The Enrollment Coalition

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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

RE: Follow-Up Recommendations Regarding Implementation of Section 71119 of the Working Families Tax Cut Legislation

Director Brillman,

The Enrollment Coalition writes to express appreciation for the December 8, 2025, the March 6, 2026, and the April 8, 2026, guidances on implementing the "Working Families Tax Cut" Legislation (Public Law 119-21) and specifically for the incorporation of several recommendations from the Enrollment Coalition's August 2025 letter.

The Enrollment Coalition is an alliance of organizations including patient advocates, health plans, health care providers, employers, and consumer advocates, whose mission is to help the eligible uninsured – people already eligible for coverage – get enrolled and stay enrolled. The Enrollment Coalition believes that a top policy priority for the coming years should be making sure that those eligible for health care today are enrolled and retained.

The Enrollment Coalition specifically appreciates that the guidances require states to:

- First attempt to use reliable information available to the state to establish whether an individual meets the community engagement requirements,
- Provide notice of noncompliance and allow the applicant 30 calendar days to demonstrate compliance
- Conduct outreach by mail (or in an electronic format), and one or more additional forms of outreach and include information who community engagement applies to and the exceptions.
- attempt to reverify a beneficiary's satisfactory immigration status through electronic data sources (i.e., Department of Homeland Security's (DHS's) Systematic Alien Verification for Entitlements (SAVE) program) before attempting to contact the beneficiary.

Additionally, the coalition appreciates that the guidances included information on federal funding to support IT updates.

The informational bulletins provides a valuable foundation as states plan for implementation ahead of the January 1, 2027 statutory deadline, and the coalition is encouraged by CMS's stated commitment to ongoing partnership with states and stakeholders. As CMS continues to issue regulations and guidance, the Enrollment Coalition offers the following recommendations. These build upon the coalition's August letter, acknowledge areas where the recent guidances have laid helpful groundwork, and request additional specificity where it would support effective, consistent

implementation that minimizes coverage losses among eligible individuals. The coalition also offers several additional recommendations informed by the recent guidances.

BUILDING ON THE COALITION'S AUGUST RECOMMENDATIONS

Recommendation 1: Identify specific data sources states should use to verify community engagement and support *ex parte* processes.

The coalition appreciates that the December guidance directs states to first attempt to use reliable information — including payroll data, Medicaid provider payments, encounter data, and information on education enrollment, job training, and community service — before requesting additional documentation from individuals. This is consistent with the coalition's August recommendation that states maximize the use of available data sources. To further strengthen this framework, the coalition encourages CMS to:

- Specifically identify the National Directory of New Hires (NDNH) as a recommended data source for verifying community engagement and support adding NDNH data to the Federal Data Services Hub. Multiple prior federal budget proposals have recommended CMS use the NDNH for income and employer verification, and the Congressional Research Service has noted that programs utilizing NDNH data have reported significant savings.[1,2]
- Educate states on the data already available through the Federal Data Services Hub (FDSH) and the ability to use FDSH code at no cost, encouraging states to take advantage of these resources before drawing on MMIS funds or Government Efficiency Grant allocations.
- Integrate additional data sources into the Federal Data Services Hub, including Veterans Administration data, to help states routinize adjudication of exemptions from community engagement requirements. This is particularly relevant given that veterans with a total disability rating are a specified excluded population under the statute.
- Reduce the per-transaction cost of using the Federal Data Services Hub and other related data sources, leveraging the federal government's purchasing power to make these verification tools more accessible and cost-effective for states.

The coalition notes that CMS is already modifying the Federal Data Services Hub to support implementation of Section 71109 of WFTC legislation, including the addition of new indicators for FFP-eligible noncitizen verification. This presents a practical opportunity to simultaneously integrate additional data sources for community engagement verification – including NDNH and VA data – rather than undertaking separate, sequential rounds of Hub modifications.

Recommendation 2: Reduce barriers for enrollees to provide eligibility and community engagement information

The coalition appreciates that the December guidance establishes important procedural protections, including the requirement that states use reliable information before requesting documentation from individuals. Building on this foundation, and particularly as enrollees navigate both 6-month redeterminations and community engagement verification simultaneously, the coalition encourages CMS to provide additional guidance requiring states to:

- Provide pre-populated forms completed with information already in the state's possession;

[1] https://crsreports.congress.gov/product/pdf/RS/RS22889
[2] https://www.acf.hhs.gov/sites/default/files/documents/olab/final_cj_2017_print.pdf

- Allow individuals to submit eligibility documentation electronically;
- Ensure online portals retain previously provided beneficiary information so enrollees do not have to re-enter it at each interaction; and
- Allow all applicants access to authorized representative support through individuals or third-party organizations.

The coalition notes that CMS's March 6, 2026 SMDL on six-month renewals affirms that states must send prepopulated renewal forms when coverage cannot be renewed through *ex parte* review and provide individuals at least 30 days to respond. The coalition encourages CMS to apply these same standards to community engagement verification, ensuring that individuals are not asked to provide information the state already has available.

Recommendation 3: Strengthen outreach requirements to reach enrollees most at risk of procedural disenrollment.

The coalition appreciates that the December guidance establishes meaningful outreach requirements, including notice by mail or electronic format plus at least one additional modality, and clear timelines for when outreach must begin relative to implementation. The coalition encourages CMS to build on these requirements by:

- Requiring states to make at least two outreach attempts using multiple modalities — such as phone, text message, or email in addition to mail — to reach enrollees regarding community engagement requirements and redeterminations. Text messaging is an effective means of communication with Medicaid enrollees, as 90% of adults earning less than $30,000 a year own a mobile phone[3] and 97% of phone owners use text messaging.[4]
- Requiring states to conduct targeted outreach to populations that experienced disproportionately high procedural disenrollment rates during the COVID-19 continuous enrollment unwinding.
- Reminding states of their existing obligations to ensure enrollment and renewal procedures are accessible to individuals with disabilities, individuals with limited English proficiency, and residents of rural areas with limited broadband access.
- Encourage a communications approach in which states establish core messaging and content, while allowing MCOs and other enrollee-facing partners flexibility to tailor outreach channels, timing, and reinforcement strategies based on member preferences, language needs, and prior engagement patterns.
- Require states to begin enrollee education sufficiently in advance of implementation, including a meaningful pre-implementation education period, so individuals have time to understand new requirements, available exemptions, and the steps needed to maintain coverage.

[3] Profiles of Medicaid Outreach and Enrollment Strategies: Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP | KFF
[4] U.S. Smartphone Use in 2015 | Pew Research Center

Recommendation 4: Work with the Federal Communications Commission (FCC) to provide regulatory clarity under the Telephone Consumer Protection Act (TCPA) for health care outreach communication

The coalition is encouraged that the December guidance recognizes text messaging as an acceptable outreach format. For years, the TCPA has created uncertainty regarding allowable outreach to Medicaid, Marketplace, and Medicare Advantage enrollees. Although texting has been successful when used in limited circumstances and is the preferred form of contact for many enrollees, many health care entities will not conduct outreach through text for fear of violating the TCPA and for fear of litigation, which is relatively common – and costly - as it relates to TCPA. It is important that there are clear rules regarding the ability to utilize modern telecommunications tactics and practices that help mitigate coverage disruption and connect with enrollees on important covered services.

While the TCPA provides for what is known as the healthcare exemption, there is significant confusion about when the exemption applies. To help states and health plans fully utilize text messaging, the coalition reiterates its recommendation that HHS work with the Federal Communications Commission to clarify that:

- The provision of a phone number to a HIPAA covered entity or business associate constitutes prior express consent for non-telemarketing health care communications; and
- The non-telemarketing health care message exemptions in the 2015 Omnibus Declaratory Ruling and Order apply to HIPAA covered entities and business associates.

Regulatory clarity on this issue would support effective outreach that will be critical as millions of enrollees learn about new requirements under the WFTC law.

Recommendation 5: Provide clear definitions of "medically frail" and "special medical needs" and establish consistent process for exemption determinations.

The December guidance helpfully outlines the statutory categories of specified excluded individuals, including those who are "medically frail or otherwise have special medical needs (as defined by the Secretary)." As the statute assigns this definitional responsibility to the Secretary, the coalition encourages CMS to use the interim final rule to:

- Provide clear definitions of "medically frail" and "special medical needs" that can be implemented across states;
- Establish processes states should use for making these determinations to support compliance and ; and
- Ensure that individuals with claims data reflecting functional limitations who are awaiting a disability determination from the Social Security Administration (SSA) are not left without coverage during that process.

Based on the experience of Enrollment Coalition members during the Medicaid continuous eligibility unwinding, additional specificity from CMS on these terms would help states implement the exclusions consistently and reduce the risk of eligible individuals losing coverage. Timely resolution of these definitional questions is also important from a systems perspective: states

cannot finalize the design of eligibility and enrollment systems for community engagement without clarity on how exemption categories will be defined, and delays in providing this specificity risk costly re-work as states build systems ahead of the January 1, 2027 deadline.

Recommendation 6: Support technology modernization to improve eligibility and enrollment systems.

The coalition appreciates that the December guidance outlines existing pathways for enhanced federal financial participation for IT system costs, including 90/10 match for system design and development and 75/25 for ongoing operations. To support states in building the infrastructure needed for effective implementation, the coalition encourages CMS to:

- Issue guidance encouraging states to modernize account transfer technology, including by adopting API-based data exchange for eligibility and enrollment data between state Medicaid agencies, the Federally Facilitated Marketplace, MCOs, and Dual Special Needs Plans. Currently, the XML-based data model used for account transfers has insufficient data quality controls, leading to incomplete and inaccurate data which can result in individuals having to complete new applications when transitioning between programs.[5]
- Encourage states with state-based marketplaces to develop unified eligibility determination systems so individuals are routed to the correct program regardless of where they apply.
- Convene a neutral, time-boxed public/private forum – led by HHS (CMCS and ASTP/ONC as convener) and including states, state-based exchanges, MCOs, X12, clearinghouses, and EDI vendors – to align state companion guides and establish a Minimum Conformance Profile (MCP) for the ANSI X12 834 within the current standard. The 834 is maintained by X12, a private ANSI-accredited standards development organization, and changes to the base standard require member consensus and federal adoption via HIPAA. A full version upgrade would be costly and slow. By contrast, aligning companion guides within the current TR3 would deliver faster, lower-cost improvements to roster quality across states. Inconsistent implementation of the 834 across states – including variation in field population, interpretation, and timing – currently drives delays, rework, and member disruption that undermines enrollment accuracy and coverage continuity. This approach mirrors proven models such as ONC's FHIR at Scale Taskforce (FAST), the CARIN Alliance, and the Argonaut project.
- Identify and support the scaling of modular IT solutions that can layer onto existing state systems for verification of community engagement requirements, particularly where interoperability between Medicaid systems and other data sources does not currently exist. Scalable, reusable solutions would be more cost-effective than the traditional state-by-state custom approach and would help ensure that limited implementation funding goes as far as possible.
- Produce model business requirements for community engagement-related systems changes that states could elect to adopt, reducing duplication of effort across states and helping to avoid expensive future re-work.

[5] Account Transfer CIB

Improved 834 consistency would also directly support implementation of Section 71103 of the WFTC legislation, which requires CMS to establish a centralized verification system by October 1, 2029 and requires states to submit enrollment data at least monthly to identify individuals concurrently enrolled in multiple states. CMS has identified approximately 2.8 million Americans potentially dually enrolled across Medicaid/CHIP and/or Marketplace coverage based on 2024 data. Standardized 834 data – including consistent residency indicators, effective dates, and maintenance type and reason codes – would reduce false positive duplicate flags, enable faster resolution of cross-state enrollment conflicts, and improve the targeting of state outreach and redetermination resources. This alignment would also smooth the transition from the current PARIS matching system to the centralized system required under Section 71103.

The coalition also notes that states will be modifying eligibility and enrollment systems for multiple WFTC provisions on overlapping timelines – including Section 71109 changes to noncitizen eligibility verification by October 1, 2026, and both six-month renewal and community engagement requirements by January 1, 2027. This compressed implementation schedule further shows the need for modular, reusable IT solutions and model business requirements that allow states to coordinate systems changes across provisions rather than managing each as a standalone build.

Recommendation 7: Require states to include renewal dates on monthly Medicaid membership files.
With the population subject to 6-month redeterminations overlapping significantly with the population subject to community engagement requirements, the coalition reiterates its recommendation that CMS require states to include renewal dates on monthly Medicaid membership files. This information allows MCOs, providers, and outreach partners to proactively engage members ahead of their renewal — a capability that becomes increasingly important as states implement both provisions simultaneously.

The coalition further encourages CMS to clarify that renewal date information should be included through standardized monthly enrollment files (EDI 834) rather than through ad hoc or one-off file transfers that can create operational burden and reduce timeliness. Providing this information on a regular cadence and sufficiently in advance of renewal would better position MCOs, providers, and outreach partners to conduct proactive outreach, support member questions, and help reduce avoidable coverage losses as states implement both 6-month redeterminations and community engagement requirements.

Recommendation 8: Confirm that states may continue to use strategies that proved effective during the Medicaid continuous enrollment unwinding.
As states prepare to manage the operational demands of both increased redetermination frequency and community engagement verification, the coalition encourages CMS to confirm that states may continue utilizing strategies that proved effective during the COVID-19 continuous enrollment unwinding, including:

- Updating beneficiary contact information using NCOA or USPS returned mail data without first sending notice to the prior address on file (used by 37 states as of November 2024);

- Updating contact information received from MCOs without first sending notice to the prior address (used by 32 states as of November 2024); and
- Allowing MCOs to assist beneficiaries in completing and submitting renewal forms (used by 22 states as of November 2024).

These strategies would help states manage the significant operational challenges in implementing new requirements without compromising program integrity.

ADDITIONAL RECOMMENDATIONS BASED ON THE DECEMBER 2025 GUIDANCE

Operational Integration of 6-Month Redeterminations and Community Engagement Verification

The December guidance acknowledges that the population subject to 6-month redeterminations under Section 71107 significantly overlaps with the population subject to community engagement requirements under Section 71119. To support efficient implementation, the coalition recommends CMS:

- Issue guidance directing states to integrate community engagement verification into the redetermination process itself, rather than treating it as a separate administrative step; and
- Provide states with operational models or best practices for streamlining these processes.
- Encourage states to share timely data with MCOs and other approved partners identifying individuals in the deeming period, or otherwise at elevated risk of coverage loss, so outreach can be more targeted, and support can be provided before disenrollment occurs.

CMS's March 6, 2026 SMDL on six-month renewals provides states with two options for transitioning to the new renewal cycle, with most states expected to maintain the existing renewal cadence and apply six-month periods as individuals come up for their already-scheduled renewals. This phased approach means that community engagement verification and six-month redeterminations will come into effect on different timelines for different enrollees, further showing the need for integrated operational guidance that helps states manage both requirements in a coordinated manner rather than as separate processes.

CMS should also address the operational complexity created by different renewal timelines within the same household. As the March 6 SMDL notes, individuals subject to six-month renewals may reside in households with members on 12-month renewal cycles, and information obtained at one member's renewal that affects the eligibility of other household members must be acted on as a change in circumstances. Integrated guidance should address how states manage community engagement verification in this context to avoid coverage disruptions for eligible household members.

An integrated approach would reduce administrative burden on both states and enrollees and minimize the risk of procedural coverage losses.

MCO Role in Supporting Implementation

The December guidance clarifies that states may not use MCOs to determine beneficiary compliance with community engagement requirements, while noting there is no statutory prohibition on other support activities and that further guidance is expected. The coalition welcomes this distinction and encourages CMS, in the interim final rule, to:

- Provide specific guidance on the appropriate role MCOs can play in outreach, education, and enrollment assistance activities;
- Encourage states to partner with MCOs to conduct outreach to their members directly or through third-party organizations regarding community engagement requirements and upcoming redeterminations; and
- Affirm that MCOs may support enrollees in understanding exemptions and exceptions for which they may qualify.
- Reiterate that while MCOs may support outreach, education, screening for potential exemptions, and referral to appropriate state or community resources, they should not be responsible for collecting or adjudicating documentation, tracking hours, submitting compliance attestations, administering work, education, or volunteer programs directly.

This is consistent with Section 71103 of the WFTC legislation, which mandates in part that states rely on MCOs as a reliable source to prevent or reduce duplicate enrollment.

Good Faith Effort Exemption Criteria

The December guidance describes the Secretary's authority to grant temporary good-faith-effort exemptions for states that are unable to meet the January 1, 2027 implementation deadline. The coalition appreciates this flexibility and encourages CMS to:

- Publish transparent criteria and a clear application process for good-faith-effort exemptions so states can plan effectively; and
- Ensure that states facing genuine implementation barriers can continue providing coverage to eligible individuals while working toward compliance.

The coalition further notes that the compressed implementation timeline — with states required to implement Section 71109 eligibility changes by October 1, 2026, followed by six-month renewals and community engagement requirements by January 1, 2027 — may present genuine implementation challenges for states managing simultaneous systems and operational changes across multiple WFTC provisions. Clear good faith effort criteria would help states prioritize and sequence these efforts while maintaining coverage for eligible individuals.

The Enrollment Coalition appreciates CMS's ongoing engagement with states and stakeholders and views the December guidance as an important step toward successful implementation. The coalition stands ready to provide additional input and share the practical experience of its member organizations to support implementation that strengthens program integrity while minimizing coverage disruptions for eligible individuals.

Thank you for considering these comments. Please reach out to Laura Pence at laura.pence@leavittpartners.com with any questions.

Sincerely,
The Enrollment Coalition