Building an evidence-informed state implementation framework

The most foundational data for a compliance-focused effort will be Medicaid E&E system data, but other data sources are needed for program verification. Additional sources may be valuable or needed to inform ongoing implementation monitoring. Exhibit 2 gives examples of relevant data sets and their uses.

Exhibit 2. Data sources supporting implementation of community engagement requirements and potential use cases

Data source	Potential use case
Medicaid E&E system data	• Compliance metrics (counts of people subject to community engagement, exempted, deemed eligible, deemed ineligible at application, deemed ineligible at redetermination) • Estimate budget impacts associated with changes in enrollment and shifts in eligibility groups
Wage data	Verify work activities
Medicaid claims and encounter data	• Identify populations exempt from community engagement requirements due to, for example, medical frailty or receipt of rehabilitation care • Estimate budget impacts associated with changes in patient health status
Medicare data	Identify beneficiaries eligible or enrolled in Medicare Part A, Part B, or both that are exempt from community engagement requirements
Correctional data	Identify inmates of public institutions that are exempt from community engagement requirements
Social services data	Identify programs for which people may already meet community engagement requirements (such as SNAP)
All-payer claims database	Monitoring metrics examining coverage transitions (for instance, number of beneficiaries losing Medicaid and CHIP coverage and transitioning to commercial or state-based marketplace plans)
State-based marketplace data	
Hospital cost reporting (HCRIS)	Monitoring metrics examining shifts from Medicaid expenditures to uncompensated care

HCRIS = Healthcare Provider Cost Reporting Information System; SNAP = Supplemental Nutrition Assistance Program

Data alone are not enough: to guide effective and efficient implementation, state systems staff and vendors must work hand in hand with policy experts to build compliant solutions that are forward thinking with the current policy context top of mind.

Technical challenge spotlight

If a person applying for Medicaid is enrolled in SNAP, a state can rely on the SNAP work requirement verification process to establish their Medicaid eligibility. However, not all SNAP beneficiaries must meet work requirements to be eligible for the program. Ensuring that the Medicaid community engagement verification system fully accounts for variation in SNAP eligibility requires strong SNAP program and policy expertise.

Establish a governance program

Developing a robust governance program is essential when implementing a complex new initiative. Community engagement implementation will need to focus on data governance, though not exclusively, as implementation requires disparate data sources that are typically housed and managed in different divisions or agencies in the state. Whether setting up a new governance structure or leaning on an existing one, both technical and policy representation will be critical for effective decision making.

In the context of the community engagement requirements, foundational steps for establishing a governance program include:

1. **Prioritize key use cases to support compliance and monitoring.** This will help guide what will likely require a staged approach to data integration, where data sources needed for community engagement verification are integrated first (e.g., wage data), and data sources needed for long-term monitoring are integrated later (e.g., all-payer claims database or state-based marketplace data).
2. **Conduct a data inventory.** Identify relevant datasets and how they are currently managed. For each dataset, articulate clear ownership and stewardship roles to ensure accountability. Assess the extent to which they are currently integrated or linked to E&E data. This can also help with prioritization as states may already have data warehouses that integrate some data sources (e.g., E&E data and Medicaid Management Information System data) and have the necessary data use agreements and processes in place for use.
3. **Define roles and responsibilities.** Every data asset and key deliverable should have an owner and steward(s), with roles and responsibilities clearly articulated.
4. **Define key policies.** Consider what policies are needed to ensure compliance with legal and regulatory requirements (e.g., data use, data sharing, and archival and destruction processes).
5. **Define data management practices,** with particular attention to standardized data integration and interoperability, data validation, and quality assurance processes.
6. **Clarify the technology needed and core vendor partners.** States must consider 1) what technology will meet their needs, and 2) what support they will need for implementation. For instance, vendors managing E&E systems may be able to support broader systems integration if a data infrastructure is already in place and relevant stakeholders are engaged, or it may require new vendor support.

7. **Establish the ability to check in, calibrate, and iterate.** Given the short timelines and anticipated federal guidance, states will likely need to pivot. Ensuring that the data and technology can support continual improvement will be an essential part of this program.

Develop data-driven strategies to identify exemptions

A key aspect of implementation will involve defining who is exempt from community engagement requirements (Exhibit 1). This requires applying complex logic to claims and encounter records from the Medicaid Management Information System, using queries that reflect a deep understanding of a state’s policy context and billing practices.

For example, individuals who are pregnant or eligible for postpartum coverage are exempt from community engagement requirements. Although some women are eligible for Medicaid on the basis of pregnancy and can be easily identified with E&E system data, others are eligible based on income and become pregnant while they are covered. To identify these women, a state may need to implement complex business rules, especially if the state leverages bundled payments for prenatal and postpartum care.³ In such states, claims are only submitted at the time of delivery, so verifying pregnancy can be challenging.

Exhibit 3 gives examples of some key exemption categories, along with the data needed and policy considerations relevant to implementing these exemptions.

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Exhibit 3. Opportunities to leverage Medicaid claims data for verifying community engagement exemptions

Medical frailty or other disabling conditions	Data needed: Inpatient, outpatient, prescription drug, long-term care claims, and encounter records Logic questions: How many claims or encounters are needed, in what setting, and over what period of time are they needed? Which conditions should be included in the definition of medical frailty and other disabling conditions? Policy considerations: If someone is applying for Medicaid/Children’s Health Insurance Program and had recent coverage, should their prior claims history be considered for exclusion?
Pregnancy	Data needed: Inpatient, outpatient claims, and encounter records Logic questions: Which codes can serve to identify prenatal and postpartum services? How do you apply appropriate look-back periods that align with gestational ages, as indicated by specific Current Procedural Terminology codes? Policy considerations: Does the state pay for pregnancy-related services using bundled payment codes? Does this include prenatal services?
Short-term hardships	Data needed: Inpatient, outpatient claims, and encounter records Logic questions: How do you identify relevant inpatient hospital services, nursing facility services, services in an intermediate care facility for people with intellectual disabilities, inpatient psychiatric hospital services, or outpatient on professional claims (assuming institutional claims are not processed in a sufficient timeframe?) Policy considerations: Does the state have a section 1115 demonstration that permits stays in institution for mental diseases for substance use disorder treatment? If so, how are services that institutions for mental diseases deliver submitted to the state?

³ For more details, see <https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf>.

Prioritize program monitoring in system design

Although monitoring is not an explicit requirement in the new law, states should expect CMS oversight of implementation experiences, which could include reporting of monitoring metrics, as CMS previously required for community engagement 1115 demonstrations. In addition, monitoring will help states ask and answer bigger questions about long-term trends in enrollment and their associated financial impacts.

- **Distribution of eligibility categories:** The basis of eligibility will change for certain people. For instance, when someone in the adult expansion program goes through redetermination, they may be deemed eligible based on a disability. The federal match for individuals is much higher for people in the adult expansion program than those with other eligibility pathways. Monitoring changes in eligibility pathways will give states important insight into shifting financial responsibility from the federal government to the states.
- **Coverage changes and shifts in overall patient health status:** Some people will lose Medicaid coverage altogether. Depending on their health and service use patterns, the overall acuity of the enrolled population may shift, which may impact overall state revenue. Understanding shifts in overall patient health status will be critical for forecasting financial implications.
- **Churn:** There is likely to be an increase in enrollment churn, at least initially, as states, beneficiaries, and applicants work through new systems, workflows, and documentation requirements. In this scenario, some enrollees may lose coverage temporarily, and states will need to be prepared to ensure continuity of care as those individuals become re-enrolled. For instance, they may want to ensure that people are assigned to the same managed care organization or primary care provider upon re-enrollment.

Recommendations

- **Leverage subject matter expertise throughout implementation.** Technical solutions require both policy and data knowledge that extends beyond Medicaid eligibility and enrollment. Integrate policy expertise throughout the implementation process, including verification of exclusions, verification of community engagement activities, and development of monitoring metrics.
- **Institute interdisciplinary governance.** This is a critical moment for collaboration between policy and data experts across programs within the state. Establishing governance programs early will ensure states can successfully use data needed from all necessary parties.
- **Monitoring is a priority.** With significant complexity and a limited timeframe for implementation, prioritize monitoring as systems are designed. Anticipate incorporating additional data feeds as partnerships and processes are implemented with other key data owners beyond the State Medicaid Agency.
- **Don't delay!** There is enough information available now about the community engagement requirements to get started to reduce compliance and timeline risks.