The Enrollment Coalition

September 24, 2026

Dan Brillman
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Centers for Medicare & Medicaid Services
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RE: Medicaid Enterprise Systems (MES) IT Standards — Request for Information

Director Brillman,

The Enrollment Coalition appreciates the opportunity to respond to the Request for Information on Medicaid Enterprise Systems (MES) IT Standards.[1] The Enrollment Coalition is an alliance of organizations from across the health care community – patient and consumer advocates, health plans, health care providers, employers, and technology and data organizations – whose mission is to help eligible uninsured individuals enroll in, and stay enrolled in, the coverage for which they already qualify.

MES IT ISSUES ARE AN ENROLLMENT PROBLEM

Medicaid eligibility systems are not merely administrative tools; they are a significant investment of taxpayer dollars, and when they malfunction or apply eligibility rules incorrectly, eligible people can lose access to health care. A report from the Government Accountability Office (GAO) found that states spent $44.1 billion on Medicaid Management Information Systems (MMIS) and eligibility and enrollment systems between FY 2008 and FY 2018, of which CMS reimbursed $34.3 billion, and that 53 percent of responding state Medicaid officials used the same contractor to develop their MMIS.[2]

Despite the significant investments, Medicaid eligibility systems have "generated incorrect notices, sent paperwork to the wrong addresses, and experienced operational failures that complicated enrollment and renewal processes for Medicaid beneficiaries."[3] For example, in 2024 an eligibility-system issue in Florida "caused some mothers and infants to lose Medicaid coverage despite state policy providing 12 months of continuous postpartum coverage."[4] Additionally, an IT error in Michigan "led to the denial of Medicaid coverage for an eligible person with a disability" and the system "incorrectly directed some applicants into inappropriate benefit categories or denied coverage altogether."[5]

[1] CMS Releases Request for Information as Part of an Effort to Launch a New MES IT Standards Initiative
[2] Medicaid Information Technology: Effective CMS Oversight and States' Sharing of Claims Processing and Information Retrieval Systems Can Reduce Costs | U.S. GAO
[3] Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued by Errors - KFF Health News
[4] Florida's Deloitte-Run Computer System Cut Off New Moms Entitled to Medicaid - KFF Health News
[5] A Deloitte-Run System Denied Medicaid Benefits for Michigan's Disabled. Now Trump's Law Piles On. - KFF Health News

As states are implementing community engagement requirements and an increased frequency of redetermination, modernizing MES systems is particularly critical for improving consumer experience, supporting accurate enrollments, and preventing coverage losses among eligible individuals.

Below, the Coalition provides responses to specific questions posed in the RFI:

RESPONSES TO SELECTED RFI QUESTIONS

Data Elements, Transactions, and Enrollment Files

SA-11 –Data Elements. In the eligibility and enrollment domain, some areas that Coalition members have encountered gaps are:

- **Renewal dates.** The Coalition recommends that CMS require states to include each member's next renewal date on standardized monthly Medicaid enrollment files. This recommendation should apply across the Medicaid population, not only to individuals subject to community engagement requirements. Consistent delivery of renewal dates would better position plans, providers, and outreach partners to engage members ahead of renewal and help reduce avoidable coverage disruptions.
- ***Ex parte* outcomes.** The Coalition recommends standardized data elements identifying whether an *ex parte* review was completed, the outcome of the review, and, where permitted, the data source supporting the determination. Standardizing these elements would support more consistent interpretation across states and reduce duplicative requests for information already available to the state.
- **Community engagement applicability, exemptions, exceptions, and compliance timing.** For individuals potentially subject to community engagement requirements, CMS should establish standardized data elements identifying whether the requirement applies, whether an exemption or exception has been established, the applicable compliance period, and the timing and outcome of compliance reviews. These elements should be clearly distinguished from renewal information that applies across the broader Medicaid population.
- **Account transfer elements and validation.** CMS has reported that the legacy account transfer model permits incomplete or unusable data to move between state agencies and the Marketplace, and that states and the Marketplace routinely duplicate verifications when accounts are transferred.[6] The Coalition recommends that CMS use Account Transfer 2.0 to address these persistent implementation gaps by establishing clear conformance expectations for a required core data set, authoritative definitions and value sets, preservation and reuse of valid prior verification results, validation at the point of exchange, and actionable error responses. CMS should provide implementation support, conformance testing, and measurable data-quality expectations, including metrics for transfer completeness, successful ingestion, duplicate verification, and error resolution.

[6] https://www.medicaid.gov/federal-policy-guidance/downloads/cib10102024.pdf

CMS should also establish a transition plan for retiring legacy exchange processes that do not reliably transmit complete and usable information.

CMS should establish a mandatory national eligibility and enrollment data profile with authoritative definitions, value sets, and validation requirements for core enrollment functions, aligned where practicable with T-MSIS standards to ensure that core data elements carry a consistent meaning across operational systems, transactions, and federal reporting. All states should be required to implement the core profile without modification. States should be allowed to implement governed extensions to address state-specific statutory requirements, approved waiver authorities, population-specific eligibility needs, integrated human-services operations, or state-specific data sources that provide demonstrable operational value. Extensions should be publicly documented, machine-readable, and subject to CMS governance. They must not alter, redefine, duplicate, or conflict with required national elements. States should demonstrate that extensions improve eligibility accuracy, renewal timeliness, administrative efficiency, program integrity, or enrollee experience, and periodically assess their impact on outcomes such as *ex parte* renewal rates, processing times, beneficiary burden, error rates, and appeal outcomes.

The Coalition recognizes that many states operate integrated eligibility systems that provide individuals and families with a single point of entry for Medicaid and other benefits programs. Federal standardization should preserve and strengthen that consumer-facing integration, not require states to create separate intake pathways or duplicate infrastructure. CMS should therefore require standardized Medicaid data definitions and interfaces on the back end while allowing states to maintain flexible, integrated front-end application and eligibility experiences across programs.

SA-12, SA-13, and SA-14 – Codes, Plan Identifiers, and Error Handling. The Coalition supports standardizing on a national maintenance type and reason code list, on the National Plan ID or HIOS ID in place of state-specific plan codes, and on a standard 824 or 999 response format. Our health plan members operate across multiple states and reconcile materially different code sets for identical enrollment events, which drives manual rework and delays member effectuation. Two implementation cautions are important. CMS should publish the national code list with a crosswalk from current state values, provide a defined dual-acceptance transition period, and make validation tools available. CMS should also establish a standardized error-code taxonomy and correction-timeframe guidance, since standardizing the acknowledgement envelope without standardizing the error content would still require state-by-state interpretation.

V-11 and SA-2 – Standardized 834 Implementations. Inconsistent implementation of the ANSI X12 834 across states – variation in field population, interpretation, and timing – drives delays, rework, and member disruption. The practical path is not a version upgrade of the base standard, which would require X12 member consensus and federal adoption through HIPAA and would be slow and costly, but alignment of state companion guides within the current technical report. We recommend CMS convene a neutral, time-boxed public-private forum – led by CMCS with ASTP/ONC, including states, state-based exchanges, managed care organizations, X12, clearinghouses, and EDI vendors – to establish a Minimum Conformance Profile for the 834,

mirroring proven models such as the FHIR at Scale Taskforce, the CARIN Alliance, and the Argonaut Project. Renewal dates should be carried on the standardized monthly enrollment file rather than through ad hoc transfers. Improved 834 consistency - particularly residency indicators, effective dates, and maintenance type and reason codes – would also directly support the Section 71103 system by reducing false-positive duplicate flags.

The Coalition also encourages CMS to promote the capture and standardized transmission of member communication preferences, including preferred communication channel, language preference, and digital communication preferences where available. As states increasingly rely on digital outreach to support renewals, eligibility verification, and member education, consistent transmission of these preferences could improve member experience, reduce duplicative outreach efforts, and help ensure communications are delivered in the manner preferred by the member.

Interoperability, Identity, and Consent

SE-6 and SE-3 – Cross-Agency Interoperability and Harmonization. The most consequential bridges for enrollment are not clinical registries but the systems that determine whether someone gets covered: the Federal Data Services Hub, the Marketplace account transfer path, state human services systems administering SNAP and TANF (which in many states share the same eligibility platform), the Social Security Administration, and DHS's SAVE system. We continue to recommend CMS expand the reliable sources available through the Hub, including National Directory of New Hires data and Department of Veterans Affairs disability data, the latter directly relevant to a statutorily excluded population under the community engagement requirements. The NDNH is used across federal programs to verify eligibility and prevent improper payments, though it does not capture non-wage workers such as independent contractors – which is why it should be one layer in a verification hierarchy alongside consent-based verification, not a substitute for it.[7] We also encourage CMS to reduce the per-transaction cost of Hub queries so cost is not a reason a state declines to check a reliable source before asking an enrollee for paperwork. Finally, states, plans, and vendors are concurrently implementing the Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs required by January 1, 2027;[8] MES standards should reuse those FHIR profiles and security patterns wherever the underlying capability is the same, and where MES requirements must diverge, CMS should say so explicitly.

SE-9 and SE-1 – Identity Management. Identity resolution is the dependency underneath nearly every other objective in this RFI: accurate *ex parte* renewal, non-duplicative account transfer, reliable cross-state duplicate detection under Section 71103, and safe use of third-party verification data. States today use materially different matching logic and demographic elements, and the resulting mismatches reach people as denied applications, duplicate records, and erroneous terminations. We recommend CMS publish a standard identity-matching profile specifying a minimum necessary demographic data set for identity-resolution purposes, using information otherwise collected and permitted under Medicaid eligibility and enrollment requirements, along with a defined match-rate measure, expectations for confidence thresholds,

[7] https://www.congress.gov/crs-product/RS22889 . CRS notes that NDNH access has been extended across federal programs to verify eligibility and prevent improper payments, and that the directory does not capture non-wage workers such as independent contractors.
[8] Advancing Interoperability and Improving Prior Authorization Processes, final rule, 89 Fed. Reg. 8758 (February 8, 2024).

and required human adjudication pathways for near matches. For access management, we recommend a federated ICAM profile aligned to NIST digital identity guidelines, with attention to assurance levels that do not exclude enrollees lacking the documentation or devices higher-assurance proofing typically requires.

SE-7 – Consent and Privacy. Consent-based verification has moved to the center of Medicaid eligibility operations. CMS's own Eligibility Made Easy platform, known as Emmy, is built on it: an open-source modular suite of CMS-developed tools that uses consent-based verification across multiple data sources to support income and community engagement reporting for applicants and enrollees.[9] Standards should treat consent as a first-class data object: how it is captured, its scope and duration, how it is revoked, how revocation propagates to downstream data holders, and how consent status is recorded for audit. State-to-plan data sharing intended to support member education and navigation should follow minimum-necessary principles, with defined allowable uses and appropriate segmentation for behavioral health and substance use disorder information consistent with 42 C.F.R. Part 2. Plans can only help members navigate new requirements if they receive timely operational data, and that sharing should be standardized rather than bilaterial and ad hoc.

Technical Assistance, Procurement, and Portability

SA-4, SA-3, and SA-5 – Technical Assistance and Checkpoints. CMS's Emmy, described above, is API-first and gives states standardized access to verification data sources, with published technical documentation, source code, and integration guidance, offered alongside hands-on CMS support whether or not a state adopts the software.[10] That is the model this program should generalize. We recommend CMS publish as reusable national assets: reference architectures and working reference implementations for common capabilities (identity resolution, verification data access, notice generation, renewal and *ex parte* rules evaluation, account transfer, appeals tracking); a conformance test harness and sandbox that vendors and states can run continuously during development rather than only at certification; model business requirements and procurement language states can adopt directly; and a curated repository for which CMS, not states, is accountable for quality and currency.

On flexibility, we recommend a federal baseline with state profiles – a mandatory core of data definitions, interfaces, and security requirements, plus explicitly optional extensions – with every requirement labeled mandatory or recommended without ambiguity and a published exception process. The Coalition believes that uncertainty about whether a flexibility is an option or an expectation leads states to default to the more burdensome path, and that burden falls on enrollees. Checkpoints should be embedded in artifacts states already produce – the APD, operational reports, and streamlined modular certification – and automated wherever possible; CMS's standardized MES templates, required as of July 1, 2026, are the natural vehicle.[11] Conformance evidence should be a byproduct of the test harness rather than a separate documentation exercise.

[9] Eligibility made easy | CMS
[10] Eligibility made easy | CMS
[11] Streamlining Medicaid Enterprise Systems Templates | Medicaid; sho25003.pdf

V-6 and SA-10 – Portability and Procurement. We recommend CMS require, as a condition of enhanced FFP, that any MES module support published open data schemas; documented APIs for all data the module holds; bulk export of the complete data set in a non-proprietary format on demand; a contractual transition obligation with defined timelines and deliverables at contract end; and at least one tested export-and-import exercise during the contract term, rather than a first attempt at migration on the day a state tries to leave. A portability requirement that has never been exercised is not a portability requirement, and CMS should make clear these obligations express rights the federal government already holds.[12] MACPAC also observes that state requirements for prior Medicaid systems experience narrow the bidder pool and can raise costs.[13] The Coalition recommends outcome-based rather than prescriptive requirements, reusable modular procurement language, continued expansion of the GSA Schedule pathway, and scrutiny of contract extensions that preserve incumbent arrangements without competition. Concerns about the accuracy of state eligibility systems have drawn sustained congressional attention, including an October 2025 inquiry by members of the Senate Finance Committee to four major eligibility systems contractors;[14] a standards program with verifiable performance and portability requirements is the most constructive response available to CMS.

Workforce, Automation, and Measurement

SA-1, SA-8, and V-10 – State Barriers, Workforce, and Implementation Risk. The Coalition urges CMS to treat the eligibility worker experience as a coverage variable rather than an internal state concern. During the unwinding, at least eleven states reported systems that were old or difficult to use, and described system problems compounding staffing shortages and high turnover among eligibility workers, with one state citing a 20 percent vacancy rate; vacancy rates exceeded 10 percent in 16 of 26 reporting states, and states have reported similar pressures ahead of community engagement implementation.[15] Complex, poorly designed worker-facing systems increase training time, error rates, and turnover, and each of those reaches beneficiaries as a delayed application, and incorrect determination, or a case that falls through when a worker leaves. The Coalition recommends that CMS include worker-facing usability and error-rate measures in the outcomes set alongside beneficiary-facing measures; publish accessibility and plain-language requirements for member-facing interfaces, including Section 508 conformance, meaningful access for individuals with limited English proficiency, mobile-first design, and low-bandwidth functionality; and treat business process analysis, configuration, user acceptance testing, and change management as a first-class drivers of cost and schedule, publishing model requirements and test scripts so this work is no re-derived in every state.

V-9 – AI and Automation. Automation has potential to reduce burden – identifying individuals likely to qualify for an exemption before they are asked to prove it, flagging cases at risk of procedural

[12] 42 C.F.R. § 433.112(b)(5)-(6).
[13] Issue Brief - State Medicaid Enterprise Systems
[14] [2025-10-10] Wyden, Warren, Sanders, Warnock Probe Medicaid Contractors on Faulty Eligibility and Enrollment Systems | The United States Senate Committee on Finance
[15] Unwinding of Medicaid Continuous Enrollment: Key Themes from the Field | KFF; Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision – Center For Children and Families; States Face Another Challenge With Medicaid Work Rules: Staffing Shortages - KFF Health News

termination for outreach, and improving data matching. The prerequisites are the subject of this RFI: consistent data definitions, reliable identity resolution, and documented provenance. Models trained on inconsistently defined fields will produce confidently wrong results. Consistent with the Coalition's prior comments to CMS on program integrity technology, we recommend that any standards addressing AI or machine learning in MES require documented and reviewable logic for any model influencing an eligibility outcome; human review before any adverse action affecting coverage, with no fully automated termination or denial; routine testing for differential error rates across populations, including by language disability status, and geography; full auditability; and clear accountability for correcting errors at scale once discovered.

V-5 and SE-5 – KPIs and Reporting Burden. National maturity measures should include the outcomes the standards are meant to produce, not only adoption counts. We recommend CMS track and publish at the state level: *ex parte* renewal rates; application and renewal processing times; terminations disaggregated by procedural versus eligibility-based cause; cure-period outcomes, reinstatements, and appeal results; account transfer completion and duplicate-verification rates; duplicate-enrollment flag volumes and the share resolved as false positives; and conformance and portability status by module. To keep burden proportionate, this should draw on data states already submit – T-MSIS, operational reports, and standardized enrollment transactions – rather than creating parallel collections, and should flow from states to CMS rather than creating new reporting obligations for managed care plans. Publication at the state level matters: the variation documented during the unwinding was visible only because outcome data were reported publicly and comparably. [16]

CONCLUSION

The Enrollment Coalition supports CMS's decision to establish clear, outcome-driven MES IT standards, and believes this initiative can materially improve the enrollment and redetermination process, as well as improve program integrity. The Coalition encourages CMS to include stakeholders, in addition to states, in standards development, state implementation planning, procurement design, conformance testing, and ongoing performance review, to the extent possible. Stakeholders that work downstream of state systems have direct experience identifying where inconsistent data definitions, transaction requirements, timing, and system workflows create operational problems. Early and ongoing engagement can help CMS and states identify downstream impacts before they result in implementation delays, costly change requests, manual workarounds, enrollment discrepancies, or member disruption. We would welcome the opportunity to serve as a resource as CMS moves from the identify phase into standards development. Thank you for your consideration of these comments. Please reach out to Laura Pence at laura.pence@leavittpartners.com with any questions.

Sincerely,
Laura Pence
Advisor to the Enrollment Coalition

[16] An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding | KFF