mhpa Medicaid Health Plans of America

July 31, 2026

Submitted via http://www.regulations.gov
Administrator Mehmet Oz
Deputy Administrator Daniel Brillman
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2454-IFC

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)

Dear Administrator Oz and Deputy Administrator Brillman,

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate the opportunity to comment on the Medicaid Community Engagement Requirements (CER) Interim Final Rule (IFR). MHPA and its member Medicaid health plans are grateful for the opportunity to collaborate with CMS and states to ensure a smooth and successful implementation of CER while ensuring that exempt or compliant enrollees retain their Medicaid coverage.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 Medicaid managed care organizations (MCOs) serving nearly 47 million Medicaid enrollees in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid enrollees receive health care through MCOs, and MHPA provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost- effective, and quality health care for Medicaid enrollees.

For over 50 years, the Medicaid program has helped ensure that millions of Americans who need health care have access to preventive, primary, and specialty services. Medicaid services a population that is particularly vulnerable and medically frail, managing conditions that may include, but are not limited to, chronic illness, disability, or substance use disorder (SUD). Coverage interruptions for this population can mean delayed treatment, missed medications, or forgone care. Administrative requirements that increase the risk of Medicaid enrollees cycling on and off coverage, often referred to as "churn", can create barriers to care with long-lasting consequences for patient health and increased health care costs.

MHPA is concerned that several provisions of the IFR introduce coverage instability for Medicaid enrollees, potentially impeding access to care. Most notably, the IFR adds a new functional-impairment standard for individuals seeking a medically frail exemption to the Medicaid CER by requiring that a physical, mental, or behavioral health condition "significantly impair" the individual's ability to satisfy the CER. In addition to the new "paperwork" burden and potential for administrative disenrollment, this added standard relies on categorical criteria that may fail to capture enrollees with fluctuating conditions, atypical clinical documentation, or limitations that are real but not consistently reflected in existing records. Individuals with SUD are particularly vulnerable because the exemption

criteria do not clearly account for the instability that often accompanies active treatment or early recovery, creating a risk of coverage loss when continuity of care is most critical.

The IFR's verification framework also assumes a level of data accuracy, matching capability, and system interoperability that many states do not yet have. As a result, eligible Medicaid enrollees could lose coverage because of incomplete records, mismatched data, or other administrative failures rather than actual noncompliance. While we support the requirement that states leverage ex parte processes to verify an enrollee's status or documentation, we recommend that CMS continue development of federal verification tools to ensure that states have the support needed to ensure a successful implementation with minimal procedurally related coverage losses.

These risks are compounded by the compressed implementation timeline, which gives states and Medicaid MCOs limited time to build the screening, verification, and data-sharing infrastructure the IFR contemplates and may force greater reliance on manual processes that are more prone to delay and error.

Recommendations to address these concerns and other specific feedback related to the IFR are as follows:

Specified Excluded Individuals – Medically Frailty

Functional Impairment Component of the Test

Overarching Concerns

MHPA has strong concerns with the functional impairment test tied to determination of medical frailty and recommends that CMS strike this test in their final rule. The functional impairment test is not required by the Working Families Tax Cut (WFTC) Legislation and exceeds the plain text of the statute, which aims to exempt individuals who are medically frail from community engagement requirements without additional constraints.

We are most notably concerned about the impact of the functional impairment test on patient access and outcomes. Eligible individuals risk losing coverage because of documentation and procedural barriers rather than true ineligibility. Coverage disruptions impact care access and service delivery for enrollees, leading to poorer outcomes and introducing inefficiencies into the system.

In lieu of the significant impairment requirement, we support the use of the International Classification of Diseases, Tenth Revision (ICD-10) or other diagnosis code corresponding to one of the five required statutory categories to establish medical frailty. A diagnosis-based standard tied to the category of condition without requiring additional functionality criteria produces a more uniform, objective, and consistent approach to evaluating medical frailty. This approach aligns with physician training, relies on information clinicians already capture in routine documentation, and is more amenable to automation through claims and encounter data. Further, this approach would improve auditability and reduce administrative costs. We believe that such an approach aligns with CMS' objectives of improving

interoperability and streamlining administrative processes in the Medicaid program, goals which MHPA supports.

Anticipated Provider Burden

We believe the functional impairment criteria requirement introduces provider burden and additional costs by requiring providers to verify medical frailty and/or functional status. Treating providers are positioned to be the default source of a Medicaid enrollee's documentation for a functional impairment determination, requiring individualized clinical substantiation rather than confirmation of a coded condition. Providers will need to build new workflows, documentation processes, and technology solutions, including electronic health record (EHR) modifications, to generate, transmit, and respond to verification requests, and to staff the associated back-office functions. Moreover, appointment capacity consumed by documentation visits crowds out clinically necessary care for the broader patient population.

The administrative costs for providers treating Medicaid expansion enrollees are compounded by the financial exposure created by the WFTC legislation's reduction of retroactive eligibility from three months to one month with Medicaid providers absorbing the costs of any services provided should enrollees be deemed not eligible. The functional-impairment test adds a layer of administrative decision-making and paperwork unrelated to direct patient care, contributing to physician burnout. The standard will generate unnecessary appointments scheduled solely to produce documentation and not to improve patient care or clinical outcomes. Provider attestations will also add to the administrative burden health professionals already face, which could impact provider participation and plans' abilities to meet network adequacy standards under Medicaid.

We note that these challenges will arise during a period where providers serving Medicaid enrollees are already facing other significant headwinds, including the implementation of new restrictions on Medicaid financing mechanisms from the WFTC Legislation, including in relation to State Directed Payments (SDPs) and provider taxes. We encourage CMS to consider the burden of this functional impairment test on providers in the broader landscape of changes impacting the Medicaid program. As noted in our letter in response to the proposed SDP rule[1], we believe that these financing restrictions are likely to cause strain for providers and may impact network adequacy for Medicaid enrollees.

Inconsistency in Medical Frailty Determinations

The functional impairment test is also likely to increase variability across providers and states and lead to an inconsistent implementation of the medical frailty exemption. Two individuals with the same diagnosis and severity may receive different determinations based on varying provider assessments, documentation practices, or state review approaches. An individualized functionality test by state invites inconsistency and the risk that providers develop reputations as more or less permissive in furnishing documentation. Additionally, we are concerned that the state eligibility staff, who are not clinically trained, will be

[1] https://www.regulations.gov/comment/CMS-2026-1916-0642

responsible for verifying medical frailty determinations that often require nuanced clinical judgment to be applied correctly. Absent more uniform definition and implementation method, functional-impairment determinations will vary across providers and states.

Impact on Quality Measurement

The functional impairment test is likely to have an impact on quality measurement in the Medicaid program. Disagreements between patients and providers over medical frailty determinations - matters unrelated to clinical quality - may depress patient-experience scores on instruments such as Consumer Assessment of Healthcare Providers & Systems (CAHPS), distorting quality measurement.

We note that additional considerations related to the verification of medical frailty can be found in our section below, titled "Verification of Exceptions and Compliance."

Considerations for Medical Frailty Based on Substance Use Disorder (SUD)

Recommending CMS Withdraw the Five-Year Recovery Period Provision

We recommend that CMS withdraw the five-year recovery period provision tied to the SUD medical frailty exemption. The inclusion of a five-year recovery period, where an individual in recovery for five or more years from a SUD, was not included in the WFTC legislation, and is duplicative with the functional impairment test that CMS included in this IFR. CMS has not provided sufficient justification for the conclusion that an individual in recovery for five or more years from SUD is no longer medically frail. Further, this five-year recovery period appears arbitrary and is likely to result in unintended consequences that could harm the enrollees that this provision of the WFTC Legislation was intended to protect. Measured from diagnosis, treatment initiation, or last use, elapsed time is not a reliable proxy for current impairment, level of care, frequency of treatment appointments (which itself can affect a person's ability to meet community engagement requirements), or risk of relapse (which speaks to the continued importance of coverage and access to care). While general assumptions can be drawn from the passage of time, a fixed endpoint substitutes a rough temporal estimate for the clinical questions that matter.

In addition, the term "recovery" is itself imprecise and difficult to operationalize. "Stable recovery" is not a formal diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) or an American Society of Addiction Medicine (ASAM)-defined stage; it is a term used in clinical, occupational, and recovery-support settings to describe a person actively engaged in maintaining recovery through treatment, counseling, medication, or similar means. Recovery is better understood as an ongoing process of improving health and wellness within a self-directed life, not a status conferred by the lapse of a set number of years.

If the agency nonetheless adopts a temporal standard, it should select the least exclusionary formulation. The DSM provides existing modifiers, early remission (3 to 11 months) and sustained remission (12 months or longer), that are clinically grounded and preferable to an invented five-year rule. The DSM-5-TR definition of sustained remission does

not specify an upper limit for definition of sustained remission. We recommend that CMS avoid tying this determination to a formal ASAM-criteria assessment or comparable evaluation, which would make the process substantially more laborious without improving accuracy.

Data Sharing Related to SUD

We also encourage CMS to provide additional operational guidance regarding the use, exchange, and verification of SUD treatment information needed to support community engagement exclusions, including how states, providers, and managed care plans may appropriately share information while remaining compliant with 42 CFR Part 2 and other applicable privacy requirements. CMS should clarify what data elements are sufficient to establish participation in a qualifying drug or alcohol treatment or rehabilitation program and whether diagnosis codes, procedure codes, service utilization data, provider attestations, or other electronic data sources may be used to support ex parte verification.

42 CFR Part 2 also poses challenges for provider attestation of medical frailty for a patient with SUD, which may require specific additional consent beyond what is ordinarily obtained, introducing further delay and administrative friction. CMS should clarify that the consent supporting a provider's attestation, whether captured on an attestation form itself or through a release of information, may address Part 2 disclosure requirements.

Additionally, CMS should explicitly state that this type of data sharing, alongside other health data sharing related to CER, is HIPAA compliant.

Promoting consistent national standards for the verification of qualifying SUD treatment participation would reduce variation across states and minimize disruptions for enrollees receiving treatment across state lines. To support state consistency, CMS should provide implementation guidance on how states can operationalize this exclusion when treatment information is unavailable through traditional eligibility verification data sources because of privacy restrictions, including the circumstances under which enrollee attestation or alternative verification approaches may be used.

ADL including IADL

The definition of Activities of Daily Living (ADLs) should expressly encompass Instrumental ADLs (IADL) to capture the full range of functional limitations the exemption is intended to address.

Verification of Exceptions and Compliance

Ex Parte Verification / Automation

MHPA supports the requirement that states leverage ex parte processes to verify an enrollee's status or documentation. An emphasis on automation, including verifying existing data sources, such as claims and encounter data for verifying medical frailty status, or income and employment data for compliance purposes, will help to minimize the administrative burden on enrollees and states as they seek to comply with CER.

We recommend that CMS continue development of federal verification tools, including the Federal Data Services Hub and Emmy. Should CMS move forward with the functional impairment test, CMS should provide guidance on how automated verification processes can be maintained when functional assessments are required for medical frailty determinations. CMS should encourage coding and data elements that allow exemptions to be verified through existing automated systems whenever possible.

Reporting and Monitoring Disenrollments

We ask that CMS clarify tracking and monitoring requirements of procedural/administrative disenrollments, including individuals inadvertently overlooked who should be exempt from CER. The risk that exempt individuals will lose coverage through administrative error, rather than non-compliance, is significant given the complexity of the exemption categories and the compressed implementation timeline. Without robust tracking of administrative disenrollments, there is no reliable mechanism to identify when exempt individuals, such as those who are medically frail, caregivers, or otherwise excluded from CER, are losing coverage due to process failures. CMS should establish clear reporting requirements that allow both CMS and states to monitor administrative disenrollment rates among exempt populations in a reasonable timeframe, with a defined corrective action process to restore coverage promptly when individuals are found to have been disenrolled in error.

Verification Relating to Medical Frailty

Verification Relating to Functional Impairment

We recommend that CMS publish a standardized diagnosis and service code framework to ensure a consistent and fair implementation of medical frailty across states. If CMS decides to move forward with the significant impairment requirement, we also recommend that CMS develop and maintain a standardized functional assessment and provider attestation tool. Many providers, especially smaller provider practices, are unlikely to have the resources to develop these tools on their own.

For the functional impairment component of the medical frailty test, we encourage CMS to consider that existing Long-Term Services and Supports (LTSS) functional assessments were not designed to evaluate an individual's ability to participate in community engagement activities and may not be appropriate for this purpose.

Clarifications on Verification, Self-Attestation, and “Period of Enrollment”

MHPA also seeks several clarifications. First, CMS should clarify whether additional digital/ex parte verification approaches based on diagnosis, service utilization, and claims/encounter information could satisfy the intent of the medical frailty standard.

Second, CMS should also clarify self-attestation policies during the 2027 transition period, including whether attestation applies for a single verification period or for the individual's entire period of enrollment.

And, finally, we recommend that CMS provide additional clarification on the definition of "period of enrollment" for the purposes of the medical frailty self-attestation provision of the IFR. While we appreciate that CMS has defined period of enrollment in the IFR to be "a continuous period of enrollment in coverage under the State plan or waiver without the individual being disenrolled, regardless of the number of consecutive eligibility periods, of redeterminations or renewals, or of transitions between eligibility groups", we believe that additional clarity and illustrative examples would be helpful for a consistent implementation. Notably, we ask CMS to confirm that if an enrollee loses Medicaid coverage for one month, and then the enrollee applies for coverage the following month, this constitutes a separate period of enrollment for the purposes of the self-attestation provision. Challenges in documentation are unlikely to change during short gaps in enrollment, and enrollees should continue to have the opportunity to self-attest to their condition when they apply for coverage.

We thank CMS for recognizing the importance of the timeliness standards as a part of the noncompliance procedures and determining eligibility. MHPA believes that CMS should further encourage timeliness of application and renewal processing in states. CMS should also provide guidance on procedures that can protect enrollees from adverse action due to a lack of timeliness on the part of the state. The promptness of application and renewal processing is key for enrollees' access to coverage and care.

Recommendations Related to Verification

We recommend that CMS not require medical frailty to be reverified every twelve months, particularly for conditions that are unlikely to change. At a minimum, we recommend CMS eliminate the reverification requirement for permanent conditions to avoid unnecessary verification and burden when the individual's impairment status and ability to engage in community engagement activities are not reasonably expected to change. This could mirror the exclusion for veterans, where veterans with a total disability rating are excluded from the CER. This is particularly pertinent for individuals with a disability under Section 1614 of the Social Security Act, as state agencies already verify medical and functional criteria for these individuals and are only required to conduct periodic reviews of the determination.

MHPA recommends that self-attestation continue to be available for medical frailty for certain vulnerable individuals where documentation is unavailable or would pose a significant administrative burden. Examples include:

- Serious illnesses and chronic conditions, such as cancer, which can exhibit periodic, intermittent, and/or unpredictable symptoms impacting one's ability to work.
- Individuals with pending disability determinations, who often have already been identified by providers or public programs as having serious limitations but are awaiting a final disability determination via a federal or state review process.
- Enrollees receiving behavioral health or SUD services where data sharing restrictions may inhibit verification processes.

Caregiver Verification

CMS should provide confirmation that adults living with a child under 14 do not need to provide documentation to prove 80 hours of assistance offered per month to qualify as a caregiver. Some states are interpreting that they need to both verify residence **and** 80 hours of care, which we believe is inconsistent with the WFTC Legislation and underlying IFR.

Further, we request that CMS provide an explicit pathway to self-attestation for caregivers, which is a group which may have difficulties obtaining documentation supporting their status. CMS should provide a template or verification to states and enrollees to support such self-attestation to streamline this process.

Claims Data 12-Month Period

We recommend that CMS extend the lookback period for claims data to support medical frailty from 12 months to 36 months. Restricting reviews to 12 months risks overlooking medically frail individuals who remain clinically vulnerable. Many serious chronic illnesses, disabling mental illnesses, cancer treatment, and SUDs may exhibit periodic, intermittent, and/or unpredictable symptoms which may not consistently generate claims during a single year despite continuing to affect an individual's ability to work or participate in community engagement activities. Examples include:

- Individuals whose conditions are reasonably managed and are not actively receiving treatment (i.e., not continuously generating claims) but nonetheless continue to impact that individual's ability to engage in community engagement activities.
- Individuals experiencing gaps or transitions in care.
- Individuals receiving services which are not captured in a state's available data sources.
- Individuals receiving behavioral health or SUD services subject to privacy and data sharing restrictions.

A restrictive lookback period could have the unintended consequence of excluding documentation supporting a condition of medical frailty, potentially causing losses of coverage for exempt individuals. Chronic or permanent conditions such as the ones that qualify for medical frailty are often unlikely to change in a 12-month period. Further, a lag in claims submitted by providers could have the consequence of creating a documentation gap despite regular appointments by the enrollee.

Self-Attestation

The IFR permits self-attestation to the medical frailty exemption without additional documentation only until January 1, 2028, after which it allows just one self-attestation for medical frailty over an enrollee's entire enrollment period and effectively requires documentation for any redetermination thereafter. MHPA appreciates that CMS will permit self-attestation in 2027 to limit unnecessary coverage losses as states and enrollees transition to the meet the new CER. Given the significant operational changes required to implement the CER, we believe temporary self-attestation serves as an important tool that

will help to protect eligible individuals from inappropriate coverage disruptions while states implement and stabilize new processes.

Moving beyond 2027, MHPA recommends that CMS provide states the flexibility to allow for the continued availability of credible self-attestation as an acceptable form of "other information" where reliable electronic data and reasonably available documentation do not exist. MHPA understands the importance of ensuring proper safeguards when verifying community engagement. However, we also believe that it is necessary to balance this oversight with a certain amount of flexibility to prevent procedurally related coverage losses. We believe extending this state flexibility would align with authorizing statutory language that directs states to use reliable information already available to them without requiring, where possible, the applicable individual to submit additional information.

We note there are some scenarios where documentation is inherently difficult to obtain, including for individuals engaged in nontraditional forms of work, such as "gig" employment. Requiring documentation in these cases could create barriers for otherwise eligible individuals. To address these and related scenarios, we request CMS issue guidance on what constitutes "reasonably available information" and other types of acceptable information when there is no reliable information available to the state.

MHPA encourages CMS to provide guidance to states on self-attestation documentation processing. While we support the use of self-attestation where permissible, we are concerned about the lack of clarity regarding how audits will be carried out, particularly due to procedural differences among states. This is an area where CMS could provide standardized procedures that states can follow to ensure compliance and avoid adverse action during an audit.

Data Sharing

MHPA requests CMS issue guidance to states on the types of information and data that should be shared from the state to MCOs. An efficient information exchange process from states to plans is necessary so MCOs know which members are subject to the CERs, who qualify for exclusions or exceptions, and other information needed to target outreach and support the members most at-risk of losing their Medicaid coverage.

For example, CMS could make recommendations for the data fields that should be included in 834 files or other state-to-plan files to the extent permissible under applicable data sharing and privacy laws. The list below includes the data points that states could include in their 834 files. Data elements related to an enrollee's exemption or non-exemption status and indicators on how the member met (or did not meet) their CER (employment, education, volunteering, work program, etc.) would be the most helpful.

- Codes that show whether a member is exempt and if so, under which exception or exclusion.
- Indicator of whether a non-exempt member supplied their community engagement information and the date range that information covers.

- Accurate justification that member's Medicaid coverage was terminated with list of reasons/codes updated to include indicators for members terminated due to failure to comply with CER, reflecting reasons for non-compliance. For instance:
    - Failure to comply with CER for a non-exempt member: required documentation not submitted.
    - Failure to comply with CER for a non-exempt member: activity hours submitted were insufficient/unqualifying.
- Codes that show through which activities a member met their CER.
- Supplemental Nutrition Assistance Program (SNAP) fields that indicate who must meet the work requirement and fields for medical exemption and work verification.
- Indicator that would identify if/when a member resides in a county that becomes eligible for a hardship exemption.
- Link to state wage data.
- Enrolled in a training program (Commonwealth Workforce Development System (CWDS) data).
- Indication if a contact number is mobile or home.
- Member email address.
- Upcoming verification dates/pending determinations.
- Noncompliance notices.
- Eligibility actions.

Finally, some data sources consistently lag such that they are not reliable information available to states as they conduct ex parte verifications, which underscores the importance of flexibility for credible self-attestations. Delays can exceed three months in some circumstances. Examples include:

- Student enrollment databases.
- Workforce program participation records.
- Interstate eligibility data.
- Community service program data.

Managed Care Implications

Medicaid Unwinding Parallels

We are pleased to see CMS' recognition that managed care organizations have an important role in support of the implementation of community engagement requirements. Plans, through their contracts with states have deep and longstanding connections with members, providers and community-based organizations that states can leverage for outreach, education and identification of individuals who may qualify for exclusions or exceptions.

The Medicaid "unwinding" process, following the end of the public health emergency, demonstrated the value of leveraging managed care plans as enrollment and retention partners. Throughout the unwinding, CMS encouraged states to work with plans to support enrollee outreach, update contact information, and assist members with renewal

processes. Many states relied on managed care organizations' care management infrastructure, provider relationships, and member communication capabilities to help eligible individuals maintain coverage and navigate complex renewal requirements.[2]

Permissible MCO Activities

Despite the success of these partnerships, we are concerned about states' flexibility to work with plans to support enrollees through this process. The IFR appropriately distinguishes between activities that plans may perform such as outreach, education, referrals and information sharing, and functions that remain the responsibility of the state, including compliance determinations, formal notices of noncompliance, and collecting data on work, community service, or educational activities. The line between permissible education and referral assistance and prohibited compliance determination or activity "tracking" is not clearly defined. Further, we encourage CMS to update and release guidance on optional support activities states may permit, like the guidance provided during the public health emergency. Specifically, CMS could include reminders of permissible activities for states in terms of application assistance and other optional activities for MCOs. Without clearly defined guidance, there is risk for MCOs and their delegated entities, including navigators and care managers, who may be employed directly by the MCO or by a third party, and for call center staff who may field member questions about the community engagement requirement without conducting outreach.

Indeed, as states move toward implementation of CER, some managed care plans are being asked to perform functions that appear to extend beyond the activities contemplated under the IFR, including substantial support for exemption documentation, compliance-related administrative processes, and other activities that are closely tied to eligibility and compliance determinations. We urge CMS to build on its existing framework of permissible activities in the IFR by issuing practical implementation guidance, model contract language, examples of permissible plan activities and creating opportunities for continued dialogue with states and plans. Additionally, we recommend that CMS establish a clear safe harbor addressing these scenarios.

MCO Outreach Modalities

As part of these efforts to support our state partners, we ask CMS to clarify that MCO outreach through modalities including telephone, text message, email, member portals, and other state-approved communication channels when supporting CER implementation are permissible activities.

Ensuring that State Mandated Support for CER is Reflected in Rates

We encourage CMS to ensure alignment between permissible MCO responsibilities, state contract requirements, and available funding mechanisms to support successful and

[2] "On the Ground Enrollment: Results from a National Survey of Medicaid Managed Care Organization Experiences During Redetermination". Medicaid Health Plans of America. https://medicaidplans.org/wp-content/uploads/2023/09/MHPA-Research-On-the-Ground-Enrollment-MCO-Engagement.pdf

sustainable implementation of community engagement requirements. Specifically, we recommend that CMS allow for administrative services relating to the implementation of CER to be reflected in the managed care rate setting process. To the extent states elect to rely on health plans for additional implementation support, CMS should clarify the mechanisms available to appropriately recognize and fund those activities. While we appreciate CMS clarifying in their IFR that voluntary services to support enrollees in the implementation of CER can be treated as value-added services and included in the medical loss ratio numerator as incurred claims, this does not address services that are mandated by the state in support of CER. To the extent that states are mandating that MCOs engage in activities to support the implementation of CER, we strongly recommend that CMS clarify that such services should be reflected in contracted rates between the State and the MCO prospectively.

States should not impose administrative responsibilities on managed care plans that exceed the activities contemplated under the IFR while simultaneously limiting the ability to reflect those activities in managed care financing and rate development.

It is important to note that Medicaid MCOs are navigating numerous regulatory changes from the 2024 Medicaid Managed Care Rule and other eligibility and financing changes from the WFTC Legislation. To ensure a healthy and financially sustainable delivery of Medicaid services, we encourage CMS to consider the full rate setting landscape and allow for these additional activities to be reflected in the rate setting process.

Good Faith Waiver

The WFTC Legislation included a provision which allowed states who make good faith efforts to implement CER but are struggling to meet the January 1, 2027 effective date to request a good faith waiver. We strongly encourage CMS to provide states with the opportunity to leverage this statutory pathway towards compliance when requested. Given the publication of this IFR just six months before the effective date of CER, we believe that many states will be justified in needing additional time to ensure a smooth and successful implementation of these new requirements.

Presumptive Eligibility

CMS should clarify how community engagement requirements apply to individuals receiving Presumptive Eligibility (PE) and Hospital Presumptive Eligibility (HPE). Individuals receiving inpatient care should not be required to demonstrate community engagement compliance while hospitalized, nor should they have to demonstrate compliance prior to a hospitalization in order to gain eligibility to the HPE option. The focus for enrollees, and their providers, should remain on necessary clinical care, not documentation of work activity.

Further, because PE/HPE determinations are made before completion of a full eligibility determination, states generally do not know whether an individual is subject to CER or qualify for an exclusion. CMS should clarify whether states are expected to collect exclusion

or community engagement information during PE/HPE determinations and whether PE/HPE application processes require modification.

Short-term Hardship Exemptions

We encourage CMS to permit states to request the unemployment hardship exemption without having to commit to implementing the other three short-term hardship exemptions. This would also support reducing state administrative burden by eliminating the need for states to submit at least three State Plan Amendments (SPAs).

MHPA notes that in some States, there are quite a few areas where the 8 percent unemployment rate is going to impact members' requirements to meet CER. CMS should consider unemployment rate as well as high SNAP rate; 30 percent of the county receiving SNAP benefits should be excluded.

In order to facilitate requesting short-term hardship exemptions for enrollees, we recommend CMS explicitly allow the use of data like authorization data and Admission, Discharge, and Transfer (ADT) data from health information exchanges (HIEs) in addition to claims data to validate short-term hardship exceptions like for hospitalizations or travel out of state for medical care.

Specified Excluded Individuals – American Indians and Alaska Natives

We recommend that CMS extend the specified excluded individual category which includes American Indians and Alaska Natives to also include Native Hawaiians.

Once again, thank you for the opportunity to provide comment on the Medicaid Community Engagement Requirements Interim Final Rule. We appreciate the opportunity to share our perspective on addressing these challenges and look forward to continuing to work with CMS to make a meaningful difference in the lives of Medicaid enrollees.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/S/

Shannon Attanasio

Senior Vice President, Government Relations, Policy & Advocacy

MHPA