Building the Next Wave of Medicaid Infrastructure Companies in the Community Engagement Era

DEC 09, 2025

Disclaimer: These views are solely my own and do not reflect those of my employ

If you are interested in joining my generalist healthcare angel syndicate, reach o
trey@onhealthcare.tech or send me a DM. Accredited investors only.

Abstract

Summary of the new community engagement requirements

Timelines that create near term procurement pressure

Key operational gaps states cannot fill internally

Business models that should exist but do not

Existing companies most advantaged in this shift

Guidance for angel investors funding early teams

Why this is a multi year regulatory tailwind with long durability

Table of Contents

Introduction

The new regulatory forcing function

How the rule changes Medicaid operations

Why the practical burden on states is enormous

Where the gaps become founder opportunity

Business models that should exist

Existing companies that benefit

What angels should fund

Why this is a generational buildout moment

Closing thoughts

Introduction

Every now and then, a federal rule hits Medicaid like a meteor that only a handf people notice at first, but a year later everyone is running around acting like it appeared out of nowhere. The new community engagement guidance is one of th meteors. It's not sexy. It's not flashy. It's buried in legislative cross-references an eligibility logic. But if you read it slowly enough, preferably with a strong coffee high tolerance for statutory language, you eventually realize this thing rewires th operational backbone of Medicaid eligibility across most states. And since Medi already buckling under the weight of its post-unwinding workload, the system c possibly absorb these new requirements without external infrastructure.

This is the kind of regulatory shift that quietly creates billion dollar companies f founders who get there early. It's very reminiscent of the environment right befo ACA marketplaces launched, where anyone who actually read the regs could pre exactly which infrastructure layers would break first and which startups would e

filling the gaps. This moment has that same feeling. A massive new compliance framework. A fixed statutory timeline. A large population. A churn heavy eligibi process. And states who, let's be honest, are still struggling to process basic paperwork without losing people in the mix.

The new regulatory forcing function

The rule requires adults who fall into the Medicaid expansion or expansion equi waiver groups to demonstrate at least eighty hours of work or qualifying activity month. Qualifying activities can include education, community service, job train and similar engagements. There are plenty of exclusions for medically frail peop caregivers, certain tribal populations, pregnant people, and a variety of edge cas turn into decision trees long enough to melt a caseworker's monitor.

The kicker is that states must verify compliance using reliable information befo they can ask the beneficiary for documentation. Reliable information basically m any data the state already has access to or can get from third party sources. Thin payroll feeds, provider records, higher ed enrollment systems, workforce trainin program logs, and community service reporting pipelines. This is a huge shift av from the older documentation-driven approach where beneficiaries had to prove eligibility manually, often by mail or by showing up to an office with papers no c wanted to photocopy.

There's also a mandatory outreach period states must complete before the rule g live. They need to inform beneficiaries of the new requirements by mail and at le two other methods, such as text or phone. And then, beginning in 2027, most of same individuals will have renewals every six months instead of annually, which basically doubles the administrative cadence. All of this sits on top of the existin complexity states are still digging out of after the unwinding, where many office already months behind on routine work.

How the rule changes Medicaid operations

If you think about the structure of the requirement, it forces Medicaid to operat more like a real time verification engine than a static eligibility program. Histor eligibility was mostly backward looking and documentation based. Did you send what we asked for. Did we receive it. Did someone open the envelope. With community engagement layered in, states now have to assess forward moving act tie it to calendar months, match it to the right person, interpret exceptions and exclusions, issue notices, provide a thirty day grace period, keep benefits active the grace window, and only then remove someone if nothing checks out. And if t rule applies to that person in multiple months, states must track which months already been satisfied.

This means states need systems that look more like workflow automation platfo than static eligibility engines. They need the ability to trigger outbound messag based on timing rules. They need identity resolution strong enough to match pa data to beneficiaries. They need documentation intake systems capable of triagi medical frailty exceptions. They need the capacity to classify uploaded evidence, determine what qualifies and what doesn't, and attach that determination to the beneficiary record. States have never needed this level of precision before, and t certainly don't have that level of tooling today.

This also introduces continuous volume rather than episodic volume. With six m renewals, people will be passing through the compliance review pipeline consta This isn't like open enrollment where everything spikes at once. It's a perpetual stream. So whatever systems states bring online need to handle consistent throu year round without buckling under load.

Why the practical burden on states is enormous

It's worth stating plainly that most state Medicaid offices are not staffed for this don't have the people, systems, or workflows. Many eligibility systems are twent old mainframes duct taped to modern portals. Document management is still shockingly physical in many places. And even where digital systems exist, they'r

usually stitched together in brittle ways with no capacity for flexible logic or rea verification.

The reliable information requirement is the most important part. It sounds bureaucratic at first, but it's quietly the biggest driver of tech demand. Because comply with that requirement, states must ingest data from payroll systems, edu systems, workforce boards, and community service organizations. They must res that data to individuals accurately enough that they don't wrongly trigger noncompliance notices. And they must do it fast enough to meet tight renewal windows.

This is not a job for state IT. Even the states with strong tech shops struggle to maintain basic eligibility operations when volumes get high. The guidance push them into a new domain that looks more like fintech compliance than traditiona public assistance. And whenever government is pushed into fintech territory, the private market fills the gap.

Another problem is the volume of exceptions. People can be excluded if they are medically frail, caregivers, tribal members, or meet one of the hardship criteria involving hospitalization, travel for medical care, or disasters. Every one of those exceptions requires evidence, documentation, or structured attestations. This m long tail of document types and a need for classification logic that recognizes wh someone is sending and how to interpret it. If a beneficiary sends a discharge summary that confirms an inpatient stay, the system needs to know how that affe compliance for that month. Humans can do it, but not at population scale.

Where the gaps become founder opportunity

The obvious opportunity is data ingestion. The rule practically begs for a compa that builds pipes into payroll aggregators, workforce training programs, commu service logs, and higher ed enrollment systems. The company doesn't even need store everything. It can normalize feeds, match identities, and send a simple

compliance flag or data packet back to the state. That alone replaces hundreds o thousands of manual verifications every year.

Another gap is identity resolution. Medicaid systems often struggle to match rec when names or addresses differ slightly. If you're trying to match payroll record beneficiaries, you need sophisticated probabilistic matching. A startup that buil Medicaid tuned identity resolution with lightweight integration can become the backbone of compliance.

There is also a major gap in beneficiary outreach. States must send notifications through multiple channels. The systems for doing that today are old, fragmentec unreliable. A company that specializes in Medicaid compliant messaging, with tracking, multilingual support, and preference management, becomes valuable overnight. And since outreach must begin months before the rule goes live, state need vendors quickly.

Another opportunity is document intake and classification. The long list of exce and hardship pathways means there will be a constant flow of documentation tha needs to be analyzed. A startup could build automated classification, evidence extraction, and routing tools specifically tuned to the categories defined in the r Think of it like a Medicaid KYC engine, where the inputs are discharge summar pay stubs, school enrollment letters, volunteer logs, and hardship attestations.

And then there's the orchestration layer. Something that plugs into existing eligi systems and handles the community engagement logic. This could be a lightweig module that tracks which months a person has satisfied, manages compliance windows, triggers outreach events, and guides caseworkers through review path It must be configurable enough for states to change their month counts and exce handling rules without breaking everything.

Business models that should exist

If you line up all the operational needs that fall out of the rule, a new ecosystem practically draws itself. The first major category is what I'd call a Medicaid

employment and activity signal network. Something that plugs into payroll feeds workforce programs, job training systems, higher ed enrollments, and even community service organizations. It doesn't need to be perfect on day one, but it needs to be good enough to satisfy the reliable information requirement. This w let states verify compliance without making beneficiaries submit documentation States get cleaner workflows. Members get fewer letters. And the vendor become core infrastructure rather than a lightweight bolt on.

The second category is a Medicaid compliance adjudication engine. This is wher documentation goes when a beneficiary can't be verified through data alone. The engine would parse documents, classify them, check evidence against state rules produce a determination that fits neatly into the eligibility system. It's a mix of C natural language interpretation, structured rules logic, and workflow routing. Bu unlike generic document classification companies, this engine would be built specifically around the community engagement exceptions. It would need clinica logic for medical frailty cases, plus logic for caregivers, veterans, tribal members hardship events. In reality, a company that solves this well could expand into all of Medicaid documentation workflows beyond community engagement, because have infinite documentation problems.

The third category is a multichannel beneficiary communications layer that state rely on. No fancy branding needed. It just needs to work every time. States must notices by mail plus one or more other formats like text or phone. A vendor that handles address resolution, language preferences, reading level filters, delivery confirmations, bounce handling, and opt in management can become a core part There's also the nuance that states need precise timing. If a beneficiary has thirty to fix an issue, the state better be confident that the message arrived. Right now a hope, not a guarantee.

The fourth category is a Medicaid compliance orchestration platform. This sits between the data ingestion layer, the adjudication engine, and the eligibility syst handles timing rules, tracks compliance windows, and coordinates outreach ever could offer dashboards for caseworkers, automate most exception pathways, and standardize how states handle operational logic. Think of it as Zapier but for

Medicaid. Except less cute and more battle hardened. States don't need whimsy. need stability.

The fifth category is a field operations network attached to the tech stack. Even all the automation in the world, some beneficiaries will always need help. They v respond to texts. They won't upload documents. They'll be medically complex or living in unstable conditions where paperwork isn't a priority. A company that b community health workers with tech infrastructure can bridge that last mile. Th where Pair Team already shines, because they've built exactly this kind of distrib field operation that can reach people states struggle to reach.

Existing companies that benefit

A few companies are positioned to ride this wave without having to reinvent themselves.

Pair Team is the most obvious example. Their entire operational model is built a reaching hard to engage Medicaid members, completing administrative tasks on behalf, coordinating services, and serving as the connective tissue between comm organizations and healthcare organizations. The new rule essentially turns that s set into a superpower. If states want to avoid inappropriate disenrollments due t noncompliance, they need people who can find beneficiaries who aren't respond explain what's needed, gather documents, and help them navigate exceptions. Pa Team has already built that muscle, and because they aren't an MCO, they clear compliance firewall.

Eligibility modernization vendors will also benefit. Companies that sell modular ons to existing state systems suddenly become central because the states will loo systems that qualify for enhanced matching funds. If a vendor can tie its functio to design, development, or installation work that CMS classifies under the enha match categories, states have financial motivation to adopt it. Founders building modular, API friendly components that can snap on to existing eligibility system find themselves in a procurement sweet spot.

Companies working on digital identity, document classification, and structured workflows will also thrive. For example, any startup with strong OCR pipelines, classification logic, and compliance workflows can adapt their core tech to Medi specific requirements. The long tail of exception categories means there will be endless document types and edge cases. A startup with the right infrastructure c turn that chaos into predictable workflows.

Organizations running workforce training, community service coordination, or j placement programs may also benefit. If they can provide structured, verifiable c that states can ingest, they become part of the reliable information ecosystem. T could open collaboration between tech vendors and community based organizati who have historically operated without much data interoperability.

What angels should fund

The most important trait to look for in founders building in this space is a willi to live in the weeds of Medicaid operations. This is not a market for armchair theorists. It requires people who understand the ugly reality of how states proce documents, how eligibility systems behave under load, and how quickly backlog form when new requirements come online. Investors should look for teams with experience in Medicaid tech, digital benefits, public sector procurement, or com operational businesses. Strong engineering is necessary but not sufficient. They product people who understand how policy translates into workflow. They need leaders who know how to manage distributed teams. And they need the patience build trust with states, which move slower than typical enterprise customers.

Look especially for founders tackling data ingestion. Payroll data is scattered ac countless employers and processors. Higher ed enrollment data is not standardi Workforce programs often use outdated systems. Community service organizatic rarely have digital reporting pipelines. A company that builds the pipes between worlds can become indispensable because it enables states to check compliance without touching beneficiaries. That reduces administrative load and minimizes churn, two things states desperately want.

Investors should also watch for founders building compliance adjudication tools exceptions are complicated enough that most caseworkers will struggle to interp them accurately. A startup that can take the rule logic, codify it, and pair it with document analysis becomes a caseworker superpower. It reduces errors, cuts dow appeals, and keeps beneficiaries enrolled when they should be.

Another area worth funding is outreach infrastructure. A startup that can delive volume messages across SMS, voice, and mail, with tracking and language suppo will get contracts quickly. States don't have the luxury of hoping messages land. need confirmation. They need retries. They need clean address data. A startup th makes outreach reliable removes a major administrative headache.

Finally, teams blending tech with field operations are worth serious consideratic Technology alone will not solve the last mile problem. Many beneficiaries don't engage digitally. They're juggling life chaos, unstable housing, or complex health conditions. A tech enabled service that can send community health workers into neighborhoods to gather evidence, assist with renewals, or get someone through hardship exemption becomes crucial. These teams are harder to build. They requ management depth and operational discipline. But if executed correctly, they be essential partners for states and for the vendors providing the tech stack.

Why this is a generational buildout moment

The rule's timeline creates a multi year runway that is unusually predictable. Outreach begins in mid 2026. Implementation begins in 2027. Exceptions and go faith exemptions can only delay things until the end of 2028. And after that, community engagement becomes a permanent part of the eligibility landscape. T the kind of clarity that founders rarely get in Medicaid. Usually the landscape is of uncertainty. Rules may be proposed, changed, paused, litigated, or quietly deprioritized. But this rule is statutory. It's baked into law, not a waiver. States c ignore it.

The sheer number of people affected means the market is huge. The adult expan population in many states is large enough that even a small percentage needing manual verification creates massive administrative volume. And since renewal cy are shifting to a six month cadence, states will touch these beneficiaries far more than before. That creates predictable demand for vendors that can reduce burde automate workflows, and keep eligible people enrolled.

The fact that states get enhanced federal match for some system upgrades makes procurement easier. Legislators love free money. Procurement teams love subsid contracts. If a vendor can align its product with the match categories, the state c justify the investment easily. This flips the usual Medicaid procurement challeng its head. Instead of hoping the state allocates scarce funds, vendors can anchor t pitch to federal matching incentives.

Another reason this is a generational buildout moment is that the rule effectivel standardizes the problem space across states. While some states may tweak their implementation details, the core requirements are harmonized. Everyone needs t verify monthly activity. Everyone must respect the exclusion categories. Everyon must allow a thirty day cure period. Everyone must provide multichannel outrea Everyone must demonstrate use of reliable information before requesting documentation. This is a national market with uniform constraints but local pol layered on top. Startups that build configurable but standardized modules can s across states quickly. If you can solve the compliance workflow in one state, you port the same module to ten more with relatively minor adjustments. That's rare Medicaid, which is usually a patchwork of fifty different interpretations of the s statute.

The final structural advantage is that states are desperate to avoid the political backlash of wrongful disenrollments. The unwinding, even in states that tried th best, created chaos. Millions of people lost coverage because of paperwork issue Legislators and governors do not want a repeat. Community engagement requirements, by definition, add new failure points. Every time a state sends a noncompliance notice based on incorrect or incomplete data, they create legal ri press risk, or federal oversight risk. Vendors who can provide audit trails, reliab

data ingestion, and strong documentation handling become politically valuable. just operationally valuable. Politically valuable. And in Medicaid, political value determines vendor longevity.

Closing thoughts

If you zoom out long enough, Medicaid's history is full of moments where regula changes created whole new market categories. The ACA did it for exchange infrastructure. Value based care regulations did it for care management and risk adjustment. The unwinding created a wave of modernization around workflows, automation, and document processing. Now the community engagement rule is s up the next wave. But unlike some earlier shifts, this one hits the absolute core o eligibility itself. It affects volume, timing, workflows, staffing, and data flows. It touches the entire life cycle of enrollment. And it forces states to behave like rea verification engines rather than slow moving paper processors.

For founders, this is the moment to build. The window is open right now, not in eighteen months. By the time states begin outreach in mid 2026, pilots must alre be running. By the time 2027 hits, vendors need to be in place. States don't have luxury of waiting for perfect products. They need workable solutions fast. Early teams can run rapid cycles with pilot counties or targeted beneficiary segments, functionality, get caseworker feedback, and build credibility that will matter du procurement.

It's also the moment for angels to get in early. Once the big federal vendors notic space, contract capture will get more competitive, and the incumbents will start burning down their proposals with promises they cannot keep. But right now, th space is quiet enough that early teams can shape the narrative. Angels who know Medicaid can identify founders who actually understand operational complexity aren't just building slideware.

A word of caution though. The companies that win here are not going to look lik typical SaaS startups. They will be messy. They will have ops teams, compliance maybe even field teams. Their margins may not look pretty initially. But if they s

real state problem, they will scale into massive, durable companies. This is infrastructure that will last decades. Medicaid eligibility does not get replaced. I gets layered with new rules. And every new rule makes the system more complex which increases the moat for vendors who have already invested in understandin system.

Another wise investing lens for angels is looking at where the most friction sits i process. Anytime a workflow involves beneficiaries sending documents that may may not meet state criteria, you have the potential for delay, backlog, and error. I company can clean up even one of those points, that is instantly valuable. For exa imagine a startup that builds a simple photo capture tool that guides beneficiari through the process of taking clear images of documents, identifies missing page detects obstructed text, and confirms that the document matches the expected categories for an exception. That sounds tiny. But when multiplied across millio documents, it prevents backlogs that can clog the entire system. In Medicaid, tir improvements often create oversized returns because scale is massive.

Another friction point is matching. If a new mother's name on a hospital dischar summary doesn't match the name on her Medicaid record because of a recent na change, states need matching logic smart enough to connect the dots. Otherwise they'll treat her as noncompliant even when she's clearly exempt. A startup that solve identity matching in a Medicaid specific way becomes essential, because po matching is one of the leading causes of mistaken disenrollments. If you want a look at places where accuracy is life or death in the eligibility workflow.

There is also enormous opportunity in streamlining provider or community organization attestations. Many exceptions require some form of attestation fror provider or a program. For example, a medically frail individual may need a clini to confirm their condition. But clinicians are overwhelmed. They don't want to f forms. A startup that builds a lightweight interface for providers to attest electronically, integrated with state systems, can reduce friction massively. It als reduces fraud risk because structured attestations are easier to audit.

On the community side, workforce programs and volunteer organizations often l
no digital reporting infrastructure. That means states cannot rely on their recor
reliable information. A vendor that builds reporting tools that community
organizations actually want to use can create a data flywheel. The value proposit
simple: make reporting easy for community orgs, provide data feeds to states, re
administrative burden for beneficiaries, and strengthen compliance pipelines. Y
effectively building the connective tissue that lets states trust the data coming fr
the field.

Another important angle for angels to consider is that the rule prohibits manage
care plans from making compliance determinations but does not prohibit them f
supporting operations. This is a quiet invitation for startups to build tools that s
both states and plans. Plans want to keep members enrolled. States want accurat
determinations. Startups can sit in the middle, providing workflow, outreach, an
documentation tools that each side uses for different purposes. This structure is
particularly well suited to companies that already work with both groups. Pair T
fits this mold because they do hands on member engagement while also working
community organizations and providers.

Founders should also consider building for state procurement processes explicit
Most state RFPs require references, pilots, proof of ability to handle sensitive da
SOC compliance, and accessibility standards. Startups that build these capabilit
early are better positioned. Angels should encourage founders to treat procurem
part of product development, not a post product box checking activity. If a startu
waits until after their first product is built to think about procurement hurdles,
they're already behind.

One more thought about why this moment matters. States are not just trying to
comply with a rule. They are trying to avoid large scale harm. Eligibility errors a
abstract. They determine whether someone's insulin is covered, whether their
pregnancy care is paid for, whether they get access to mental health services. Wh
states get overwhelmed and beneficiaries fall through the cracks, the consequen
are immediate and severe. Vendors who help states reduce harm become trusted
partners. That trust compounds over time, creating multi decade relationships.

Angels should invest in companies that approach this work with seriousness, hu and operational empathy. This is not a place for quick flips. It's a place for build who want to shape the future of public benefits infrastructure.

The companies that emerge from this era will not just solve community engagem compliance. They will position themselves to solve whatever comes next. Medica always evolves. New eligibility groups get added. New documentation rules appe New verification requirements get layered on. A company that solves community engagement well will have the infrastructure to tackle future rules, whether rela income verification, household composition, residency, or work requirements in programs. That's why the moat here is not just the product. It's the accumulated and familiarity with state operations.

As more founders enter this space, the smartest ones will realize that the real m implementation. Anyone can read the rule and build software. But not everyone deploy it in states with ancient systems, complex policies, and limited staff. The winners will be the companies that invest early in implementation teams that ca translate product into state workflows. Angels should encourage founders to bu implementation as a first class capability, not an afterthought.

Another interesting dimension here is the interplay between technology and on ground operations. Many beneficiaries who fall under the community engageme rule will not have stable employment, consistent addresses, or reliable access to technology. They may be housing insecure, dealing with chronic conditions, or navigating other complicated life circumstances. A tech only approach will not w Startups need hybrid models that combine software with people. Angels should comfortable funding operationally heavy startups if the margins can improve ov time through smart workflow automation. Medicaid businesses often start messy become more efficient with scale and experience.

The regulatory environment also creates a natural opportunity for cross state lea States that implement early will become templates for others. Startups with earl traction can package those learnings into playbooks for future states. Angels sh encourage founders to think about scalability from the start but pilot in a small

number of states with receptive agencies. The goal is to build repeatable, defens processes that can be exported.

The final point worth emphasizing is that Medicaid infrastructure companies bu during regulatory shifts tend to endure. They become part of the architecture of public benefits. They get written into RFPs. They get referenced in state plans. time they become so integrated that replacing them would be disruptive. Angels should view this as a chance to fund companies with deep durability. The downs that these companies are hard to build. The upside is that once they're built, the stick.

The community engagement rule might look narrow on paper, but its implicatio wide. It forces states to overhaul data ingestion, identity matching, outreach, documentation handling, workflows, and timing engines. It exposes the fragility current systems. It creates urgency. And it makes the market hungry for solutior Founders who build the right layers can slot themselves into a permanent place Medicaid ecosystem.

Pair Team is one of the few companies already positioned to help on day one bec of their operational footprint and their ability to engage members who state syst cannot. But this market is big enough for many winners. Data companies. Work companies. Outreach companies. Document processing companies. Hybrid ops companies. Identity resolution companies. The ecosystem will not form overnigh it will form. And angels who back founders now will be part of shaping that landscape.

The next two years will determine which companies become the canonical vendc Those who move early, build with states, and focus relentlessly on solving real operational pain will win. And they will not just win contracts. They will define future of how Medicaid manages eligibility, compliance, and the human beings b those processes.

This is the moment. The rule is the signal. The tailwinds are massive. And the founders who build now will be the ones whose infrastructure quietly powers th

decade of Medicaid.

2 Likes • 1 Restack

← Previous

Nex

Discussion about this post

Comments Restacks

Write a comment...

Abdullah Abdulkarim Dec 9

Love how you broke down the implications of the rule

Most folks were just saying “this is a big tailwind” and move on haha

LIKE REPLY