



The Enrollment Coalition

Kate Massey
Executive Director
MACPAC

Building on MACPAC’s April 2026 Discussion: The Enrollment Coalition’s Recommendations on Community Engagement Implementation

Dear Kate:

[The Enrollment Coalition](#) appreciates MACPAC’s thoughtful engagement on community engagement implementation, particularly the Commission’s focus on data source adequacy and the risk of inappropriate disenrollment due to administrative barriers. As MACPAC develops its recommendations, we offer the following coalition perspectives for consideration.

Recommendation 1: Expand the data source discussion beyond employment verification to address gaps across qualifying activities and exemptions.

The Coalition strongly supports MACPAC’s recommendation that CMS explore additional and emerging data sources for employment verification, including consent-based income verification tools, given that existing sources such as Equifax’s The Work Number do not adequately capture non-traditional employment such as gig work. We encourage MACPAC to expand this analysis to recognize that data source gaps extend well beyond employment. For many qualifying activities (e.g., volunteer service, educational participation, community service) and exemptions (e.g., medical frailty, caretaker status), no comprehensive third-party data sources currently exist. Without acknowledgment of these broader data gaps, states risk defaulting to documentation requirements that place the burden of proof entirely on beneficiaries, contributing to the administrative disenrollment risks MACPAC has already identified.

Recommendation 2: Affirm self-declaration as a core verification method for activities and exemptions that lack reliable third-party data, particularly during the early years of implementation.

For qualifying activities and exemptions where no electronic data source exists, self-declaration — paired with appropriate post-eligibility audit and verification protocols — is the most practical and least burdensome verification method. Analysis from the Center on Budget and Policy Priorities finds that combining client self-attestation with available data sources can lower administrative costs, reduce the risk that eligible individuals lose benefits because of paperwork barriers, and improve overall accuracy of eligibility determinations.¹ Self-attestation is already an established practice across Medicaid eligibility determinations. CMS guidance recognizes that some types of income and assets lack an electronic data source, and states may elect to accept self-attestation in those circumstances. Extending this principle to community engagement activities and exemptions would be consistent with existing practice.²

¹ <https://www.cbpp.org/research/health/how-to-streamline-verification-of-eligibility-for-medicaid-and-snap>

² [Verification of Financial Eligibility for Medicaid and the Children’s Health Insurance Program](#)

This approach is especially critical in the early years of implementation, when states are still building systems, training staff, and developing data-sharing arrangements. CMS’s December 8, 2025 CMCS Informational Bulletin itself acknowledges that without proper alignment between policy design and technological capabilities, states may create administrative burdens that undermine program effectiveness — demonstrating the need for verification flexibility during early implementation.³

As states move toward implementation on differing timelines and with varying operational approaches, clear sequencing would help ensure that verification practices remain consistent and least burdensome. We therefore encourage MACPAC to recommend that CMS provide guidance to states establishing a practical verification hierarchy that proceeds in the following order:

- *Ex parte* verification first, drawing on reliable existing data sources wherever they are available;
- Self-declaration where reliable third-party data does not exist, paired with appropriate post-eligibility audit and verification protocols; and
- Additional documentation only where necessary and reasonable, rather than as a default requirement

This guidance should be directed to states, recognizing that verifying compliance and collecting documentation are state functions rather than managed care plan responsibilities. A clear default sequence would give states a consistent starting point, reduce uncertainty about which expectations are federal and which remain state-specific, and reinforce the auditable self-attestation and member-driven verification approaches that several states are already developing.

Relatedly, we encourage MACPAC to recommend that CMS clarify how states may operationalize short-term hardship and labor-market-based exceptions in the least burdensome manner. Where such exceptions can be established through reliable public data, CMS could clarify whether states may apply them automatically where permitted, rather than requiring member-by-member documentation. Because identifying, verifying, and administering these exceptions are state functions, this clarification would reduce unnecessary documentation for members and states alike without creating new responsibilities for managed care plans.

Recommendation 3: Strengthen the distinction between administrative and compliance-related disenrollment, and recommend specific guardrails against inappropriate coverage loss.

The Coalition strongly supports MACPAC’s call for metrics and evaluation criteria that distinguish appropriate from inappropriate disenrollment and administrative from compliance-related causes. A robust evidence base supports the urgency of this distinction.

The administrative burden framework developed by Herd and Moynihan, widely cited in public administration and health policy literature, provides a useful conceptual foundation. This

³ [State Requirements to Establish Medicaid Community Engagement Requirements](#)

framework identifies learning, compliance, and psychological costs as the three dimensions of administrative burden, all of which can block access to health-promoting services and disproportionately affect vulnerable populations.⁴ A core insight of this research is that administrative burdens are not unintended byproducts but the result of deliberate policy and implementation choices — meaning the verification methods, documentation standards, and reporting cadence states adopt are themselves burden choices that warrant explicit evaluation. Recent peer-reviewed work applying the framework to Medicaid further finds that opaque, time-intensive processes can effectively ration access to benefits even where individuals remain eligible, which is precisely the dynamic MACPAC identified in its discussion of inappropriate disenrollment.^{5,6}

Building on this evidence, we encourage MACPAC to recommend that CMS guidance and state implementation include specific guardrails to prevent administrative disenrollment, such as adequate cure periods, clear reinstatement pathways, multi-modal noticing, and reasonable accommodations for individuals with limited English proficiency or disabilities. We also encourage MACPAC to recommend that CMS publish disaggregated disenrollment data so that administrative versus compliance-related causes can be tracked transparently and used to inform continuous program improvement.

To make this distinction operational, we encourage MACPAC to recommend that CMS establish standardized state reporting categories for monitoring and evaluation. This reporting should flow from states to CMS and should clearly separate coverage loss attributable to a member's failure to meet community engagement requirements from coverage loss attributable to administrative or procedural causes, such as:

- Paperwork or missed notices;
- Inability to verify information or incomplete documentation; and
- Other process barriers.

Without this distinction, it will be difficult to determine whether implementation is identifying genuine noncompliance or instead producing avoidable coverage loss among otherwise eligible individuals. To support that assessment, and in addition to disenrollment data, we encourage MACPAC to recommend that CMS include state reporting on:

- Cure-period outcomes;
- Reinstatements;
- Appeals and fair hearings;
- Exemption approvals and denials;
- Renewal outcomes; and
- Churn following disenrollment.

These metrics would help determine whether implementation is causing avoidable coverage loss among otherwise eligible individuals. Consistent with the coalition's broader approach, this

⁴ <https://www.sciencedirect.com/science/article/abs/pii/S0277953624001308>

⁵ <https://www.jstor.org/stable/27202897>

⁶ Rationing Rights: Administrative Burden in Medicaid Long-Term Care Programs | Journal of Health Politics, Policy and Law | Duke University Press

reporting should rely on existing data sources where possible and should flow from states to CMS rather than creating new reporting obligations for managed care plans.

Recommendation 4: Encourage CMS to provide clearer guidance on medical frailty verification.

Medical frailty determinations have drawn substantial state attention, in part because the relevant clinical data can be complex to interpret. We therefore encourage MACPAC to recommend that CMS provide clearer guidance on how states may verify medical frailty, including the appropriate use of claims data, reasonable lookback periods, and consideration of clinically relevant diagnosis fields. Rather than adopting a rigid national definition, CMS should establish minimum guardrails and illustrative criteria while preserving state flexibility to adopt broader or more protective approaches. In doing so, CMS should encourage states to use approaches broad enough to avoid missing individuals with chronic or complex conditions, including consideration of secondary diagnoses where clinically appropriate.

Recommendation 5: Encourage standardized, privacy-protective operational data sharing from states to health plans to support member education and navigation.

Plans are well positioned to help members understand and respond to community engagement requirements, but only when they receive timely, reliable information from states. Where states share member-level information with health plans to support member education, navigation, and referrals, we encourage MACPAC to recommend that CMS promote standardized data elements and formats to avoid one-off manual files and unnecessary administrative burden. Useful standardized elements could include:

- Whether a member is subject to the community engagement requirement;
- Whether an exemption applies;
- Renewal timing and compliance-check timing; and
- The reason for any adverse action

This should not create new managed care plan reporting obligations; the objective is for states to provide clearer, more standardized operational data so that plans can help members navigate the appropriate state process. Because exemption-related data sharing is likely to be complex and may vary by state, we also encourage MACPAC to recommend that any such data sharing follow privacy-protective principles, including minimum necessary data standards, clearly defined allowable uses, and appropriate protections for sensitive health, behavioral health, and substance use disorder information, consistent with applicable federal and state privacy requirements.

Recommendation 6: Allow reasonable phase-in flexibility and safeguard against year-one transition risk.

Early implementation experience suggests that states may rely on more flexible approaches at launch but could move toward more documentation-intensive processes over time. We encourage MACPAC to recommend that CMS allow reasonable phase-in flexibility and require appropriate

safeguards before states increase documentation burdens, particularly while eligibility systems, data-sharing processes, and member education materials are still being developed. This flexibility would protect members and reduce state administrative strain during the transition, without shifting work to plans or delaying compliance.

Recommendation 7: Align community engagement implementation with renewal processes wherever operationally feasible.

Many states appear to be considering community engagement requirements and eligibility renewals together, though specific approaches vary. We encourage MACPAC to recommend that CMS support integrated, member-centered implementation that aligns community engagement requirements with renewal processes wherever operationally feasible, rather than running parallel processes that increase member confusion. Coordinating these processes would support clearer state workflows and reduce the risk that members receive duplicative or conflicting instructions.

Recommendation 8: Provide CMS model notices, toolkits, and plain-language materials, and clarify permissible outreach channels.

To promote consistency across states while reducing administrative burden, we encourage MACPAC to recommend that CMS provide model notices, plain-language templates, sample FAQs, standard definitions, and implementation checklists. Shared materials of this kind would help reduce the risk of confusing or conflicting member messages.

We also encourage MACPAC to recommend that CMS, in coordination with appropriate federal partners where needed, clarify permissible outreach channels, including text messaging where allowed under federal and state law. This clarification should address allowable outreach methods while maintaining existing privacy and consent protections, and is not intended to override existing communication rules.

Recommendation 9: Include community resource and referral capacity in monitoring and evaluation.

Because successful participation in community engagement requirements depends in part on the availability of qualifying opportunities, we encourage MACPAC to recommend that CMS and states consider access to community resources, workforce supports, education and training programs, and referral pathways as part of monitoring and evaluation. This monitoring should focus on identifying system-level gaps and enabling operational feedback from appropriate partners, and should not make health plans responsible for reporting statewide community-based organization capacity, guaranteeing resource availability, or tracking referral completion.

Taken together, these recommendations are intended to reflect the implementation realities now emerging across states, including variation in state approaches, compressed timelines, evolving verification standards, gaps in available data, and the complexity of determinations such as medical frailty. Addressing these issues through clear federal guidance and standardized state

reporting would help ensure that community engagement requirements identify genuine noncompliance while minimizing avoidable coverage loss among otherwise eligible individuals.

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

Sincerely,
The Enrollment Coalition