The Enrollment Coalition

July 30, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals — Interim Final Rule with Comment Period (CMS-2454-IFC); RIN 0938-AV98; 91 Fed. Reg. 33348 (June 3, 2026); Docket No. CMS-2026-2047

Administrator Oz,

On behalf of the Enrollment Coalition, we appreciate the opportunity to comment on the interim final rule with comment period (IFC) implementing the Medicaid community engagement requirement under section 1902(xx) of the Social Security Act, as added by section 71119 of Public Law 119-21. The Coalition has followed CMS's implementation of this provision closely, including the December 2025, March 2026, and April 2026 guidance, and we appreciate CMS's continued engagement with states and stakeholders as the agency works to operationalize a significant and time-sensitive new requirement on a compressed timeline.

The Coalition approaches this rule from a shared premise: **enrollment access and program integrity are complementary goals, not competing ones.** Using accurate, existing data and clear, consistently applied standards will both strengthen program integrity and keep eligible individuals enrolled in coverage. Where verification is burdensome, ambiguous, or dependent on paperwork that eligible people struggle to produce, the predictable result is procedural coverage loss among eligible individuals. Our comments are offered in that spirit and focus on operational areas where additional CMS direction would help states implement the statutory requirements and help eligible individuals maintain coverage.

ABOUT THE ENROLLMENT COALITION

The Enrollment Coalition is an alliance of organizations from across the health care community – patient and consumer advocates, health plans, and health care providers, employers, and technology and data organizations. Our mission is to help eligible uninsured individuals enroll in, and stay enrolled in, the coverage for which they already qualify. We believe a top policy priority for the coming years is ensuring that those eligible for coverage today are enrolled and retained.

THE IFC AND CMS GUIDANCE REFLECTS SEVERAL COALITION RECOMMENDATIONS

The Coalition appreciates that the IFC and related guidances **incorporate several recommendations the coalition has provided.** In particular, the rule directs states to first use reliable existing income and eligibility data to verify status on an *ex parte* basis before requesting information from individuals. *Ex parte* renewals are critical: nationally roughly 69 percent of those disenrolled during the recent Medicaid continuous eligibility unwinding lost coverage for paperwork or procedural reasons rather than a determination of ineligibility, while only about 31 percent were found ineligible, and about 61 percent of renewals were completed automatically through *ex parte*

processes.[1] Maximizing reliable-data verification is therefore central to retaining eligible people while supporting program integrity.

To support states in increasing the percentage of *ex parte* renewals, we encourage CMS to expand the reliable data sources available to states through the Federal Data Services Hub – including the National Directory of New Hires, which multiple federal proposals have identified as a tool for income and employment verification and which the Congressional Research Service has noted has produced significant program savings.[2] Doing so, would further reduce reliance on enrollee-supplied paperwork for both six-month renewals and community engagement verification.

1. PROVIDE CLEAR, AUDITABLE STANDARDS FOR THE FUNCTIONAL-STATUS ELEMENT OF "MEDICALLY FRAIL" AND SPECIAL MEDICAL NEEDS IN ORDER TO ENSURE THE DEFINITION, IF RETAINED, CAN BE IMPLEMENTED

The IFC defines a "medically frail" individual not only as someone who falls within one of the enumerated condition categories, but also as someone whose condition "significantly impairs the individual's ability to comply with the community engagement requirement." This second, functional-status element is not required by section 71119 of Public Law 119-21. The statute enumerates the qualifying categories and delegates definition detail to the Secretary, but it does not itself condition the exclusion on a separate finding that an individual's condition impairs their ability to comply with the community engagement requirement. Layering an individualized functional assessment on top of the enumerated clinical categories converts what could be a categorical exclusion into a case-by-case determination that is administratively burdensome for patients, providers, and Medicaid programs. For example, CMS cautions that states cannot rely on diagnosis lists alone – noting that a serious or complex condition will not necessarily be serious or complex for every patient at all times – yet the rule offers limited direction on which methods of documenting functional status are acceptable. The result is a determination that is inherently individualized, likely to require documentation from physicians and other clinicians, and difficult to apply consistently.

This ambiguity creates real burden for the individuals who must establish the exclusion and for the providers – particularly safety-net providers – who must supply supporting documentation, and it raises the risk that eligible individuals are not appropriately excluded from the community engagement requirements. Should CMS retain the significant-impairment requirement, the additional direction described below will be necessary to make determinations workable, consistent, and auditable. Specifically, we recommend that CMS:

- Identify acceptable methods for documenting the functional-status element, including self-declaration;
- Provide model documentation standards that states can adopt to promote consistency and auditability without imposing excessive paperwork on enrollees or clinicians; and
- Ensure that individuals with claims data reflecting functional limitations, including those awaiting a disability determination from the Social Security Administration, are not left without coverage while that determination is pending.

2. PRESERVE AND CLARIFY VERIFICATION FLEXIBILITY UNTIL STATES' DATA AND PROCESSES ARE PROVEN

[1] https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8
[2] The National Directory of New Hires: An Overview | Congress.gov | Library of Congress

The Coalition appreciates that the rule permits states to accept a self-declaration or other information in the early implementation period, but the standard governing that flexibility is unclear in ways that may discourage its use. The IFC tells states to rely first on reliable existing data and, through 2027, allows states to accept self-attestation or other information for certain determinations, including medical frailty; beginning January 1, 2028, states must require documentation where it is reasonably available and accept "other information" only where it is not. It is not clear from the rule whether accepting self-attestation in 2027 is a state option or an expectation, what qualifies as "reasonably available" documentation, or what constitutes sufficient "other information."

The lack of clarity could have a significant impact on states' willingness to use permitted flexibilities. If states are uncertain, many could decline to use the flexibilities the rule allows – defaulting to documentation requests that fall hardest on eligible enrollees, especially those combining several activities (for example, caregiving, education, and volunteering) to reach 80 hours, for whom "reasonable" documentation can become substantial. Experience outlines what is at stake here. In a peer-reviewed study about Arkansas' first-year implementation of community work requirements, it was found that more than 95 percent of those subject to the policy already met the requirement or should have been exempt, that the policy was not associated with a significant change in employment, and that coverage losses were driven largely by beneficiaries' lack of awareness and confusion about how to report – administrative barriers rather than ineligibility.[3] Accordingly, we recommend that CMS:

- Clarify that, through 2027, states may accept self-attestation or other information as a usable option when reliable data are unavailable, and confirm the circumstances in which it applies;
- Provide clear, auditable guidance on acceptable forms of documentation and "other information" so that states can confidently use permitted flexibilities; and
- Preserve self-attestation flexibility – including the medical-frailty allowance – until states' verification data and processes are functioning reliably, so that eligible individuals are not disenrolled while systems and data sources mature.

3. STRENGTHEN FEDERAL SUPPORT FOR OUTREACH TO POPULATIONS MOST AT RISK OF PROCEDURAL DISENROLLMENT

The Coalition supports the rule's multi-modal initial outreach and periodic outreach requirements but believes the framework provides too little support for reaching populations most at risk of procedural disenrollment. Beyond the initial notice, the IFC establishes few requirements for targeted outreach, and CMS expressly seeks comment on whether to set a different frequency for periodic outreach and whether to allow states to define what "periodic" outreach means in the future. Given that awareness gaps were a leading driver of procedural coverage loss during the Medicaid continuous eligibility unwinding, and that MACPAC has recommended CMS develop a transparent plan to monitor and evaluate these requirements and provide technical assistance to states,[4] we recommend that CMS:

- Maintain a meaningful federal floor for the frequency of periodic outreach so that at-risk enrollees receive timely, repeated notice;

[3] Medicaid Work Requirements — Results from the First Year in Arkansas | New England Journal of Medicine
[4] Implementing Community Engagements Requirements in Medicaid - MACPAC

- Provide resources, model notices, and best-practices to help states communicate clearly about new requirements, available exceptions, and the steps needed to maintain coverage; and
- Encourage and support state coordination with community-based organizations and navigators to assist individuals with documentation and the submission of eligibility information across multiple modalities.

4. CLARIFY THE SUPPORT ROLE OF MANAGED CARE ORGANIZATIONS AND ADDRESS SUSTAINABLE FUNDING

The Coalition supports the rule's allocation of responsibilities: verification, exemption administration, and reporting are appropriately state functions, while managed care organizations are well positioned to support outreach, member education, and navigation. The IFC reiterates the conflict-of-interest parameters established in P.L. 119-21, confirming that plans may conduct outreach and education and make referrals, but may not verify eligibility or compliance or issue noncompliance notices on the state's behalf. Two questions, however, remain unresolved and would benefit from the supplemental guidance CMS has signaled.

First, states and plans need specificity on **which support activities may be delegated to managed care organizations**, so that plans' frequent, direct contact with members can be used to help identify potentially affected individuals, explain requirements and exemptions, and connect members to resources – without crossing into the verification, exemption-determination, or reporting functions that remain the state's responsibility. Second, because the rule provides that the costs of these support activities cannot be included in capitation rates, states and plans need clarity on **how this work can be sustainably funded and accounted for.** Without a workable funding and accountability pathway, the very outreach and navigation support that helps retain eligible members may not be available to individuals and families when it is most needed. We encourage CMS to issue guidance that defines the delegable support activities and establishes a sustainable funding and accountability framework consistent with federal rate-setting requirements.

5. APPLY A GOOD-FAITH-EFFORT EXEMPTION ON A GENUINE CASE-BY-CASE BASIS THAT RECOGNIZES STATE PROGRESS

The Coalition is concerned that the agency's posture on good-faith effort exemptions could deter states that are working diligently yet cannot be fully ready by January 1, 2027. The IFC signals that initial approvals will generally extend no longer than six months and that exemptions will be limited to extraordinary, severe, or unexpected issues. States face an unusually compressed and overlapping set of obligations under the Working Families Tax Cut law – including eligibility verification changes due October 1, 2026 and both six-month renewals and community engagement requirements due January 1, 2027 – and many are making demonstrable progress while still confronting genuine implementation barriers. We encourage CMS to weigh good-faith-effort requests on a genuine case-by-case basis that recognizes the substantial work states have already done and must still complete, to avoid signaling a posture that discourages diligent states from applying, and to ensure that eligible individuals retain coverage while states work towards full compliance.

CONCLUSION

The Coalition appreciates CMS's work to implement section 71119 in a manner that advances program integrity, and we believe the recommendations above would help ensure the requirement

is administered accurately and consistently while minimizing coverage losses among eligible individuals. We welcome the opportunity to serve as a resource and to share the practical experience of our member organizations as implementation proceeds. Please reach out to Laura Pence at laura.pence@leavittpartners.com with any questions.

Sincerely,
The Enrollment Coalition