July 31, 2026

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

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the Community Engagement Requirement for Certain Individuals interim final rule with comment (IFC).

NAMD is a professional community of state and territory leaders who provide health insurance to almost 75 million individuals and families through Medicaid and the Children's Health Insurance Program (CHIP) in each of the 50 states, the District of Columbia, and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives. In addition to supporting Medicaid Directors, NAMD serves over 500 Medicaid leaders, including convenings with subject matter experts in finance and budget, technology, eligibility policy, and communications to share operational expertise, support policy implementation, and exchange promising practices across states and territories.

As a nonpartisan membership association, NAMD does not endorse specific policies or engage in litigation. When NAMD comments on federal regulations, as we do in this letter, our comments originate from and reflect the operational experience of all state and territory Medicaid programs and are developed such that they are representative of the range of viewpoints across our members.

These comments are focused on the operational, administrative, and implementation considerations Medicaid agencies have identified through forums facilitated by NAMD. The topics addressed in this letter are intended to support effective implementation of the IFC. Although these comments do not comprehensively address every aspect of the IFC for which Medicaid agencies may need additional support, they highlight the most pressing implementation considerations identified by NAMD's members.

NAMD appreciates CMS's consideration of Medicaid agencies' perspectives on these matters and the dialogue with our members following the publication of the IFC. **NAMD remains committed to serving as a trusted partner to CMS and looks forward to continued collaboration on behalf of all Medicaid agencies.**

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Executive Summary

NAMD appreciates the strong collaboration between Medicaid agencies and CMS that is informing implementation approaches to community engagement (CE) in the Medicaid program. The publication of the IFC is a significant milestone, providing discrete policy direction to NAMD's members that is foundational to state-level operational decisions such as budgeting, staff resource allocations, and systems modifications. Medicaid agencies are committed to implementation of the IFC in their programs and appreciate continued collaboration with CMS to maximize operational success.

As the entities directly responsible for operationalizing policy articulated in the IFC, Medicaid agencies are uniquely positioned to provide CMS with operational insights to most effectively deploy technical assistance (TA) resources and, where necessary, provide further policy clarity. These areas include, but are not limited to, the following:

- Operationalizing the IFC's distinctions between excluded individuals and specified applicable individuals, and the sequencing of data collection and verification activities associated with these distinctions;
- Operationalizing the medical frailty exclusion, with particular attention to determining if a condition significantly impairs an individual's ability to comply with CE requirements;
- Maximizing a "data first" approach for CE verifications and exemptions, including incorporating data made available through the Federal Data Services Hub (the Hub) and how individual self-attestation can be used on and after 2028;
- Sequencing notices and member communications, particularly those associated with post-enrollment exception categories, opportunities to demonstrate CE compliance when the state determines an individual is non-compliant, and states electing the short-term hardship exceptions; and
- Compliance with data reporting elements and CMS oversight expectations for CE implementation.

Implementation of CE presents a series of interconnected policy, operational, systems, and communications issues for Medicaid agencies and their partners to navigate. Each of these factors influences each other – policy direction informs state-level operations, themselves influenced by systems design and change timelines, all of which affects the messages that Medicaid members and stakeholders need to understand the state's implementation approach. Overall, the IFC's policies provide clarity that invites additional operational considerations for implementation. However, certain policies may require states to revisit these interconnected implementation domains and adjust their implementation approach. These decisions will be state-specific and contextual, and NAMD encourages CMS to look to individual state comments and continue individual state engagement to fully appreciate where each state is situated on its implementation journey.

It is possible that some states, based on their good faith reading of statute, made implementation decisions that need more time to adjust than is available under the January 1, 2027 implementation timeline. **NAMD encourages CMS to utilize its statutory authority to offer good faith effort exemptions to account for state-specific implementation challenges as they emerge.**

NAMD also encourages CMS to:

- Maintain a flexible and iterative approach to CE implementation as our members continue to move these significant changes in Medicaid eligibility processes and operations forward;
- Provide clear point in time documentation to support future audits and program integrity efforts associated with these changes, particularly in relation to future Payment Error Rate Measure (PERM) audit processes and the changes to PERM audits taking effect in FY 2030; and
- Where possible, memorialize in regulation and/or sub-regulatory guidance policy and operational clarifications surfaced in dialogue with states.

Priority Areas for TA and Implementation Dialogue

As CMS considers its TA strategy, Medicaid agencies encourage the agency to prioritize flexible, implementation-oriented support in the following areas. These recommendations are intended to identify topics where additional guidance would be most helpful, rather than prescribe specific operational approaches. While this is not intended to be an exhaustive list of TA needs, it reflects the areas that Medicaid agencies currently view as the highest implementation priorities leading up to January 1, 2027, and where to most effectively utilize the first year of implementation to iterate and improve.

Addressing Eligibility Systems and Workflows to Support Validation of Meeting CE Requirements and Validation of Specified Excluded Individuals

The implementation of CE requirements represents one of the largest changes to Medicaid eligibility policy in years, and itself overlays other eligibility policy changes affecting the same population such as conducting redeterminations every 6 months and adjustments to retroactive eligibility periods. As Medicaid agencies review the array of changes to their state-level policies, procedures, systems, and operations, they consistently indicate two prominent areas of focus: first, navigating the procedural and operational aspects of validating an individual demonstrating CE; and second, identifying and validating specified excluded individuals.

The IFC is clear that, in general, states must identify and assess whether an individual is a specified excluded individual before moving on to assessing whether an individual demonstrates CE in the period the state has selected for review. The IFC is also clear on expectations around using ex parte processes and known data sources to the fullest extent possible before turning to documentation or individual self-attestation. However, these broad goals and parameters manifest differently in each state's eligibility system configuration and data environment.

Several areas under these broad topics that NAMD wishes to highlight include, but are not limited to:

- **Identification of less than half-time educational program enrollment:** Medicaid agencies appreciate CMS's clarification that less than half-time educational program enrollment should be computed into equivalent hours of CE demonstration activities, and the granularity of the computation provided in the IFC. However, several states have articulated challenges associated with obtaining consistent data on less than half-time enrollment, notably variation in academic calendars, how educational institutions define credit hours, and distinctions between classroom instruction, online courses, self-directed study programs, and how to account for individuals who add or drop courses during an educational term or enroll in multiple institutions. Best practices on obtaining reliable information that accounts for these factors would be appreciated.

- **Distinguishing between caregivers exempt from CE requirements vs. caregiving activities that count towards demonstrating CE:** Medicaid agencies appreciate the IFC's clarification on the different categories of family caregivers, but these clarifications in turn invite further operational questions that CMS can support states in addressing. In particular, developing frameworks that can assist states in clearly operationalizing the delineation between caregivers who are exempt from CE based on their caregiving responsibilities and relationship to the individual receiving care versus those caregivers whose caregiving hours count as CE qualifying activities will be very helpful. States have several questions around CMS's expectations on verification of the latter category starting in 2028 when self-attestation becomes more limited, including what kind of information CMS will require to verify the disability status of the individual for whom the CE-applicable individual is providing care.
- **Distinguishing between individuals exempt from CE requirements based on unpaid community service through a structured program versus community service activities that count toward demonstrating CE:** Similar to the distinction described above for caregivers, Medicaid agencies appreciate the IFC's clarification on the role of community service but have additional operational questions about how Medicaid agencies should distinguish between individuals whose participation in unpaid community service through a structured program versus those whose community service hours count as CE qualifying activities contrasted with those whose community service activities may instead be considered unpaid work. Additional guidance and technical assistance from CMS will be helpful as states develop frameworks to operationalize this distinction, including any differences in documentation and verification requirements.
- **Post-enrollment verification of specified excluded individuals:** Generally, CMS contemplates states first assessing whether an individual is a specified excluded individual who is not subject to CE before moving to determine CE compliance when reviewing eligibility. However, under certain scenarios an individual may be found Medicaid eligible on the basis of income through ex parte review using known data sources, with those same data sources indicating compliance with CE requirements (for example, an income verification check that shows an individual's monthly income is above $580) while also attesting to a disease state or condition that could result in a medical frailty determination. The IFC directs states to provide Medicaid coverage in these circumstances and conducti a post-enrollment verification of the medical frailty attestation. These types of scenarios require notable adjustments to existing eligibility processes and workflows, and NAMD encourages CMS to continue developing frameworks and approaches to assist states in effectuating these post-enrollment verification activities.
- **Supporting state systems and process changes regarding self-attestation from 2027 to 2028 and beyond:** NAMD's members are appreciative of CMS's approach to permitting the use of individual self-attestation to different elements of CE in 2027. This appropriately acknowledges the complexity of the work states are navigating and the iteration and improvement that will help realize CMS's goals for a data driven, maximally automated CE program in implementation year two and ongoing. That said, making the transition in 2028 towards utilizing data and reasonable sources of available documentation first, with self-attestation as the last option, will require significant TA and supports for Medicaid agencies. This is particularly pronounced in the medical frailty exclusion, discussed in further detail below.

NAMD's membership is mindful of the layering effect of these different changes on the overall readiness of eligibility systems and workforces, as well as the status of member-facing communications. **NAMD recommends that CMS maintain its open and effective lines of communication with states to address the array of implementation issues articulated here and elsewhere in these comments.**

Operationalizing the Medical Frailty Exclusion
In this IFC, CMS specifies that someone who is medically frail or otherwise has special medical needs (collectively referred to in this section as "medical frailty" or “medically frail”) is considered to be a specified excluded individual from CE requirements.[1] The rule further clarifies that, to qualify for the exclusion, an individual must both have a qualifying condition and demonstrate that the condition impairs their ability to meet the required 80 hours of qualifying activities or applicable income amounts.

Medicaid agencies have been working steadfastly since the enactment of H.R. 1 to develop the policies, operational processes, and system changes necessary to implement the medical frailty exclusion. Over the last year, Medicaid agencies have deployed a range of tools in order to implement the medical frailty provision, including, but not limited to:

- Organizing cross-agency working groups of medical professionals and Medicaid staff to develop code sets and criteria;
- Identifying forms of verification documentation that can be accepted to validate medical frailty determinations;
- Creating screening tools for use at application and renewal;
- Developing forms and mechanisms for self-attestation;
- Training and educating eligibility workers on the types of permissible documentation and data sources available;
- Sharing ICD-10 code sets with other Medicaid agencies and CMS to facilitate aligned approaches across programs;
- Working with vendors or their in-house systems teams to develop reporting and tracking mechanisms;
- Educating Medicaid members through public webinars, public messaging campaigns, individual outreach and notification, and related activities.

CMS discusses in the IFC different considerations for assessing the severity of a medically frail condition and its impact on an individual’s ability to demonstrate CE, with particular emphasis on different data sources that can support this work (ICD-10 diagnosis codes, the Diagnostic and Statistical Manual of Mental Disorders, claims histories, etc.). NAMD’s members would benefit from continued focus on the operational aspects of identifying and validating medical frailty, including potential frameworks that support CMS’s “data first” approach articulated throughout the rule. As these conversations take place, NAMD encourages CMS to prioritize the following areas for consideration:

- **Preservation of state flexibility in determining medical frailty within the parameters of the rule**, including data sources and methodological approaches;
- **Supporting streamlined methods of obtaining provider documentation** when such documentation is necessary for validation of medical frailty determinations, with an emphasis on reducing administrative burden for providers;
- **Protection of sensitive medical information necessary for medical frailty determinations**, particularly in county-administered eligibility systems where staff may serve relatively small populations and have greater familiarity with applicants; and
- **Navigating different medical frailty designations for individuals receiving alternative benefit plan (ABP) coverage**, as some states see operational complexity and potential member

[1] § 435.554(c)(5)

confusion for individuals who may be determined medically frail for benefit purposes but not medically frail for CE purposes.

Expediting Available Data into the Federal Data Services Hub

The IFC identifies nine categories of individuals who might be considered a "specified excluded individual."[2] For some of these categories, the Medicaid agency is planning on relying on available state data sources, such as information for identifying former foster care youth. For other categories, verifying whether someone is a specified excluded individual through ex parte is more complex and Medicaid agencies will need to rely on federal data or third-party sources.

CMS has indicated in conversations with Medicaid agencies that work is underway with the Department of Veterans Affairs (VA) and the National Student Clearinghouse to integrate data into the Hub. Medicaid agencies are appreciative of these efforts that may result in a streamlined ability through ex parte to verify whether an individual has a qualifying VA disability rating for an exclusion or has CE qualifying activities on the basis of educational program enrollment, reducing administrative burden for both Medicaid agencies and beneficiaries.

Given that Medicaid agencies are making vital systems changes and testing operational fluidity now, agencies encourage CMS to move expeditiously to make these and other available data sources accessible through the Hub. At the same time, agencies will need sufficient time to test new verification pathways, validate system functionality, and implement any necessary systems changes before relying on these data sources in production. Timely availability, coupled with adequate testing time and caseworker training, will be essential to ensure accurate and efficient implementation for a minimum viable product in 2027 and maximizing ex parte processes heading into 2028 and beyond.

Highlighting Best Practices and Supporting Vendor Solutions for Harder to Collect Data Streams

Medicaid agencies are also working diligently to develop systems and processes for capturing information related to specified excluded individual categories and qualifying activities where federal or state data sources are unavailable or insufficient. **Medicaid agencies report that additional TA, implementation examples, opportunities for ongoing dialogue with CMS, and the sharing of promising practices from other Medicaid agencies would assist in developing operational approaches that are both administratively feasible and consistent with the intent of the IFC. Medicaid agencies would also appreciate support in ensuring vendors are able to meet implementation deadlines.**

For example, Medicaid agencies are working through the operational complexities of identifying individuals who qualify as specified excluded individuals because they are a parent, guardian, caretaker relative, or family caregiver of a dependent child under age 13 or a disabled individual. In these cases, Medicaid agencies are grappling with how individuals will report their caregiving responsibilities, how those responsibilities should be documented, and how to operationalize the reporting requirements. Many parents, guardians, and family caregivers provide care that extends beyond a traditional full-time work schedule, often in ways that are difficult to quantify or document. In the absence of the ability to use ex parte, requiring these individuals to track and report caregiving hours could create significant administrative burden for both Medicaid members and the Medicaid agency.

[2] Former foster care children; American Indians; Parent, Guardian, Caretaker Relative, or Family Caregiver of a Dependent Child 13 Years of Age and Under or a Disabled Individual; Veteran With a Disability Rated as Total; An Individual Who is Medically Frail or Otherwise has Special Medical Needs; Individuals Compliant With TANF Work Requirements and Individuals Not Exempt From SNAP Work Requirements; Participant in a Drug or Alcohol Rehabilitation or Treatment Program; Inmate of a Public Institution; and Pregnant or Entitled to Postpartum Coverage

Medicaid agencies are also working through how to operationalize more complex family and caregiving arrangements, such as shared custody, or situations where someone may be caring for a stepchild who has not been formally adopted by the Medicaid member.

Similarly, Medicaid agencies would benefit from additional TA on verifying compliance with CE requirements in situations where existing federal or state data sources are not available. For example, the IFC provides that a Medicaid member may demonstrate compliance with CE requirements through participation in unpaid community service through a structured program. **While Medicaid agencies appreciate the ability to use self-attestation in 2027, they will need greater support for utilizing a "data first" approach beginning in 2028.** Medicaid agencies would appreciate continued opportunities for CMS to highlight emerging state practices, facilitate peer learning, and engage vendors on scalable verification solutions. These mechanisms would help Medicaid agencies identify approaches that reduce administrative burden while preserving flexibility for implementation.

Medicaid agencies report that they are exploring a range of approaches to integrate community service participation into ex parte verification processes wherever feasible. For example, some Medicaid agencies are in the initial stages of standing up pre-approved host-sites to support verifying attendance with direct connectivity to the state agency. Others are gleaning lessons learned and insights from their peers in state government who administer the Supplemental Nutrition Assistance Program (SNAP), including approaches used to identify work requirements for Able-Bodied Adults Without Dependents (ABAWDs) in the SNAP program.

Generally, Medicaid agencies would appreciate continued support from CMS in engaging the vendor community. Many Medicaid agencies rely on a small number of vendors, all of whom are working to implement multiple federal, state, and territory policy and systems changes under compressed timelines. As a result, NAMD has heard that agencies have concerns regarding vendors' capacity, additional costs for vendor services, and the ability to develop, test, and deploy new systems functionality in time for 2027. Medicaid agencies also see value in federally developed, reusable tools that can help reduce duplicative systems development across Medicaid agencies. Therefore, CMS should consider investing in and promoting open-source tools that leaders in state-managed systems and vendors can adapt to their individual operational environments.

Effectuating Short-Term Hardship Exceptions

In the IFC, CMS indicates that states electing to adopt the short-term hardship exceptions must do so in totality – that is, Medicaid agencies must elect all hardship exceptions and may not choose a subset of available exceptions. **If possible, NAMD encourages CMS to consider pathways that would permit states to elect individual hardship exception options to maximize potential uptake.**

As NAMD's membership continues to assess implementation of the hardship exceptions, certain operational issues associated with each have emerged for further consideration and support from CMS. **Writ large, several members have indicated that the relative complexity of the hardship exceptions policy, particularly around noticing and member requests for two of the options, will inhibit readiness to effectuate these exceptions by January 1, 2027.** Some states indicate reservations around the potential volume of notices that will be required as these exceptions become available and as they sunset, which may create confusion for Medicaid members. NAMD encourages CMS to work with Medicaid agencies on model notice language that can promote clarity and consistency across the available hardship exceptions.

- **Receipt of Certain Institutional Services or Outpatient Services of Similar Acuity:** States indicate that workflows associated with identification of receipt of these services, noticing

processes informing individuals of the availability of the exception, and processes for obtaining necessary data and documentation validating receipt of these services are complex under the policy framework in the IFC. While states will likely have a straightforward ability to identify receipt of applicable services in claims data for current enrollees, Medicaid agencies anticipate challenges in incorporating the options for individuals to elect the hardship in their existing notices in a manner that is clear, understandable, and promotes their overall use – particularly if the receipt of institutional services is ongoing and may not have a clear, defined end date.

- **Travel Outside the Community for Receipt of Care:** NAMD appreciates CMS's deferral to states regarding defining community and travel for purposes of this exception, though further opportunities for states and CMS to explore approaches to these definitions would be welcome to reduce overall implementation burden. That said, Medicaid agencies anticipate operational challenges in identifying and validating out of community travel for individuals and/or their dependents, as these care episodes tend to be highly individualized and episodic in nature, which complicates the potential for automated processes embedded in state eligibility systems and notice processes. The level and types of documentation required for verification of the impacts of a dependent's travel on an individual's ability to meet CE requirements are particularly complex and will require further implementation dialogue.
- **High Unemployment Rate:** Two primary areas of further consideration emerge under this exception. First, more clarity on the process under which CMS will consider alternative sources of unemployment data provided by the state that may be more timely than data available through the Bureau of Labor Statistics and the timeline by which CMS will adjudicate the state's request based on such data; and second, the layering effect of multiple potential rounds of notices to beneficiaries of the application of the hardship when it is first sought and the secondary notice of its known end date, given that a state will not be able to know at the point of request when the county's unemployment rate will fall below the thresholds that permit the hardship exception.
- **Natural Disaster Declarations and Public Health Emergencies:** Further clarification regarding the policies and procedures for states to provide CMS with their plans to effectuate a hardship exception related to a natural disaster declaration would be helpful, particularly the timeline by which states must provide this material for CMS review and approval. Considering disaster declarations and accompanying relief actions can be exigent, NAMD recommends a streamlined submission and approval process that can allow for rapid activation of this exception. NAMD also recommends CMS consider how its authorities under Section 1135 disaster declarations can facilitate targeted waiving of Title XIX requirements in states that have not elected to adopt the CE short-term hardship exceptions.

Providing Additional Time and Flexibility for Federally Mandated Reporting and Oversight Requirements

Medicaid agencies appreciate CMS' goal of monitoring implementation of the CE requirement, including how the requirement affects eligibility, enrollment, retention, and compliance outcomes. However, states have significant concerns about the timeline for implementing new reporting requirements, including new T-MSIS data elements and related Eligibility Processing (EP) and Performance Indicator (PI) metrics, by January 1, 2027.

Medicaid agencies are already making major systems and operational changes to implement CE by the statutory deadline. This includes building processes to identify applicable individuals, apply exclusions and exceptions, verify compliance, update notices and applications, train eligibility staff, and coordinate

with vendors and other state agencies. Adding new reporting requirements to this same timeline creates additional systems work at the same time states are still building the core eligibility processes.

The new reporting categories are not simple measures that Medicaid agencies can necessarily pull from existing systems. Agencies may need to report whether someone is excluded from the requirement, subject to the requirement and meeting it through an activity, deemed compliant through a mandatory exception, deemed compliant through a hardship exception, or denied or terminated for procedural versus eligibility reasons. These distinctions are appropriate from a monitoring perspective, but many states do not currently capture them in a structured way that can be reported through T-MSIS, EP, or PI metrics without systems changes that are themselves contingent on ongoing policy and operational decisions.

Therefore, NAMD urges CMS to provide additional time for states to implement new reporting requirements after final technical specifications and related guidance are issued. CMS should consider a phased approach that allows states to focus first on core eligibility operations and member-facing implementation, followed by staged reporting once systems and workflows are more stable. CMS should also avoid requiring production-level reporting on new CE metrics until Medicaid agencies have had enough time to build, test, and validate data submissions.

NAMD also encourages CMS to limit new reporting requirements during the initial implementation period to the minimum data necessary for federal oversight. Any additional reporting elements should be developed with state input and accompanied by clear technical guidance and sufficient implementation time. During early implementation, CMS should prioritize TA and data quality improvement over corrective action tied to new reporting challenges.

Presumptive Eligibility

The IFC specifies that states must incorporate community engagement requirements into presumptive eligibility (PE) determinations if they have adopted the adult Medicaid expansion group or elected to cover a Section 1115 demonstration population that includes applicable individuals and have also elected the option to provide presumptive eligibility for that population. This requirement also applies to hospital presumptive eligibility (HPE) programs in these states. To implement this provision, states will need to revise PE and HPE application materials and eligibility determination notices, update training materials, and provide additional training to hospitals and other qualified entities.

Medicaid agencies anticipate operational complexity to make these changes. PE and HPE are designed to provide a streamlined pathway to temporary Medicaid coverage while an individual's full application is processed.

NAMD encourages CMS to provide technical assistance on how Medicaid agencies and qualified entities should assess and document compliance with CE requirements during PE and HPE determinations, including how to address exemptions, exclusions, verification requirements, notices, and transitions from presumptive to ongoing eligibility. CMS should also consider TA with Medicaid agencies around model applications, example notices, and training materials that can be adapted to their programs.

Next Steps and Moving Forward in Collaboration

Medicaid agencies appreciate the significant TA CMS has provided over the last year to support the implementation of CE requirements. As implementation continues, NAMD encourages CMS to build on these efforts by continuing to provide timely and flexible TA through written guidance, collaborative

discussions with other state leaders, engagement with the vendor community, and promoting forums to engage with CMS leadership.

Implementation will continue to evolve beyond January 1, 2027, as Medicaid agencies refine and mature policies, eligibility systems, and identify unanticipated challenges that will only emerge after they begin implementation. NAMD remains committed to serving as a trusted partner to CMS by convening Medicaid leaders across eligibility, policy, financing, technology, operations, and communications roles to identify emerging issues, share innovative approaches, and support continuous improvement as implementation matures in 2027 and beyond.

Sincerely,

Stuart Portman

Stuart Portman
NAMD Board President
Georgia Medicaid Director

Lee Grossman

Lee Grossman
NAMD Board President Elect
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