Chapter 1:

Implementing Community Engagement Requirements in Medicaid

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Recommendation

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

Key Points

- Beginning on January 1, 2027, states, for the first time, will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement (CE) activities, pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act).
- Before enactment of the 2025 Budget Reconciliation Act, states could use Section 1115 demonstrations to implement work and CE requirements. Though few states fully implemented CE requirement demonstrations, early data provided insight into enrollment effects and administrative spending associated with implementation.
- MACPAC identified principles for implementing community engagement requirements in four areas: the need for timely guidance, ensuring coverage of eligible individuals, prioritizing efficiency in information technology systems updates, and the need for timely monitoring and evaluation.
- Implementation of CE requirements will require substantial effort and resources from the Centers for Medicare & Medicaid Services (CMS) and states, and will affect Medicaid eligibility and enrollment moving forward.
- The 2025 Budget Reconciliation Act did not establish requirements for monitoring or evaluating implementation of CE requirements.
- CMS has the authority to collect and publish data for monitoring and evaluation, which the agency previously exercised in response to major policy changes, such as the public health emergency unwinding.
- Monitoring can help identify changes in eligibility and enrollment associated with CE requirements, and evaluation would provide insight into how CE requirements affect employment, health, and other outcomes of interest. Monitoring and evaluation can also help identify the need for policy and operational adjustments, and identify effective practices that other states may wish to replicate.

CHAPTER 1: Implementing Community Engagement Requirements in Medicaid

For the first time, states will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement (CE) activities pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act). Operationalizing these requirements will be a considerable undertaking for states, particularly in the timeline the statute provides for implementation. States are also in the midst of implementing other substantial changes to their Medicaid programs established by the same law, including more frequent eligibility redeterminations for adults in the expansion group, referred to as the new adult group, and new limits on their ability to finance the non-federal share.[1]

To identify considerations for implementing CE requirements, MACPAC conducted stakeholder interviews between June and August 2025, when Congress was considering and then approved the 2025 Budget Reconciliation Act.[2] Interviewees provided policy as well as operational insights, including from prior state implementation of similar policies under Section 1115 demonstration authority. The Commission also hosted two panel discussions in the fall of 2025 to gain additional insights from state and federal officials and other experts.[3]

Based on the evidence gathered through stakeholder interviews and expert panels, the Commission identified four principles and a recommendation for implementing CE requirements, which are intended to inform the ongoing work of states and the Centers for Medicare & Medicaid Services (CMS). The following principles reflect the findings from our research and complement the recommendation:

- CMS should provide timely federal guidance and technical assistance to states.
- CMS and states should ensure that eligible individuals can gain and maintain coverage.
- CMS and states should prioritize efficiency when procuring, updating, and operating state information technology (IT) systems.
- CMS and states should use timely monitoring and evaluation data to inform policy and operations.

MACPAC's research findings underscore the importance of transparent monitoring and evaluation of CE requirements in Medicaid. As a result, the Commission recommends the following:

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

To provide context for the recommendation, this chapter presents findings from stakeholder interviews and expert panels as well as MACPAC's review of the literature. The chapter begins with background on CE requirements in Medicaid and an overview of the statutory requirement in the 2025 Budget Reconciliation Act. Then it outlines the Commission's principles and corresponding considerations for implementing CE requirements as supported by the research. The chapter concludes with a discussion of the Commission's recommendation for monitoring and evaluation.

MACPAC developed this chapter before CMS published its statutorily required interim final rule (IFR) on CE requirements. As such, the chapter does not describe the contents of the IFR or the extent to which the IFR addresses the Commission's recommendation and other considerations that emerged from our stakeholder interviews.

Background

Although work requirements are a long-standing feature of certain low-income benefit programs, such as the Temporary Assistance for Needy Families (TANF) block grant and the Supplemental Nutrition Assistance Program (SNAP), there has been limited use of such requirements in Medicaid.[4] Before enactment of the 2025 Budget Reconciliation Act, Section 1115 demonstrations were the only way for states to condition Medicaid eligibility on completion of specified work and CE activities.[5,6] Several states have used Section 1115 demonstration authority to propose or establish work and CE requirements in recent years. However, legal challenges, changing federal policy priorities, and other factors prevented most of these states from receiving CMS approval or fully implementing their demonstrations.

Section 1115 demonstrations

In 2018, CMS issued guidance inviting states to design Section 1115 demonstrations that made work and CE requirements a condition of Medicaid eligibility for certain beneficiaries. In the guidance, CMS highlighted evidence suggesting that addressing certain determinants of health, such as employment, could improve health outcomes and described the agency's long-standing work with states to support employment, particularly for beneficiaries with disabilities.[7] CMS posited that the ability of these programs to increase beneficiary earnings and participation in job training and work referral programs suggested that other incentives, including work and CE requirements, could yield similar outcomes. Although CMS noted this as a shift in agency policy, it described the new approach as "anchored in historic CMS principles that emphasize work to promote health and well-being" (CMS 2018).

Between 2018 and 2020, CMS approved Section 1115 work and CE demonstrations in 13 states.[8] These demonstrations required (or require, in the case of Georgia's ongoing demonstration) certain non-disabled, non-elderly, non-pregnant individuals to meet work and CE requirements as a condition of Medicaid eligibility. Although the details of their programs varied, states that pursued these policies generally shared the expectation that work and CE requirements would lead to improved beneficiary health and well-being through increased self-sufficiency and reduced reliance on public programs, which would in turn improve the fiscal sustainability of Medicaid. However, due to legal challenges and shifting federal and state priorities, only two states—Arkansas and Georgia—implemented their work and CE programs for more than a few months.[9] Although Arkansas's demonstration was halted by the courts, Georgia's demonstration continues through the end of 2026 (Box 1-1).[10,11]

Arkansas, Georgia, Indiana, Kentucky, New Hampshire, and Wisconsin proceeded far enough in their demonstrations to provide early insight into the anticipated enrollment effects and administrative spending associated with implementing work and CE requirements. Observed and projected coverage losses were substantial and often affected beneficiaries who were already meeting the requirements or should have been exempt (Sommers et al. 2020, HHS 2019). Lack of awareness and communication about the requirements, substantial barriers to employment (e.g., lack of transportation), and administrative barriers to beneficiary reporting were among the most common reasons for non-compliance (ASPE 2021). Moreover, the Government Accountability Office (GAO) found that administrative costs in five states varied considerably, ranging from less than $10 million in New Hampshire to more than $250 million in Kentucky (GAO 2019).[12] Costs varied based on several factors, including the length of demonstration at the time of the study, the number of individuals subject to the requirements, and planned Medicaid IT systems changes. More recently, GAO found that Georgia spent a total of $54.2 million in administrative expenditures to support implementation of its work and CE demonstration (GAO 2025).

BOX 1-1. Arkansas's and Georgia's Work and Community Engagement Demonstrations

Arkansas implemented its Section 1115 work and community engagement (CE) demonstration, Arkansas Works, in June 2018. By December 2018, more than 18,000 beneficiaries were disenrolled because they did not comply or report their compliance with work and CE requirements (DHS 2018). Studies showed that many beneficiaries did not know if they were subject to the requirements and how to demonstrate compliance (DHS 2025). Inadequate beneficiary outreach and administrative challenges, such as trouble accessing the online portal for reporting compliance, created additional barriers to beneficiaries retaining coverage (Hill and Burroughs 2019).

Georgia launched its Section 1115 work and CE demonstration, Pathways to Coverage, in July 2023 and received Centers for Medicare & Medicaid Services approval for a temporary extension through December 2026 (CMS 2025b). Pathways was the first demonstration to apply work and CE requirements to new applicants as well as existing beneficiaries. Enrollment in the first year of the demonstration was lower than expected, according to the state's interim evaluation, which found that of 26,000 applicants, only 4,300 individuals were enrolled, compared to the state's projection of 25,000 (CMS 2026a). Georgia made several changes to address enrollment and administrative barriers identified through the interim evaluation, including reduced frequency of beneficiary compliance reporting and the addition of two new qualifying work activities (GDCH 2025).

Overview of CE Requirements

The 2025 Budget Reconciliation Act requires states to implement a CE requirement for beneficiaries in the new adult group and certain other adults with low incomes by January 1, 2027, unless the states receive a time-limited exemption from CMS, as detailed below. Resulting coverage losses are expected to generate substantial federal savings. The Congressional Budget Office (CBO) estimates that 5.3 million fewer people will have insurance in 2034 because of the policy, which would yield an estimated $326 billion in savings over the same period (CBO 2025a, 2025b).[13]

Key provisions

Details of the CE requirement are described below. States are prohibited from waiving any aspects of the requirement under Section 1115 demonstration authority. The law requires the U.S. Department of Health and Human Services (HHS) to issue an IFR to implement the requirements by June 1, 2026.[14]

Individuals subject to the requirement. The law requires states to implement CE requirements for individuals who are applying for or enrolled in the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as well as individuals who are applying for or enrolled in a Section 1115 demonstration that provides minimum essential coverage to individuals who are age 19–64, not pregnant, not dually eligible for Medicare, and not otherwise eligible for coverage under the state plan.[15]

Required CE activities. To enroll in Medicaid and maintain eligibility, individuals must participate in 80 hours of work, a work program, community service, education, or a combination thereof or be enrolled in an education program at least half-time in a given month.[16] Individuals are also compliant if they have a monthly income that is equal to or above the federal minimum wage requirement multiplied by 80 hours.[17] For seasonal workers, average monthly income is assessed for the previous six-month period.[18]

Compliance verification. Individuals subject to the requirement have to demonstrate compliance for up to three consecutive months (as specified by the state) immediately preceding the month in which they apply for coverage and for one or more months (as determined by the state) as part of their eligibility redetermination. States can choose to verify compliance with CE requirements more frequently, such that verification happens more than twice during a 12-month period (e.g., monthly).[19]

States must, in accordance with standards established by the Secretary of HHS (the Secretary), establish processes and use available information (e.g., payroll data) without requiring, where possible, the individual to submit additional information to verify compliance. This practice is commonly referred to as "ex parte verification."

Beneficiary outreach. In accordance with standards specified by the Secretary, states must notify individuals who are subject to the requirements at least three months before the start of the compliance look-back period immediately preceding December 31, 2026, and periodically thereafter. For example, a state that plans to implement the requirements on January 1, 2027, with a three-month compliance look-back would have to notify anyone who is subject to the requirements by June 30, 2026.

Notices must be delivered by regular mail or an electronic format, if chosen by the individual, and provided in one or more additional forms, such as by telephone, text message, website, or other commonly available electronic means, and other forms as the Secretary determines appropriate. States must include information about: (1) how to comply with the requirements, including an explanation of who the requirements apply to; (2) the consequences of non-compliance; and (3) how to report any change in the individual's status that could affect whether they are subject to the requirements.

Non-compliance. If an individual's compliance with CE requirements cannot be verified, the state must provide the individual with a notice of non-compliance that includes information, in accordance with standards specified by the Secretary, about: (1) how to demonstrate compliance, (2) how to demonstrate that the individual is not subject to the requirements, and (3) how to reapply for Medicaid if the individual is disenrolled or their application is denied. Individuals have 30 days from the receipt of the notice to demonstrate that they comply with the requirements or should not be subject to them. Failure to do so results in disenrollment by the end of the month following the 30-calendar-day period (i.e., opportunity to cure) or the denial of the individual's enrollment application. Before disenrolling beneficiaries or denying new applications, the state must determine whether the individual could be enrolled in Medicaid under a different eligibility category (and therefore not subject to the CE requirement). States must also ensure that individuals have the opportunity for a fair hearing (§ 1902(a)(3) of the Social Security Act (the Act)).

Individuals who would otherwise be eligible for Medicaid but are denied enrollment or disenrolled for failure to meet CE requirements are barred from receiving premium tax credits for the purchase of insurance through the exchanges.

Mandatory exclusions. The law identifies specified excluded individuals who are not subject to CE requirements (Box 1-2). These individuals are:

- youth formerly in foster care;
- parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 years and younger or a disabled individual;
- medically frail or otherwise have special needs, as defined by the Secretary, including individuals:
  - who are blind or disabled;
  - with a substance use disorder or disabling mental health condition;
  - with a physical, intellectual, or developmental disability that substantially impairs their ability to perform one or more activities of daily living; or
  - who have a serious or complex medical condition
- pregnant or entitled to postpartum Medicaid coverage;
- American Indian or Alaska Native;[20]
- veterans with a total disability rating;[21]

- incarcerated;
- meeting TANF work requirements or receiving SNAP benefits and subject to SNAP work requirements; or
- participating in a drug addiction or alcohol treatment program.[22]

Similar to their processes for verifying compliance, states must, in accordance with standards established by the Secretary, use available information such as claims and encounter data to identify exclusions and minimize the need for individuals to report their qualifying conditions or circumstances (i.e., ex parte).

Mandatory exceptions. The law identifies mandatory exceptions for individuals who are subject to CE requirements (Box 1-2). The state must deem compliant individuals who, for all or part of a month, were:

- a specified excluded individual eligible for a mandatory exclusion, as described above;
- younger than age 19;
- entitled to or enrolled in Medicare;
- enrolled in a mandatory categorically needy eligibility group; or
- incarcerated at any point in the three months before the month in question.

Short-term hardship exceptions. States can choose to provide short-term hardship exceptions to individuals who have experienced certain events under procedures established by the state, in accordance with standards specified by the Secretary (Box 1-2). An individual is considered to have experienced a short-term hardship event and is deemed compliant if, for part or all of such month, any of the following conditions apply:

- The individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including related outpatient services) as the Secretary determines appropriate.
- The individual lives in a county or equivalent unit of local government affected by a federally declared emergency or disaster.
- The individual lives in a county with a high unemployment rate (at or above the lesser of 8 percent or 1.5 times the national unemployment rate).
- The individual or their dependent must travel outside their community for an extended period to receive medical services necessary to treat a serious or complex medical condition.[23]

BOX 1-2. Overview of Community Engagement Requirement Exclusions and Exceptions

Mandatory exclusions. As described in Section 1902(xx)(9)(A)(ii) of the Social Security Act (the Act), specified excluded individuals are not subject to community engagement (CE) requirements as a condition of eligibility if they meet one of the criteria for any of the listed exclusions.

Mandatory exceptions. As described in Section 1902(xx)(3)(A)) of the Act, individuals with mandatory exceptions are still subject to CE requirements, but states must deem them compliant in a given month if they meet one of the mandatory exception definitions.

Optional short-term hardship exceptions. As described in Section 1902(xx)(3)(B) of the Act, states may provide exceptions to CE requirements for individuals who have experienced certain qualifying events. These individuals would be deemed compliant for the month.

Individuals must request a short-term hardship exception from the state when it is related to their use of acute care or travel outside of their community for medical services, whereas individual requests are not required for states to grant hardship exceptions related to federally declared emergencies or areas with high unemployment. A state must request CMS approval to apply a short-term hardship exception for individuals residing in counties with high unemployment.

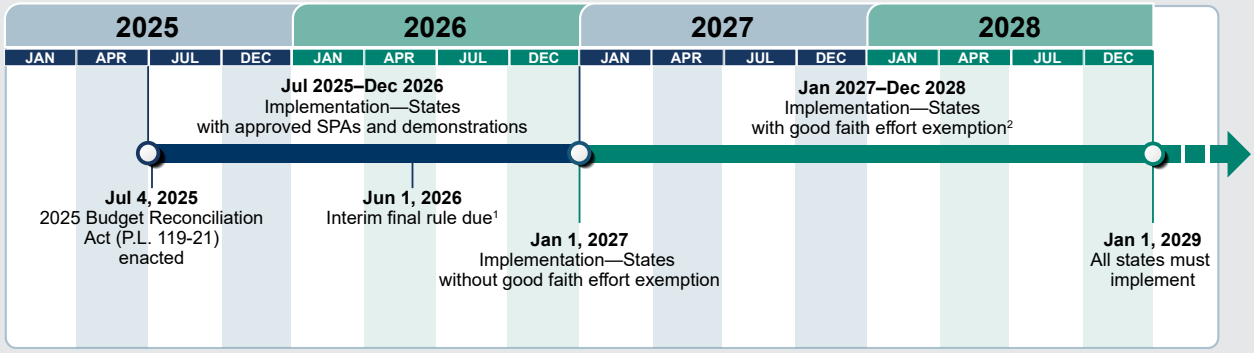
Prohibiting conflicts of interest. States cannot use a Medicaid managed care entity or other specified entity (as defined in Section 1903(m)(9)(D)) of the Act) or other contractor to determine beneficiary compliance with CE requirements unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity or other specified entity that is responsible for providing or arranging for coverage of Medicaid services for individuals enrolled with the entity under a contract with the state.

Implementation timeline. States may implement CE requirements at different times, contingent on CMS approval (Figure 1-1). The law allows states to implement the requirements before January 1, 2027, via a state plan amendment or Section 1115 demonstration. Additionally, states that demonstrate a good faith effort to implement CE requirements can receive up to two additional years for implementation (through December 31, 2028) if they request and receive the Secretary's approval for an exemption. In reviewing such requests, the Secretary must consider any actions taken by the state toward compliance, any substantial barriers to or challenges in meeting the requirements, the state's detailed plan and timeline for achieving full compliance, and any other criteria established by the Secretary. States granted an exemption must submit quarterly reports on their progress toward full compliance and information on specific risks or new challenges, including plans for mitigating such risks and challenges.

Funding. To establish systems necessary to implement CE requirements and other provisions of the law affecting Medicaid eligibility determinations or redeterminations, the law provides $200 million to the Secretary to make grants to states in fiscal year (FY) 2026. CMS distributed the first half of the funding to the 50 states and the District of Columbia in equal amounts, totaling almost $2 million for each state and the District of Columbia (Mills-Gregg 2026). CMS awarded the other half of the funding based on the number of individuals subject to the requirement in a given state relative to the total number of individuals subject to the requirement in all states as of March 31, 2025 (CMS 2026b).

To support implementation, the law also provides $200 million to the CMS administrator in FY 2026, to remain available until expended.

FIGURE 1-1. Key Dates for Implementing Medicaid Community Engagement Requirements



Notes: SPA is state plan amendment. Demonstration is Section 1115 demonstration. The 2025 Budget Reconciliation Act (P.L. 119-21) is an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14.

[1] The Secretary of the U.S. Department of Health and Human Services is responsible for issuing the interim final rule.

[2] The statute allows good faith effort exemptions to last through 2028; however, state exemptions will be granted pursuant to Centers for Medicare & Medicaid Services guidance and may extend for a period of less than two years.

Source: MACPAC, 2025, analysis of the 2025 Budget Reconciliation Act.

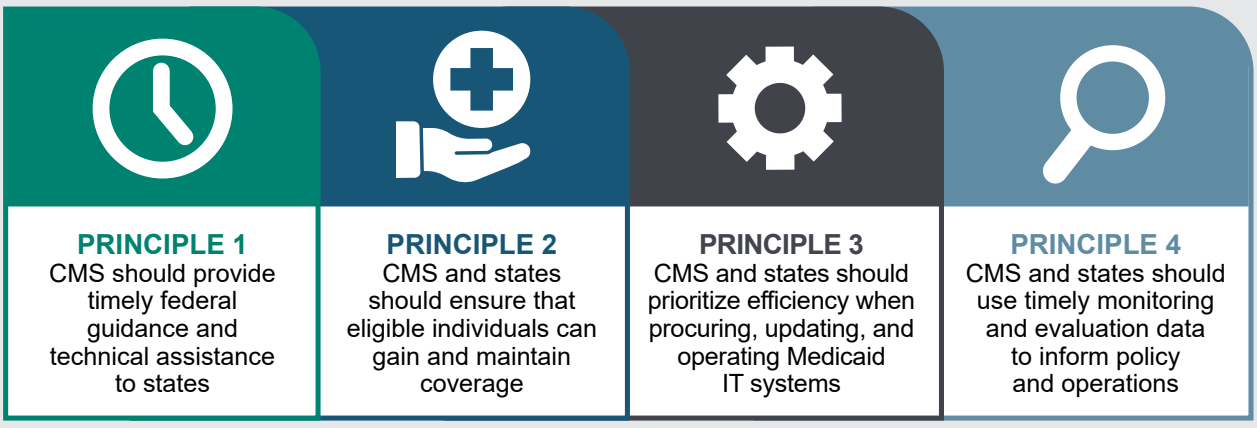
Principles for Implementing CE Requirements

MACPAC's principles for implementing CE requirements reflect the views of the Commission and findings from stakeholder interviews (Figure 1-2). The first principle speaks to the importance of CMS providing states with timely guidance and technical assistance. States are working quickly to implement CE requirements by the statutory deadline and need federal guidance and technical support in several areas. The second principle highlights the importance of CMS and states ensuring that eligible individuals can gain and maintain coverage when CE requirements take effect. The use of ex parte processes and automation will be central to avoiding inappropriate coverage losses by minimizing the need for individuals to report their compliance, exclusion, or exception status. The third principle underscores the importance of CMS and states prioritizing efficiency when procuring, updating, and operating state IT systems, particularly given the magnitude of state and federal spending on systems changes implemented under previous Section 1115 work and CE demonstrations (GAO 2025, 2019). The final principle reflects the view that CMS and states should use timely monitoring and evaluation data to inform policy and operations, and it corresponds to the Commission's recommendation on monitoring and evaluation discussed later in the chapter.

CMS should provide timely federal guidance and technical assistance to states

Early CMS engagement with states is critical to ensuring successful and timely implementation of CE requirements in Medicaid. Among stakeholders interviewed by MACPAC, there was a general recognition that to meet the January 2027 deadline, states would have to initiate key policy, operational, and systems changes well before publication of the IFR in June 2026. Interviewees suggested that CMS provide interim guidance so states could move forward with procurement and other changes that require considerable lead time. At the time of our interviews in the summer of 2025, states noted that they could wait for guidance and risk failing to meet the implementation deadline or could move forward and risk having to make potentially time-consuming and costly changes once CMS guidance is issued. States relayed that simply having a clearer understanding of the topics CMS planned to address in the IFR would help them plan and prioritize more effectively.

FIGURE 1-2. MACPAC's Principles for Implementing Community Engagement Requirements in Medicaid



Note: CMS is Centers for Medicare & Medicaid Services. IT is information technology.

CMS has published limited formal public guidance on CE requirements as of this writing in May 2026, though it has previewed guidance on select topics in state-only forums. An informational bulletin released in December 2025 reiterated the law's requirements and highlighted topics for future CMS guidance. The informational bulletin also offered new insights into CMS's interpretation of the statute regarding compliance verification at renewal. CMS explained that states must deem beneficiaries compliant if, in the period between renewals, they met CE requirements for the number of months specified by the state. States cannot dictate the specific months in which beneficiaries have to demonstrate compliance (CMS 2025a).

In addition to CMS publishing guidance, stakeholders underscored the value of scenario-based forums in which CMS could provide guidance on addressing key challenges that arise in multiple states, such as those convened during the end of the public health emergency (PHE) when states were unwinding the continuous coverage provisions in Medicaid (referred to as "PHE unwinding").[24] Stakeholders described this approach as a highly constructive way to support states. States and other stakeholders also highlighted the role that CMS could play in hosting multistate online forums that enable cross-state learning on topics such as beneficiary outreach. One state Medicaid official said that this type of sharing of effective practices was particularly helpful during the PHE unwinding.

CMS has been hosting regular state-only calls to discuss CE requirement implementation, in addition to providing other types of assistance and technical support. In January 2026, CMS announced that 10 health technology companies with existing Medicaid eligibility and enrollment contracts with states had pledged to offer more than $600 million in no-cost and substantially discounted technology products and services to support CE implementation and broader modernization of Medicaid IT systems (CMS 2026c). CMS is also offering states technical assistance with using Eligibility Made Easy (Emmy), a CMS-developed suite of open-source tools designed to streamline income and CE reporting for Medicaid applicants and beneficiaries (CMS 2026d).

A CMS-developed readiness checklist could help states assess risks and prioritize in a way that best positions them to meet the deadline for CE requirement implementation. Such a tool could be part of CMS's state readiness review process. CMS plans to use the Advanced Planning Document (APD) process to review state readiness to implement CE requirements. CMS reviews and approves APDs, which permit states to obtain enhanced federal matching funds for the design, implementation, and operation of their Medicaid IT systems. CMS described building on the APD review framework by hosting monthly calls with states to discuss the status of their Medicaid IT systems changes as well as other aspects of their implementation efforts, including policy development, staff training, and obtaining state legislative approval (Knapp 2025).

Additional considerations for CMS guidance are discussed below. We address technical assistance pertaining to specific topics, such as Medicaid IT systems, in later sections.

Good faith effort exemptions. States raised questions about the criteria and process for obtaining a good faith effort exemption, which provides additional time for implementation. Some states expressed interest in pursuing an exemption, particularly as they are working to implement other new federal requirements that require simultaneous changes to Medicaid policies, operations, and IT systems. At the time of our interviews in the summer of 2025, CMS officials said they were considering the criteria for good faith effort exemptions and planned to provide additional guidance to states. In other forums, CMS's remarks suggested that the agency anticipates granting a limited number of good faith effort exemptions.

Mandatory exclusions. Interviewees had questions about the criteria for identifying individuals who qualify for mandatory exclusions and noted areas that have a need for CMS guidance (Table 1-1). States were particularly focused on the criteria for medical frailty and expectations for verification, given how substantially CMS guidance on the topic will affect implementation. One state noted that waiting until June 2026 for guidance on medical frailty would not leave enough time to establish policies and modify their systems, including revisions to their application and renewal forms. The state described moving forward with their "best guess" about the definition and potential verification requirements for medical frailty and making modifications as needed to come into alignment with CMS guidance when it is released.

TABLE 1-1. Key Questions about Exclusions Cited by Interviewees

Topic	Key questions
Medical frailty	• What types of medical conditions will qualify an individual for an exclusion on the basis of medical frailty?
Substance use disorder treatment	• What types of substance use disorder treatment will qualify an individual for an exclusion? • How can states ensure that exclusions are made for individuals receiving medications for opioid use disorder?
Caregivers	• Will individuals caring for parents or other adult family members, including those at risk of institutionalization, qualify for an exclusion? • What is the definition of a dependent child?
Compliance with other work requirements	• What will qualify as evidence that an individual is meeting the work requirement in SNAP or TANF? • Will an individual qualify for an exclusion if they are exempt from the SNAP work requirement due to local market conditions?
Verification	• Will CMS specify claims and diagnosis codes for identifying certain exclusions? • Will a medical provider's note suffice for documentation of qualifying conditions? • To what extent will self-attestation be permitted? • How often will an individual's exclusion status be reassessed?

Notes: SNAP is the Supplemental Nutrition Assistance Program. TANF is the Temporary Assistance for Needy Families Program. CMS is Centers for Medicare & Medicaid Services.

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Optional short-term hardship exceptions. States and other stakeholders raised questions about the circumstances that will allow an individual to qualify for a short-term hardship exception and the extent to which states will be permitted to rely on self-attestation (Table 1-2). Although some states included certain events, such as bereavement and short-term illness, as qualifying hardships under their previous demonstrations, it is unclear if they will be allowed to do so when implementing CE requirements as described in the law.

It will be important that states have the flexibility to use self-attestation when the data to verify optional short-term hardship exceptions are not available. One state expressed concern about the level of documentation CMS may require from individuals seeking a short-term hardship exception, noting as an example the complications that would arise if local eligibility offices were required to collect documentation of medical service use in a different state. That scenario would require thousands of local office caseworkers to understand the short-term hardship exception policy and implement it appropriately, and it would have implications for the results of the state's payment error rate measurement (PERM) program audits.[25]

Stakeholders also raised questions about the length of the look-back period that states will be permitted to use to calculate the unemployment rate for granting hardship exceptions. This question was not addressed in MACPAC's interview with CMS; however, KFF reported that CMS officials plan to follow subregulatory guidance that already exists in other programs with similar provisions (e.g., SNAP) where possible. Current SNAP regulations allow states to waive work requirements based on 12-month average unemployment rates. KFF found that allowing states to identify counties that meet the criteria for a short-term hardship exception from Medicaid CE requirements using 6-month or 3-month average unemployment rates, in addition to a 12-month average rate, would increase the number of counties that qualify (Bell et al. 2025).

TABLE 1-2. Key Questions about Optional Short-Term Hardship Exceptions Cited by Interviewees

Topic	Key questions
Definition of hardship	• Will states be able to grant short-term hardship exceptions for any of the following events: – major weather issues (e.g., snowstorms); – transportation barriers (e.g., temporarily inoperable vehicle); – bereavement following the death of a family member; – caring for a seriously ill family member; – short-term illness (e.g., flu, COVID-19); or – divorce?
Local market conditions	• Over what period of time will states have to assess the local unemployment rate for granting short-term hardship exceptions?
Verification	• To what extent will self-attestation be permitted for certain short-term hardships (e.g., travel outside the community for medical care)?

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Definition of CE. Stakeholders expressed interest in CMS giving states flexibility to further define the criteria for meeting the CE requirement to reflect the various ways in which individuals participate in work, work programs, education, and community service. They raised questions about whether CMS would grant states such flexibility. For example, there appeared to be ambiguity about whether states would be allowed to assess an individual's hours of CE over a period of several months to account for the various factors that might result in a person working more or less than 80 hours in a given month. Similarly, it was unclear if states would be permitted to deem a non-seasonal worker compliant based on the individual's average income over a period of more than one month, as the statute provides them the option to do for seasonal workers.

States and other stakeholders noted that they need further clarity regarding the activities that would qualify as CE. Several interviewees pointed to ambiguity in the definition of the term "work program" and the need for guidance to clarify whether that includes job search activities. There was concern that people who are looking for work, including those who have been laid off, will be unable to gain or maintain Medicaid coverage. This would be a particular issue during an economic downturn that results in substantial job loss.

Some states were also seeking clarity concerning individuals participating in work programs, such as supported employment programs for individuals with behavioral health conditions, who are working toward but not yet meeting the 80-hours-per-month threshold for compliance.

Additionally, states and other stakeholders raised questions about whether activities, such as caregiving, will qualify as community service. This question could be especially relevant for individuals who provide substantial amounts of unpaid care to an elderly parent or other adult (e.g., a neighbor) but may not qualify for the caregiver exclusion.

Ex parte processes. Stakeholders raised questions about CMS's expectations for the use of ex parte verification. As states begin implementing CE requirements, stakeholders suggested they would benefit from guidance that highlights viable data sources and expectations for data recency as well as other potential guardrails related to the use of data matching. One interviewee noted that CMS provided similar guidance during the PHE unwinding, following initial confusion about what data sources could be used for income verification and the parameters for accepting data matches. Requiring states to rely on available data sources could help establish and

maintain eligibility for more people by minimizing the need for individuals to separately verify their compliance or exclusion or exception status. CMS guidance could also identify free or low-cost data sources that states should check (e.g., state quarterly wage data) before paying to access other data sources (e.g., Equifax's The Work Number).

Beneficiary supports. Some stakeholders expressed concern that the law does not require or encourage states to address factors that make it difficult for individuals to participate in CE activities and report their compliance (e.g., lack of transportation or broadband access), noting that this is an area in which CMS guidance could establish relevant expectations. CMS previously required states pursuing work and CE requirements through Section 1115 demonstrations to describe their strategies to help beneficiaries achieve compliance, including their approaches to linking individuals to additional resources for job training or other employment services, child care assistance, transportation, or other work supports (CMS 2018).

Two of the states we interviewed cited a need for CMS to clarify whether federal matching funds will be available for addressing barriers to CE and reporting. The states noted the historic lack of federal matching funds for such supports as a major challenge, particularly in light of increasingly strained state budgets. States with Section 1115 work and CE demonstrations did not receive federal matching funds for these beneficiary supports, though some received matching funds for costs associated with the development of systems that helped connect beneficiaries to employment-related resources and supports (GAO 2019, CMS 2018). States primarily relied on workforce development and other state appropriations, which may be more challenging to obtain in the current fiscal environment.

Opportunity to cure. One stakeholder noted the importance of CMS guidance to address questions about how states will operationalize the requirement that beneficiaries have an opportunity to prove their compliance, exclusion, or exception status when it cannot otherwise be determined by the state. Beneficiaries will have 30 days from receipt of the notice of non-compliance to demonstrate that they meet the requirements or risk losing coverage. However, the law does not specify the period for which a beneficiary must demonstrate their compliance. If a beneficiary is non-compliant in January and receives a notice of non-compliance in February, for example, it is not clear if they can retain eligibility by proving that they were compliant in January or February or either month.

CMS and states should ensure that eligible individuals can gain and maintain coverage

Stakeholders emphasized that states' use of ex parte processes can reduce administrative burden for beneficiaries and, in turn, minimize coverage loss among individuals who meet CE requirements or qualify for an exclusion or exception.[26] Research shows that the administrative burden individuals experience during the application and renewal process can have a substantial effect on their access to Medicaid and other safety net programs (Arbogast et al. 2024, Sommers et al. 2012, Currie 2006). Using available data to renew Medicaid eligibility has been identified as an important tool for reducing churn and coverage loss that occurs when states have insufficient information to determine eligibility (i.e., procedural denials) (Herd et al. 2025; MACPAC 2023, 2021; Ku and Platt 2022).[27]

Limited funding and time for CE requirement implementation will affect the extent to which states can use ex parte and automate data checks.[28] States currently verify income as part of the eligibility determination process; however, many will look to capture more comprehensive information, including income from gig work and self-employment. In addition, states may seek to add data sources or modify their use of existing data (e.g., claims) to make ex parte determinations of compliance, exclusions, and exceptions.

Stakeholders suggested that states prioritize using low-cost, easily accessible data sources that can provide information on a substantial share of their population, including data from other state agencies (e.g., education, corrections). States should also consider modifying the Medicaid application to collect needed information and to obtain beneficiary consent for the release of compliance information (e.g. employment records), if it is not already provided.

When data are not available to determine compliance, stakeholders suggested states provide a user-friendly, consumer-facing portal through which individuals, employers, and community service managers can submit required documentation. Commissioners noted that some systems may have the ability to pull in information from payroll records and other sources to prepopulate forms and reduce administrative burden for Medicaid applicants and beneficiaries. It will be important that states have the flexibility to accept self-attestation, especially for individuals who are new to Medicaid and those participating in community service, for whom existing data may be less readily available.

Identifying mandatory exclusions. Stakeholders identified several data sources for identifying individuals who meet exclusion criteria, including Medicaid applications, enrollment data, claims, and managed care data (Table 1A-1). The data sources and considerations for identifying excluded individuals vary by population, including whether they are newly applying for Medicaid or have prior coverage.

States are more likely to have existing data that can be used to identify exclusions for beneficiaries with prior Medicaid enrollment than they are for individuals with no prior enrollment. Because the Medicaid application functions as an initial source for gathering information on individuals applying for Medicaid, some stakeholders noted that adding targeted questions could help states identify if individuals qualify for an exclusion. States could use claims data to identify individuals with certain medical conditions that indicate they are medically frail or disabled. However, claims data do not always provide timely or reliable information for assessing beneficiaries' functional status for determining disability status. Stakeholders pointed to managed care data, including encounters and case management data, as a more timely and reliable data source. For example, states could use their managed care organization (MCO) case management algorithms to identify excepted population groups, such as pregnant or disabled individuals. One state noted that they are considering using their health information exchange as a real-time data source for identifying some of these populations.

Verifying employment. Verifying traditional employment will pose fewer challenges than verifying non-traditional employment (e.g., gig workers and babysitting), community service, and engagement in multiple qualifying activities. Most states and other stakeholders noted that wage and income data will likely be the primary data sources used to verify employment. States already use wage and income data for determining Medicaid income eligibility; however, implementing CE requirements will require states to use those data in new ways.

The two main data sources identified in our interviews were state quarterly wage data and Equifax's The Work Number (Table 1-3). Quarterly wage data include individual-level, gross income data reported by employers in the state. Many states and stakeholders noted that one of the main advantages of state quarterly wage data is that it is free to states and could cover a sizeable share of the population. However, they also noted that the data are not timely and do not include income from non-traditional employment (e.g., gig work). The Work Number is a database that provides verification services, such as employment and income verification, for commercial and government entities, charging users per query.

Although The Work Number provides more timely and detailed income data (i.e., it is not aggregated and includes deductions) relative to state quarterly wage data, stakeholders consistently raised concerns about the cost to states. For example, the cost of North Carolina Medicaid's Equifax contract nearly doubled in recent years, going from $11.6 million in 2022 to $22.5 million in 2025 (Kliff et al. 2025). Stakeholders also cautioned that The Work Number may not include a large portion of the population in some states.

Several stakeholders noted that the Federal Data Services Hub (the Hub), through which states can access multiple data sources for determining Medicaid eligibility, is a tool that CMS could leverage to offer free or lower-cost access to The Work Number, which would prevent states from having to negotiate individual contracts with Equifax. Currently, states can access The Work Number through the Hub under CMS's national contract, which establishes standardized pricing and query parameters, and states are responsible for their usage costs. One state Medicaid agency official expressed interest in states being able to access The Work Number data without charge under CMS's national contract, as was previously allowed during the PHE unwinding. Another

expert suggested this could be done on a short-term basis as states begin implementing CE requirements to alleviate initial cost pressures and the challenge of establishing ex parte verification of qualifying work activities in a short period of time.

Individuals who are self-employed or engage in gig work often do not receive conventional pay stubs, making their income difficult to verify using traditional wage and income data and requiring states to consider other approaches. Several stakeholders highlighted CMS's consent-based verification application, Emmy, as a way to address these challenges by enabling income reporting for gig and self-employed workers.[29] Emmy and other consent-based verification tools are newer forms of income verification that allow users to log into their personal payroll, bank, or other accounts and consent to sharing their income information with the state, upon the state's request when needed to determine Medicaid eligibility.[30] CMS is piloting Emmy in several states and plans to add modules for CE, such as education and volunteering verification (Singleton and Wagner 2026).

Stakeholders shared several other ideas for employment verification. Some suggested that states or CMS could work with the employers that employ the largest share of Medicaid beneficiaries and develop an automatic feed of needed information with the employees' consent or could create a streamlined process for reporting compliance. In Georgia, beneficiaries use an electronic verification system that can be linked to the employer for employment verification; if the employer is not listed in the system, beneficiaries can upload supporting documentation directly through that system. Another stakeholder suggested the use of e-mail parsing, which is a process of automatically extracting information from e-mails. For example, a beneficiary could e-mail their supporting documentation to a master e-mail address that automatically attributes the information to that beneficiary, reducing the need for manual attribution (this could be a tool for verifying compliance through employment as well as other qualifying activities, including community service).

TABLE 1-3. Summary of Considerations Regarding Most Commonly Identified Wage Data Sources Cited by Interviewees

Attribute	Quarterly wage data	Equifax's The Work Number
Contents	• Individual-level gross income data reported by employers in the state, typically aggregated to the quarter	• Detailed, net income data
Data frequency	• Quarterly (lagged by up to three months)	• Real-time data (though this can vary based on various factors)
Advantages	• Free data source • Could provide data for a sizeable share of individuals	• Timely data • Detailed income information (including deductions)
Limitations	• Data are not timely • Data lack details • Share of individuals included in data can vary • Does not include non-traditional employment	• Costly • Timeliness of data can vary • Share of individuals included in data can vary • Does not include non-traditional employment

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Verifying enrollment in education. Stakeholders noted using school enrollment data as one of the main data sources for verifying enrollment in educational programs. Two states shared that they are working with their departments of education to determine what school enrollment data can be shared to verify compliance. In Georgia, the only state with an active work and CE requirement demonstration, one stakeholder noted that beneficiaries can submit their class schedule as evidence to demonstrate compliance with the requirements.

Verifying community service participation. States and other stakeholders generally agreed that verifying community service will be challenging, and a few offered ideas that states may consider. For example, state Medicaid agencies could leverage the processes their judicial systems use for verifying court-mandated community service. Another option noted was accepting beneficiary-submitted documents, such as a calendar noting the days community service was completed or a signed letter from the organization noting the number of community service hours completed as well as a supervisor's contact information for verification.

Self-attestation. It will be important that states have the flexibility to allow individuals to self-attest to their compliance, exclusion, or exception status when data are not immediately available to verify their circumstances. This flexibility will be particularly important for new applicants, for whom the state does not have claims or other information to determine compliance, exclusions, and exceptions, as well as for individuals who participate in community service or non-traditional employment (e.g., babysitting), for which the state cannot access third-party data. Some interviewees noted that self-attestation is an existing practice in the eligibility determination process, and therefore, it should be acceptable for determining CE compliance as well.

Conducting beneficiary outreach. MCOs and community partners can play a critical role in effective beneficiary outreach. One outreach strategy is for states to leverage trusted community organizations such as food banks, community health centers, pharmacies, and faith-based organizations to share information and help beneficiaries navigate the new requirements. Another strategy, which proved effective during the PHE unwinding, is for states to partner with MCOs to obtain more current and reliable beneficiary contact information and to support community outreach efforts.[31] Stakeholders also emphasized the importance of notices written in clear and plain language to promote beneficiary comprehension and urged states to use multiple means of communication to ensure information reaches targeted individuals.

One stakeholder, drawing on experience from the PHE unwinding, highlighted the importance of CMS guidance on allowable outreach activities by states and MCOs, which encourages the use of text messaging, including through platforms such as WhatsApp, to raise awareness about CE requirements and collect needed information from beneficiaries. States have found that some beneficiaries are more likely to respond to text messages than to other communications, such as mail or e-mail (Boozang et al. 2023). Reflecting on the PHE unwinding, the interviewee underscored the efficacy of text messaging and prior confusion around its use, which was later clarified in a ruling by the Federal Communications Commission (FCC 2023).

Assistance with beneficiary reporting. Several stakeholders expressed expectations that states will offer beneficiaries assistance in meeting and reporting their compliance with CE requirements. For example, states could use enrollment assisters, enhanced call center capacity, and application kiosks in public libraries to help individuals complete the application and compliance verification process. This type of assistance is particularly important for older adults who might require more support using technology to submit required documentation. Several stakeholders also suggested that states provide beneficiaries with a list of organizations (for employment or community service opportunities) that have an established verification process with the state.

CMS and states should prioritize efficiency when procuring, updating, and operating Medicaid IT systems

Prior state experience suggests that Medicaid IT systems changes associated with implementing CE requirements will be costly for states and the federal government, which provides enhanced matching funds for the design, development, and implementation of Medicaid IT systems (CMS 2025a).[32] The GAO found that IT systems changes accounted for the largest share of administrative spending for Georgia's Pathways demonstration ($50.8 million out of a total of $54.2 million in administrative expenditures) in FY 2021 through the second quarter of FY 2025. Georgia made a range of changes to its eligibility and enrollment system before and after launching the demonstration, changes that stakeholders noted are likely to be mirrored in other states as they establish processes for determining compliance, exclusions, and exceptions. For example, Georgia added functionality to allow beneficiaries to report engagement in qualifying activities, in addition to automating the verification of some qualifying activities. The state made additional systems changes later on to streamline income verification and other processes (GAO 2025).

The magnitude and cost of required system change will depend, in part, on the state's Medicaid IT infrastructure—for example, whether a state has a legacy or more recently modernized system or if its system is integrated with other human services programs (e.g., SNAP and TANF). To verify compliance and determine exclusions and exceptions, states will need to assess what data they have and what data they need, assess what new functionality is required, and establish the minimum viable product by their implementation date.[33] These decisions will inform what systems changes are feasible by the implementation deadline, including the extent to which states prioritize automation.

States will need greater initial investments of resources and time to incorporate new data sources into their workflows in an automated way, compared to adding a data source that is used for manual verification. For example, a state could have caseworkers manually enter information from a new data source into a beneficiary's record or have their system automatically extract and incorporate information from the data source without requiring manual entry. The Commission's prior work found that automating ex parte processing for renewals can free up staff time for other eligibility-related tasks, such as responding to new applications or processing renewal forms completed by beneficiaries whose eligibility could not be renewed on an ex parte basis. Moreover, increasing automation can reduce the amount of training required to ensure that eligibility case workers understand complex renewal processes; the training typically demands considerable time and investment, especially during periods of high staff turnover (MACPAC 2023).

States and other stakeholders expressed concern that states may not be able to competitively procure a vendor to implement the needed systems changes due to the short implementation timeline, leading to concerns about unfair pricing. States may therefore be limited to using their current vendor to make changes, which could result in higher expenses for lower-quality work.[34] To help mitigate those concerns, stakeholders and states suggested that CMS offer states support in the procurement process to make needed Medicaid IT systems changes. They noted that CMS has a stake in ensuring this process is efficient and cost effective because the federal government will pay an enhanced share of the cost. Several stakeholders suggested that CMS provide states with an estimated cost range for the required systems changes, which could provide helpful parameters for state-vendor negotiations. CMS could leverage the APD process by informing states and vendors that APDs with a scope or cost beyond the expected range will be subject to greater scrutiny and require further justification. During the PHE unwinding, CMS worked with states and vendors to troubleshoot issues, which stakeholders noted that states found helpful.

As noted, CMS published a list of vendors that are offering no-cost and discounted health technology solutions to support CE requirement implementation (CMS 2026c). To help with state procurement of these solutions with transparent pricing, CMS has encouraged states and vendors to consider participating in the General Services Administration Schedule. The General Services Administration Multiple Award Schedule's Cooperative Purchasing Program is a contracting vehicle that states can use to procure products and services from certain vendors through a streamlined process, whereby vendors have agreed to certain prices with prenegotiated terms (CMS 2026e, 2026f).

States and other stakeholders raised additional ideas about the APD process, including whether CMS could streamline it for IT systems changes associated with CE implementation. States have a limited window in which to make changes to their IT systems, and gaining approval of their APDs is a central component of that effort. One expert expressed concern that CMS will not have adequate staff and resources to review and approve APD requests in a thorough and timely manner. Identifying ways to streamline and expedite that process could alleviate resource and time constraints for states as well as CMS. One way to do that could be for CMS to create a template of standard business requirements (i.e., expected system capabilities) that could be shared with vendors to streamline APD approval.

CMS and states should use timely monitoring and evaluation data to inform policy and operations

Reflecting on previous state demonstrations and the PHE unwinding, stakeholders underscored the importance of monitoring to identify and address issues that may contribute to coverage loss among eligible individuals. CMS shared that it intends to monitor CE implementation and is using the experience from PHE unwinding to inform the agency's approach. Several interviewees also highlighted the need for evaluation to assess whether CE requirements further the goals of improving health and increasing employment, particularly given the level of administrative spending that is anticipated for implementing and maintaining the requirements. Although states were required to conduct independent evaluations of their Section 1115 work and CE demonstrations, most demonstrations did not proceed far enough to allow for evaluation results, and findings from other evaluations are limited. Georgia, the only state with existing work and CE requirements, is in the fourth year of its demonstration, and the state's interim evaluation includes findings for the demonstration's first 13 months.[35]

Monitoring and evaluation are distinct activities with different purposes and timing. Monitoring provides ongoing updates on implementation and collects data on process and outcome measures, which may help states and CMS identify whether policy or operational adjustments are needed. Evaluations often take several years and are completed after a policy has been implemented for a specified period; their purpose is to assess whether policies have achieved their goals and to inform decisions about the future of the policy being evaluated (MACPAC 2020a).

CMS and other stakeholders regularly use state-reported data on eligibility operations, enrollment, and service utilization for program monitoring, policy development, and research. States submit these data through a variety of reporting mechanisms, including performance indicator data, eligibility processing data, and the Transformed Medicaid Statistical Information System (T-MSIS).[36] States were first required to submit eligibility processing data during the PHE unwinding to provide insight into their renewal processes and outcomes (CMS 2024c).[37] CMS used eligibility processing data as well as performance indicator and T-MSIS data to publish a monthly snapshot on key eligibility and enrollment metrics during the PHE unwinding. The monthly snapshot provided transparency into states' eligibility operations and enrollment as states resumed routine redetermination activities. CMS continues to publish the monthly snapshot, though it is no longer statutorily required to make public certain monthly data about activities related to eligibility determinations and redeterminations.

Several stakeholders and CMS pointed to the PHE unwinding as a useful model for the development of metrics for monitoring CE requirement implementation. In developing PHE unwinding metrics, CMS reviewed other data states were reporting to prevent duplication, seeking a balance between data needed for monitoring and state reporting burden. Additionally, to ease the submission process, CMS directed states to report these data using the same timelines and platforms they use to submit existing performance indicator data (CMS 2022b).[38] Stakeholders noted that some states made additional data publicly available during the PHE unwinding, including through the development of public-facing dashboards, and states used those data to identify issues and adjust their outreach and other strategies accordingly.

Stakeholders stressed the importance of selecting meaningful metrics and identified several that CMS may consider for state reporting. Table 1-4 lists these potential metrics and their data sources and notes whether the data are currently publicly available.

TABLE 1-4. Potential Metrics for Monitoring Eligibility and Enrollment Effects following Implementation of Medicaid Community Engagement Requirements

Metric category	Proposed metric	Data source	Publicly available?
Call centers	Average call center wait times	PI	Yes
	Average call center abandonment rate	PI	Yes
Applications	Number of applications received	PI, EP	Yes
	Processing time for determinations at application	PI	Yes
	Number of pending applications or redeterminations	PI, EP	Yes
	Total number of individuals determined eligible at application	PI	Yes
	Total number of individuals determined ineligible at application	PI	No
	Total number of individuals determined ineligible at renewal	EP	Yes
	Total number of individuals determined ineligible, by reason for termination (e.g., due to non-compliance with CE requirements)	Not collected[1]	–
Renewals	Number of renewals up for annual redetermination	PI, EP	Yes
	Total number of individuals determined eligible at annual renewal	PI, EP	Yes
	Number of renewals completed on an ex parte basis	EP	Yes
Enrollment	Total Medicaid enrollment	PI, T-MSIS	Yes
	Total Medicaid disenrollment[2]	PI, T-MSIS	Yes
CE	Number of Medicaid beneficiaries subject to CE requirements • Number of Medicaid beneficiaries subject to CE requirements who qualify for an exclusion or exception • Number of Medicaid beneficiaries subject to CE requirements that lose coverage due to non-compliance	Not collected	–
	Number of Medicaid beneficiaries subject to CE requirements who qualify for an exclusion or exception, identified on an ex parte basis • Non-compliance due to not meeting CE requirements • Non-compliance due to not submitting evidence of compliance	Not collected	–
	Number of Medicaid beneficiaries subject to CE requirements satisfying the requirements, total and by each type of qualifying activity (i.e., employment, school, community service, or a combination) • Number of Medicaid beneficiaries satisfying the requirements, verified on an ex parte basis, total and by type of qualifying activity • Number of Medicaid beneficiaries satisfying the requirements, verified manually, total and by type of qualifying activity	Not collected	–

Notes: PI is Medicaid and State Children's Health Insurance Program performance indicator data. EP is Medicaid and State Children's Health Insurance Program eligibility processing data. CE is community engagement. T-MSIS is Transformed Medicaid Statistical Information System. The metrics in this table were recommended by stakeholders and are meant to be illustrative.

– Dash is not applicable.

[1] PI and EP data include information about procedural denials that occur when the state does not have sufficient information but do not provide more specific reasons for why individuals were determined ineligible.

[2] Medicaid disenrollment is not reported as a standalone metric but can be determined by calculating the difference between the enrollment in the month of interest and the prior month.

Sources: MACPAC, 2025, analysis of stakeholder interviews; 2025 PI data dictionary; and 2025 EP data report specifications.

Although the CE-specific metrics would require new state reporting, CMS collects and publishes most of the other suggested metrics (e.g., call centers, applications, and renewals).[39]

Commission Recommendation

The Commission's research findings highlight the importance of monitoring and evaluation to help states and CMS identify needed policy or operational adjustments and to assess whether the requirements further the stated goals of improving health and increasing employment. The Commission therefore recommends that CMS develop a plan for monitoring and evaluating CE requirements.

Recommendation 1.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

Rationale

MACPAC's research highlights the need for monitoring changes in eligibility and enrollment following CE requirement implementation. Realized and projected changes in enrollment resulting from Section 1115 work and CE demonstrations in several states suggest that CE requirements can lead to substantial disenrollment of otherwise eligible beneficiaries, including among individuals who meet the requirements or qualify for an exclusion or exception. Monitoring is needed to help CMS and states identify trends and areas requiring policy or operational adjustments to mitigate coverage loss among eligible individuals. Monitoring can also assist in identifying effective practices that other states may wish to replicate.

The 2025 Budget Reconciliation Act did not establish requirements for monitoring implementation of CE requirements. CMS has the authority to collect and publish data for program monitoring and has previously exercised this authority in response to major policy changes, such as the PHE unwinding.[40] CMS indicated that the agency is developing a monitoring plan that will leverage existing metrics and data and include new CE-specific metrics. However, as of May 2026, CMS has not publicly released details of the plan, and it was unclear if those plans or resulting state reporting would be made public.

With input from states, beneficiaries, and other stakeholders, CMS should develop and make public a monitoring plan that includes new, meaningful metrics for tracking changes in eligibility and enrollment associated with CE requirements, such as those suggested by stakeholders in Table 1-4. Although states already submit eligibility and enrollment data, additional publicly reported metrics are needed to track CE requirement compliance and exceptions and the extent to which such determinations are made ex parte. It will also be critical to monitor procedural denials and disenrollment among individuals subject to CE requirements, which can indicate whether individuals are facing administrative barriers to completing the application or redetermination process (e.g., difficulty using online portals for reporting their compliance). Tracking metrics over time and stratifying data by certain characteristics, such as demographic characteristics, eligibility group, and application type (i.e., new applications and renewals), may help identify targeted areas in need of policy or operational adjustments.

CMS should share its monitoring plan in a transparent and timely manner so states have time to modify their IT systems accordingly. To the greatest extent possible and to minimize state burden, CMS should leverage data that are already collected and use existing mechanisms for new state reporting, as they did during the PHE unwinding. Additionally, CMS should make state reporting publicly available on a monthly basis and provide context to aid interpretation, such as

information about state variations that may contribute to differences in reporting.

Although monitoring can help identify needed policy and operational adjustments, a federally led evaluation would provide insight into how CE requirements affect employment, health, and other outcomes of interest. Policies that make participation in work and other CE activities a condition of Medicaid eligibility are relatively new and have not been widely evaluated. Among other outcomes, CMS should evaluate the extent to which CE requirements contribute to churn as well as changes in health care access and health status among individuals who are disenrolled and later reenrolled in Medicaid. CMS should also consider approaches to assessing health status, employment, and coverage among individuals who were disenrolled due to CE requirements and did not later return to Medicaid.

Evaluation is also needed to assess state and federal administrative spending associated with implementing and maintaining CE requirements, which prior experience suggests will be substantial. Local government spending should also be considered in states where counties or municipalities are responsible for processing Medicaid applications and renewals. In these instances, local governments will have to invest additional resources to hire and train staff, upgrade IT systems, update policies and procedures, and implement other changes to operationalize CE requirements. Tracking administrative spending will help policymakers consider the cost-effectiveness of CE requirements by providing insight into the financial investment required to operationalize them relative to any realized gains in employment or other potential benefits.

CMS has the authority to evaluate Medicaid policies and is developing a plan for evaluating CE requirements. States may choose to sponsor independent evaluations of CE requirements in their states; however, it is unclear how many will do so. Designing and carrying out a rigorous evaluation requires staff and financial resources, and such state efforts may be limited by competing priorities and increased budget pressures. In addition, states often experience methodological and administrative challenges in carrying out rigorous evaluations, despite federal efforts to improve the quality of state-led evaluations (MACPAC 2020a).[41]

HHS has conducted federal evaluations of state policy changes and can draw on that experience to evaluate the effect of CE requirements. In doing so, HHS should solicit stakeholder input and consider past evaluation approaches, such as the meta-analytic approach used for evaluating Section 1115 substance use disorder and serious mental illness or serious emotional disturbance demonstrations under contract with qualified health services researchers. This approach would allow CMS to assess whether CE requirements are meeting the desired goals in the states selected for study and provide insight into state variations that may contribute to different outcomes. These evaluation efforts would be aided by HHS's timely access to certain federal data sources, such as T-MSIS and employment data from the Internal Revenue Service.

In addition to carrying out and making public the results of a full-scale, multiyear evaluation, CMS should prioritize the development and publication of rapid cycle evaluation reports that provide timely, actionable insights to support continuous improvement. For example, these reports could examine how states make the CE requirements operational (e.g., their processes for determining medical frailty and data sources used to verify compliance) and consider the relationship between state policies and relevant process measures, such as rates of ex parte and procedural terminations. Other reports could focus on the experience of individuals subject to CE requirements to understand factors that contribute to the successful fulfillment of CE requirements as well as coverage denial and termination. Rapid cycle evaluation could also examine the implications of CE requirements on MCOs and safety net providers, particularly in rural areas. It will be important to understand how the requirements affect the stability of providers (e.g., by assessing levels of uncompensated care or bad debt) as well as MCOs, which may experience changes in the risk profile of their enrolled members.

Implications

Federal spending. The CBO estimates this recommendation would increase federal direct spending by less than $10 million over a 10-year period. The increase in spending would be associated with the federal match for administrative costs associated with states collecting data in standardized formats and reporting new metrics.

States. This recommendation would require states to collect and submit additional data to CMS. CMS could elect to use existing reporting mechanisms to minimize state reporting burden. Additionally, data collected and reported for monitoring could support states in their own monitoring and program improvement efforts.

Enrollees. This recommendation would not have a direct effect on enrollees. However, this recommendation could help safeguard coverage for eligible individuals by enhancing state and federal monitoring of eligibility and enrollment trends that might signal coverage loss or inability to gain coverage among individuals who meet or should not be subject to CE requirements. Also, evaluation of CE requirements, particularly rapid cycle evaluation reports, could help states and CMS identify and address issues that affect coverage.

Plans. This recommendation would not have a direct effect on managed care plans. However, managed care plans may benefit from increased transparency into eligibility and enrollment trends that affect their business model.

Providers. This recommendation would not have a direct effect on health care providers. However, providers may benefit from transparent monitoring of eligibility and enrollment changes to the extent that such activities help CMS and states ensure that individuals who are eligible for Medicaid can gain and maintain coverage.

Looking Ahead

Implementation of CE requirements will require substantial effort and resources from CMS and states and will affect Medicaid eligibility and enrollment moving forward. The Commission will continue to monitor federal and state activities related to CE requirements in Medicaid and identify areas in which additional analysis may inform policymakers.

Endnotes

[1] Beneficiaries in the new adult group are individuals age 19–64 with incomes up to 133 percent of the federal poverty level who are eligible to enroll under the state plan in the adult group described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Section 71107 of the 2025 Budget Reconciliation Act requires states to redetermine eligibility for individuals in the adult expansion group every six months.

[2] MACPAC conducted 22 interviews between June and August 2025. Interviewees included representatives from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, national associations, beneficiary advocacy organizations, and vendors as well as subject matter experts from think tanks, academia, and consulting firms.

[3] The expert panels included two Medicaid directors, an enrollment assister, a Medicaid systems expert, and representatives from CMS and the National Association of Medicaid Directors.

[4] TANF provides cash assistance and other benefits and services to families with low incomes. Most adults in the program are required to work or participate in related activities, such as job search or training (Falk 2023). SNAP is a much larger program than TANF that helps individuals and households with low incomes purchase food. Relative to TANF, fewer adults in SNAP are subject to work requirements; however, the 2025 Budget Reconciliation Act expands the SNAP work requirement by applying it to older adults and parents and caregivers of dependents age 14 and older and by restricting states' abilities to waive the requirement in areas with high unemployment (NACo 2025, CBO 2022).

[5] Several optional Medicaid eligibility groups, such as Medicaid buy-in, condition Medicaid eligibility for certain beneficiaries with disability on earned income (Balanced Budget Act of 1997, P.L. 105-33; Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170).

[6] Section 1115 of the Act provides the federal government with broad authority to waive federal Medicaid requirements to allow states to make changes to their Medicaid programs. Specifically, this authority allows the Secretary of the U.S. Department of Health and Human Services (the Secretary) to waive most of the requirements under Section 1902 of the Act to the extent necessary to enable a state to carry out an experimental, pilot, or demonstration project that the Secretary deems likely to assist in promoting the objectives of Medicaid.

[7] Examples include Medicaid buy-in programs that allow workers with disabilities to earn higher incomes and still maintain Medicaid coverage, voluntary work and job-training referral programs, and other employment supports. These eligibility groups were established with the goal of preserving the Medicaid eligibility of individuals who would otherwise lose coverage due to their earned income. Historically, participation has been optional (i.e., not a requirement of eligibility) and focused on people with disabilities or people who are receiving home- and community-based services under state plan authority in Section 1915(c) or Section 1915(i) of the Act (CMS 2018).

[8] The 13 states with approved demonstrations were Arizona, Arkansas, Georgia, Indiana, Kentucky, Maine, Michigan, Nebraska, New Hampshire, Ohio, South Carolina, Utah, and Wisconsin.

[9] Arkansas and Georgia were the only two states that implemented their demonstrations for more than a few months due to litigation and the Biden administration's decision to rescind approval for work and CE demonstrations. A federal judge allowed Georgia's Pathways to Coverage demonstration to proceed because it applies work and CE requirements to a newly eligible population. Georgia's demonstration is the only one still in operation.

[10] In March 2019, the U.S. District Court for the District of Columbia vacated CMS's approval of the Arkansas Works demonstration and remanded it to CMS for further review. The U.S. Court of Appeals for the District of Columbia Circuit upheld that decision in February 2020. The Biden administration later withdrew CMS's approval of Arkansas's demonstration.

[11] The data on Georgia's demonstration in Box 1-1 are from the interim evaluation report prepared by the Public Consulting Group in December 2024, which provides application and enrollment information from the first year of Georgia's Pathways to Coverage demonstration (CMS 2026a).

[12] The five states that the GAO examined were Arkansas, Indiana, Kentucky, New Hampshire, and Wisconsin. The GAO examined administrative spending from the start of each demonstration (between 2016 and 2018, depending on the state) through 2018 (GAO 2019).

[13] Other estimates of potential coverage losses are higher than those provided by the CBO. The Center for Budget and Policy Priorities, for example, estimates that 7.1 million fewer people will have coverage in 2034 as a result of Medicaid CE requirements (Zhang and Lukens 2025).

[14] IFRs are promulgated without advanced notice and comment. Agencies solicit public comment after publishing the IFR, which may go into effect as soon as 30 days later. The agency subsequently issues a final rule that may reflect public feedback (Nielsen 2023).

[15] Minimum essential coverage is defined in Section 1902(xx)(9)(A)(i)(II)(aa) of the Act. CMS is evaluating which populations enrolled through a Section 1115 demonstration will be subject to CE requirements, beyond those in Georgia and Wisconsin (CMS 2025a).

[16] An educational program includes an institution of higher education, as defined in Section 101 of the Higher Education Act of 1965 (P.L. 89-329), and a program of career and technical education, as defined in Section 3 of the Carl D. Perkins Career and Technical Education Improvement Act of 2006 (P.L. 109-270). A work program, defined in Section 6(o)(1) of the Food and Nutrition Act of 2008 (P.L. 88–525), includes certain approved federal, state, and veteran employment and training programs but excludes job search–only programs.

[17] The federal minimum wage at the time of this writing in May 2026 is $7.25 per hour, and the income threshold for meeting the 80-hour requirement is $580.

[18] Seasonal worker, defined in Section 45R(d)(5)(B) of the Internal Revenue Code of 1986 (P.L. 99-514), is a worker who performs labor or services on a seasonal basis, as defined by the Secretary of Labor, and retail workers employed during holiday seasons.

[19] Section 71107 of the 2025 Budget Reconciliation Act requires states to redetermine eligibility for individuals in the adult expansion group every six months. Unlike the CE requirement, the six-month renewal requirement does not apply to states that cover a portion of the expansion population through a waiver (e.g., Georgia and Wisconsin).

[20] This includes American Indian or Alaska Native individuals who meet one of the following criteria: is an Indian or an Urban Indian (as defined in paragraphs (13) and (28) of §4 of the Indian Health Care Improvement Act (P.L. 94-437)), is a California Indian (as described in §809(a) of such act), or has otherwise been determined eligible as an Indian for the Indian Health Service under HHS regulations (CMS 2025a).

[21] Specified excluded individuals include veterans with a total disability rating (38 USC § 1155). A total (100 percent) disability rating is the highest rating assigned by the U.S. Department of Veterans Affairs for service-connected compensation purposes. This rating is reserved for veterans with extremely debilitating service-connected conditions, which typically make them unable to work and care for themselves. Veterans must meet strict criteria to qualify for this rating (Chisholm Chisholm & Kilpatrick 2026).

[22] An individual must be participating in a drug use disorder or alcohol use disorder treatment and rehabilitation program as defined in Section 3(h) of the Food and Nutrition Act of 2008, which means any such program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under part B of Title XIX of the Public Health Service Act (42 USC. § 300x et seq.) to provide treatment that can lead to the rehabilitation of individuals with drug use disorder or alcohol use disorder.

[23] The term "serious or complex medical condition" is not defined in reference to hardship exceptions or the definition of a specified excluded individual.

[24] During the PHE, the Families First Coronavirus Response Act (P.L. 116-127) provided states with a temporary increase in the federal medical assistance percentage (FMAP) if they met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. The Consolidated Appropriations Act, 2023 (P.L. 117-328) decoupled the end of the continuous coverage requirement from the PHE and established March 31, 2023, as the end of the continuous coverage requirement, after which time states would need to begin redetermining eligibility for Medicaid beneficiaries.

[25] The purpose of the payment error rate measurement (PERM) program is to measure and report an unbiased national improper payment rate for Medicaid and the State Children's Health Insurance Program (CHIP) as required by federal law. PERM counts a payment as an error if the payment or eligibility decision did not comply with applicable federal regulations and state policies. Improper payments include both expenditures that should not have occurred and instances in which insufficient or no documentation is available to support the payment or eligibility decision as proper (MACPAC 2020b). Improper payments are erroneous but are not necessarily the result of fraud.

[26] Administrative burden for individuals includes three components: (1) learning costs, including time and effort needed to learn about a program and how to gain access; (2) compliance costs, including the provision of information and documentation to demonstrate eligibility; and (3) psychological costs, including stress that arises from uncertainty about one's ability to navigate the eligibility process (Herd and Moynihan 2025).

[27] "Churn" refers to a short-term break in coverage wherein a beneficiary is disenrolled from the program and then reenrolled shortly thereafter (often measured within a 12-month time frame). Churn can be an indicator of administrative barriers that disrupt coverage for beneficiaries who continue to meet income and other eligibility requirements (MACPAC 2021).

[28] For Medicaid renewals, some states currently use fully automated data checks, in which computer programs automatically connect to electronic data sources and compare results to the applicable income and asset thresholds. However, full automation is not required to achieve a high rate of ex parte renewals. Some states using a combination of manual and automatic procedures have been able to renew more than 50 percent of their Medicaid beneficiaries via ex parte processing (Brooks et al. 2023, MACPAC 2023).

[29] Emmy was previously known as "Income Verification as a Service," or "IVaaS."

[30] In addition to Emmy, other consent-based verification options include Argyle, Digital Consent-based Income Tool by Digital Public Works (now called Verify My Income), Income Passport by SteadyIQ, and Truv (Singleton and Wagner 2026).

[31] Relatedly, 32 states received time-limited authority under Section 1902(e)(14)(A) of the Act during the PHE unwinding to accept updated beneficiary contact information from managed care plans without first contacting the beneficiary to confirm the accuracy of the updated information (CMS 2024a, 2022a).

[32] Consistent with long-standing Medicaid law, states may receive enhanced federal matching funds for costs associated with their Medicaid IT systems, including changes necessitated by CE requirements. CMS will provide a 90 percent match for the design, development, and implementation of IT systems and a 75 percent match for the maintenance and operations of these systems (CMS 2025a).

[33] Minimum viable product is an IT product that meets basic requirements but will continue to be improved to comprehensively meet states' requirements.

[34] Without competition, vendors may not feel the pressure to offer the best price, and states would lose the opportunity to consider other vendors that may be better positioned to meet the state's objectives.

[35] The interim evaluation report prepared by the Public Consulting Group in December 2024 provides application and enrollment information from the first year of Georgia's Pathways demonstration. The interim evaluation found that Pathways enrollment was lower than expected; only 4,300 individuals were enrolled compared to the state's projection of 25,000. Among applicants eligible for Pathways, not accounting for the work and CE requirement, 28 percent were denied coverage due to failure to report a sufficient number of hours of participation in a qualifying activity. This percentage was higher (39 percent) among older applicants age 50–64 years (CMS 2026a). A summative evaluation report is due to CMS within 18 months of the end of the demonstration period, currently slated for December 31, 2026 (CMS 2025b, 2024b).

[36] Performance indicator data refer to data from the Medicaid and CHIP Eligibility and Enrollment Performance Indicators project. Eligibility processing data refer to Medicaid and CHIP Eligibility Processing Data.

[37] Section 5131(b) of the Consolidated Appropriations Act, 2023 required that states submit to CMS, and CMS then make public, certain monthly data about activities related to eligibility determinations and redeterminations conducted between April 1, 2023, and June 30, 2024. Although the statutory requirement has since lapsed, CMS continues to require states to report these metrics and then makes them public (CMS 2024a).

[38] States submit monthly performance indicator data on key Medicaid and CHIP operations, including enrollment, total applications, and modified adjusted gross income application processing.

[39] States submit specific metrics to CMS about Medicaid and CHIP renewals initiated and completed for a given month. These metrics support CMS efforts to monitor states' retention and disenrollment of Medicaid and CHIP beneficiaries through the eligibility renewal process. States submitted their first eligibility processing data reports in February, March, or April 2023, depending on the state. These data were used to monitor state unwinding activities (CMS 2025c).

[40] CMS has the authority to collect needed information from states under Sections 1902(a)(4)(A), 1902(a)(6), and 1902(a)(75) of the Act to ensure proper and efficient administration of the Medicaid program.

[41] Prior MACPAC work identified these challenges with respect to Section 1115 demonstration evaluations; however, the methodological and administrative challenges identified are likely also relevant for states evaluating CE requirements under the state plan.

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APPENDIX 1A: Data Sources and Considerations for Identifying Mandatory Exceptions

TABLE 1A-1. Examples of Potential Data Sources and Relevant Considerations for Identifying Individuals Excluded from Community Engagement Requirements Cited by Interviewees

Excepted population group	Potential data sources	Considerations
Youth formerly in foster care	• Enrollment data	Identifying youth formerly in foster care could be challenging, particularly for individuals formerly in out-of-state foster care.
American Indians or Alaska Natives	• Enrollment data	None identified in our interviews with select stakeholders.
Parents, guardians, caretaker relatives, or family caregivers[1]	• Enrollment data • Claims or managed care encounter data	States could use enrollment data to identify beneficiaries with a dependent child younger than age 14 or with a disabled individual in their household. Also, states could identify recent births in claims or managed care data to identify parents or guardians with a dependent child. Some states noted that identifying caregivers in particular can be challenging, and clear CMS guidance could help address this issue.
Veterans with a total disability rating	• Data from state or local agency that governs veterans' affairs	Not all states exchange data with their veterans' affairs agencies, and therefore, they will need to develop processes for obtaining information on this population. In addition, the disability criteria used for veterans may not align with the criteria used by Medicaid. One state noted that because of these challenges, they will check eligibility for this exclusion only if a beneficiary does not meet the criteria for any other exclusion or exception.
Individuals who are medically frail or otherwise have special needs[2]	• Claims or managed care encounter data • Clinical data (e.g., medical record data from a health information exchange)	The criteria for individuals in this category are not well defined, and states' ability to identify them will be highly dependent on CMS guidance. Claims and managed care encounter data have limitations, including timeliness and reliability, that affect their use for identifying individuals in this group. Clinical data could serve as a timelier source of information compared to claims.

TABLE 1A-1. (continued)

Excepted population group	Potential data sources	Considerations
Individuals meeting TANF work requirements or receiving SNAP benefits and subject to SNAP work requirements	• Integrated eligibility system • Data from state or local TANF or SNAP agency	States with integrated eligibility systems, relative to those without, can more easily identify Medicaid beneficiaries compliant with SNAP or TANF work requirements. Stakeholders raised questions regarding the alignment, or lack thereof, between Medicaid CE requirements and those in SNAP or TANF, including the potential for beneficiaries to experience added burden if their compliance with Medicaid and SNAP requirements are assessed at different times.
Individuals participating in a drug addiction of alcohol treatment program	• Claims data • Data from behavioral health providers	Stakeholders noted data privacy concerns related to behavioral health data for obtaining the needed information to identify this population.
Individuals who are incarcerated	• Data from state and local correctional authorities	States may need to obtain additional data to identify individuals who are incarcerated. One state noted that they have a process for data exchange with state prisons but not with local jails.
Pregnant or postpartum women	• Enrollment data • Claims or managed care data • Self-attestation	Individuals eligible for Medicaid via a pregnancy-related pathway can be identified in enrollment data. Beneficiaries in the new adult group that become pregnant could be identified using claims or managed care data.

Notes: CMS is the Centers for Medicare & Medicaid Services. TANF is the Temporary Assistance for Needy Families Program. SNAP is the Supplemental Nutrition Assistance Program. CE is community engagement.

[1] Individuals in this category must be caregivers (as defined in § 2 of the RAISE Family Caregivers Act (P.L. 115-119)) of a dependent child age 13 years or younger or of a disabled individual.

[2] Individuals in this category could include individuals who are blind or disabled; with a substance use disorder; with a disabling mental disorder; with a physical, intellectual, or developmental disability that substantially impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition.

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on May 7, 2026.

Implementing Community Engagement Requirements in Medicaid

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

1.1 voting result	#	Commissioner
Yes	15	Allen, Bjork, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, Nardone, Snyder
No	2	Brown, McCarthy