THE PARTNERSHIP FOR MEDICAID

July 31, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicaid Program; Community Engagement Requirements for Certain Individuals CMS-2454-IFC

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net plans, and counties— the undersigned organizations appreciate the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS') "Medicaid Program; Community Engagement Requirements for Certain Individuals" interim final rule with comment period.

Here is a summary of the main points of our comments:

- Applicable Individuals and 1115 waivers – CMS should clarify that waivers with a population of likely excluded individuals are excluded entirely, not individually.
- Work and Income – we generally support how CMS has defined work and income.
- Education – we have no comment on the formula that CMS uses to convert educational credits into hours of monthly activity, but CMS should use rounding when calculating the conversion
- Work Program – we urge CMS to clarify that when an individual is working for pay using supported employment services, such work would qualify as hours of *work*, not a *work program*.
- Caregivers – we generally support the definitions and approach taken by CMS, but we urge CMS to include the full definition from the RAISE Family Caregivers Act.
- Medical Frailty and Other Special Health Care Needs – we strongly oppose the addition of the extra-statutory requirement that individuals who are medically frail or otherwise have special health care needs must *also* demonstrate that they are significantly impaired in complying with the community engagement requirement.
- Data Sharing – we support CMS's efforts to rely on data, but we are concerned that the new requirement for medical frailty will limit the utility of such data sharing and limit ex parte decisions.

- Reverification – we encourage CMS to expand the groups that do not need to be reverified and clarify where states may not conduct reverification of statuses that do not change
- Self-attestation – we strongly oppose the extra-statutory limitation on self-attestation; it should be available in the way Congress wrote into the statute.
- Short-Term Hardship Exception – we appreciate the inclusions of these exceptions but are concerned that the look-back period may limit these exclusions in a way that departs from Congressional intent; we encourage an exception for when a dependent needs inpatient care in the local community
- Outreach and notices – CMS should encourage states to use all modalities available, including phone, mail, and text messages

Applicable Individuals and 1115 Waivers

We are concerned that CMS's analysis of 1115 waivers that may fall under this requirement is overbroad. In the preamble section about who may be an applicable individual under an 1115 waiver, CMS includes a discussion of 1115(a)(2) waivers that include an eligibility criterion under which anyone eligible for the demonstration would be a specified excluded individual. CMS gives the specific example of an 1115 demonstration that includes only those who meet an institutional level of care and receive home and community-based services (HCBS). CMS says that those in this demonstration population would each be a specified excluded individual because they would be medically frail or otherwise have special medical needs. It is implied that CMS believes that this population would also meet the second prong of the medical frailty requirement, that it significantly impairs their ability to comply with the community engagement requirement.

CMS then states "individuals in this demonstration would not be subject to the community engagement requirement." [1] However, it is unclear whether CMS meant that the entire 1115 would not be considered as "a waiver of such plan" for purposes of section 1902(xx)(9)(A)(i)(II), or if each individual would have to document their medical frailty status and inability to comply with the community engagement requirement.

More information from CMS has only muddied the waters. In a webinar the week after the interim final rule was released, CMS presented information on what 1115 waivers it would include. The list included an Oregon 1115 targeted at Youth with Special Health Care Needs as an 1115 waiver that would include populations subject to community engagement, despite being targeted at people with special health care needs.

[1] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33354 (June 3, 2026).

When an 1115 demonstration population includes those likely to meet the definition of a "specified excluded individual," we urge CMS to exclude the 1115 waiver population as a whole, rather than on an individual basis. Such individual determinations would be a waste of resources and threaten the coverage of individuals that CMS has already determined – by nature of their enrollment in the waiver – should be excluded.

Demonstrating Community Engagement

Work and Income
In general, we support the definitions of work and income that CMS has provided. Specifically, we support CMS's reading of the statute that calculations of monthly income should be based on the federal minimum wage, regardless of whether a state or locality has a higher minimum wage.

Education
In general, we support the way that the Department has considered the various types of education individuals may be enrolled in, as well as the academic calendar. We agree that enrollment half-time alone fulfills the community engagement requirement and we agree that the definition of half-time enrollment should be defined by the educational institution. We also strongly support the coverage of school breaks, including summer.

However, we do have concerns with how CMS calculated the hours of education when less than half-time enrollment needs to be combined with other activities. Here, we strongly encourage CMS to round-up the number of hours calculated. While we have no comment on the specific formula that CMS uses to convert credit hours into monthly hours of activity for community engagement, we note that each of the hour calculations result in numbers with a 9 after the decimal point. Rounding up would create much simpler calculations for states and individuals and avoid absurd situations where an individual has lost coverage because they lack 0.01 hours of community engagement.

For example, if an individual is enrolled in 1 credit hour, equivalent of 12.99 hours of community engagement activity, works for pay 60 hours a month, and volunteers 7 hours a month, they would have 79.99 hours of community engagement activity that month and lose coverage. This scenario is absurd and CMS should clarify it.

Work Program
In general, we support the definition that CMS has developed for a work program. Relying on the definitions used in the Supplemental Nutrition Assistance Program (SNAP) will make it easier for states to implement and for individuals to understand the program rules.

However, we are confused by the discussion of supported employment in the work program section. The preamble describes state partnerships with managed care plans to provide supported employment services to people who receive home and community-based services (HCBS) under a 1915(c) or 1915(i) waiver, then states that "these Medicaid-covered employment services are different from work programs defined at §435.552(b) and do not independently satisfy the work program community engagement requirement."[2]

This section is puzzling for a number of reasons. First, according to the CMS HCBS Taxonomy[3], supported employment includes assistance to maintain self-employment or paid employment. Regardless of how supported employment is funded, hours spent working with this assistance should be counted under *work* not a *work program* because the individual is working for pay. Second, supported employment is not exclusively delivered through managed care; it is delivered both through managed care and fee-for-service payment models. Finally, individuals enrolled in 1915(c) and 1915(i) waivers are likely to be specified excluded individuals, so their hours spent in supported employment need not be considered as either work or a work program. CMS should clarify this section, and especially make clear that hours spent working for pay, including with supported employment, count as work.

Caregivers

In general, we support the approach to defining exclusions for parents, guardians, caretaker relatives, and family caregivers. The definitions appropriately take into account many different types of family and caretaking relationships. The use of the Americans with Disabilities Act definition also appropriately takes into account the broad range of disabilities that a person may need assistance with.

However, we are concerned with where CMS departs from the statute regarding the definition of family caregiver from the RAISE Family Caregivers Act. Congress specifically cited to this definition, which is: "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[4]

CMS changed this definition in two ways. First, it added the word "care within" to between "provides" and "a broad range of assistance." This addition is unnecessary. Second, CMS replaced "an individual with a chronic or other health condition, disability, or functional

[2] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33356 (June 3, 2026).
[3] Centers for Medicare and Medicaid Services, Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions. Accessed June 28, 2026. https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf
[4] 42 USC §3030s

limitation" with "a dependent child or a disabled individual." The statutory cross reference should be interpreted to expand the exclusion beyond the care recipient populations expressly specified in the Act. When Congress referenced the RAISE Family Caregivers Act, if they meant to limit the care recipients in that definition, they would have done so.

Medically Frail or Otherwise Has Special Medical Needs

We strongly oppose CMS's decision to depart from the statute and Congressional intent and add an additional requirement to the definition of medically frail or otherwise has special medical needs. This addition now requires that a condition or diagnosis must also significantly impair the individual's ability to comply with the community engagement requirement. This additional requirement goes beyond the statute and creates an unreasonable burden on applicants, enrollees, providers, and states.

HR 1 created a list of conditions or diagnoses which would render a person a specified excluded individual on the basis of medical frailty or other special medical needs. In the list of conditions or diagnoses, Congress included 1) blind or disabled under Section 1614 of the Social Security Act 2) a substance use disorder, 3) a disabling mental disorder, 4) a physical, intellectual, or developmental disability that significantly impairs the ability to perform one or more activities of daily living, and 5) a serious or complex medical condition.

If Congress had intended to focus on conditions that inhibit ability to work, it could have chosen only to include the Social Security disability definition. However, Congress included four other categories. The inclusion of multiple other categories shows that Congress intended the exclusion to be broader, not stricter, than the Social Security disability standard and cover more individuals, not fewer, than those who are unable to work.

And the standard that CMS has created is indeed stricter than the Social Security definition. The Social Security definition takes into account ability to engage in substantial gainful activity (generally, work for pay). The standard that CMS created takes into account all community engagement activities, including training and education. This means that, in order to be found medically frail or with other special medical need, a state would need to find not only that an individual cannot work 80 hours a month, but that they cannot even attend school at least half-time. This is not what Congress intended and is a potentially impossible standard to implement.

Legislative History
Throughout the debate of HR 1, members of Congress repeatedly referred to the exclusion for people under the medical frailty category. Nowhere in the legislative history does any member of Congress refer to an additional burden. Instead, members of Congress repeatedly refer to the conditions or diagnoses alone, emphasizing the simplicity of the exclusion.

On May 13, 2025, the Chairman of the Energy & Commerce Committee Brett Guthrie said in his opening statement to the markup of HR 1, "Let me be clear – these work requirements would only apply to able-bodied adults without dependents who don't have a disqualifying condition."[5]

On June 24, 2025, Senator Chuck Grassley stated from the senate floor, "We have reasonable exemptions for…Individuals who are medically frail or otherwise have special medical needs. Individuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition."[6]

On July 15, 2025, Senate Majority Leader John Thune issued a press release that stated, "The work requirement doesn't apply to anyone who is disabled, pregnant or caring for a child younger than age 14."[7]

These are just a few of the statements from members of Congress emphasizing that people with certain conditions would not be subject to the community engagement requirement. Nowhere did any member discuss that people with a qualifying condition or diagnosis would also have to show that their condition or diagnosis significantly impairs them from complying with the community engagement requirement. Most, like Majority Leader Thune, discussed the exclusion in the same breath as categories that require no such second requirement, such as pregnancy or caregiving.

In addition to exceeding the statute and Congressional intent, this second requirement has a number of problems: it lacks definition, and it imposes significant burden on applicants or beneficiaries, on health care providers, and on states. Finally, CMS failed to take into account the burden on beneficiaries and providers in its regulatory impact analysis and analysis of the information collection requirements.

Lack of Definition

First, this second requirement lacks a definition. CMS simply states that the condition or diagnosis must significantly impair the individual's ability to comply with the community engagement requirement. CMS provides no other information in the preamble or the regulatory

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[5] Chairman Guthrie Delivers Opening Statement at Full Committee Markup of Budget Reconciliation Text, May 13, 2025, https://energycommerce.house.gov/posts/chairman-guthrie-delivers-opening-statement-at-full-committee-markup-of-budget-reconciliation-text. Accessed June 28, 2026.

[6] Floor Remarks by Senator Chuck Grassley of Iowa Senate President Pro Tempore "Empowering Able-Bodied Adults to Work" Tuesday, June 24, 2025 https://www.grassley.senate.gov/news/remarks/grassley-supports-common-sense-medicaid-work-requirements-for-able-bodied-adults, Accessed June 28, 2026.

[7] Republicans' Reconciliation Bill Strengthens Medicaid, https://www.republicanleader.senate.gov/newsroom/research/republicans-reconciliation-bill-strengthens-medicaid, Accessed June 28, 2026.

text about what would constitute, or how a state would measure, a significant impairment in complying with the community engagement requirement.

The second requirement has created a standard that is impossible to implement. CMS describes how states may use diagnosis codes, utilization data, and other factors to determine medical frailty. For determining whether an individual has a certain condition, such a process may be straightforward. But the addition of the second requirement makes such a process unworkable. Diagnosis codes and utilization data cannot easily tell a clinician or a state whether a person is significantly limited in complying with the community engagement standard. CMS provides no additional information on how a state might implement this standard.

For example, it is unclear that recipients of Medicaid hospice would automatically demonstrate Medical Frailty. Without this automatic exclusion, individuals in their final months and days of life could be forced to seek additional documentation to maintain their coverage. Failure to do so, could compromise their eligibility for Medicaid and terminate their hospice services.

Other federal programs that must make similar determinations have an extensive process. For example, a disability determination from the Social Security Administration (SSA) is a multi-step process that takes into account an individual's medical, vocational, and educational history to determine if an individual is able to engage in substantial gainful activity. In contrast, CMS provides no guidance on how to determine if an individual's condition or diagnosis significantly impairs their ability to comply with the community engagement requirement.

Burden on Applicants and Beneficiaries

The second requirement places a significant burden on individuals to obtain documentation to prove their impairment in meeting community engagement requirements. CMS makes clear that states must verify this information and obtain documentation. The preamble describes one source of documentation – a clinical provider.

CMS vastly underestimates this burden. In Section IV, CMS estimates that it will take 2 hours for a beneficiary to document and submit their information or documentation regarding community engagement.[8] CMS provides no justification for this estimate and employs it for all categories of beneficiaries. If CMS had done research into the challenges faced by many Medicaid beneficiaries accessing care and obtaining documentation, or even acknowledged additional burden imposed by the second requirement, the extent of this underestimate would have become clear.

[8] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33434 (June 3, 2026).

The addition of the second requirement – a new and vague standard never before used in any state or federal program – means that beneficiaries are unlikely to have this information on hand. CMS only lists clinical providers as means of documentation, which means that beneficiaries will need to have an appointment to obtain this information. CMS does not discuss how the second requirement will require an appointment; it's as if when CMS conducted its burden estimate the second requirement didn't exist.

Scheduling, attending, traveling to and from, and following up on this appointment alone will take many beneficiaries more than 2 hours. Many Medicaid beneficiaries rely on public transportation, have limited English proficiency, have disabilities, have unstable work schedules, or face other barriers which create challenges in scheduling and attending appointments and make each step of the process take longer. CMS failed to account for any of these considerations, or even the need to schedule an appointment.

Burden on Health Care Providers

The second requirement places a significant burden on health care providers. The rule will add more paperwork to a system already facing clinician burnout and capacity constraints and lengthen wait times for all people as appointment slots fill up with documentation requests.

CMS estimates that 44% of beneficiaries will not have their eligibility processed ex parte and will need to provide information to the state.[9] As discussed above, this is likely to mean each of them needs a new appointment. CMS describes a number of clinicians who may provide documentation of medical frailty. However, most of these clinicians are not experts in occupational medicine and may not feel comfortable or qualified to document impairment complying with the community engagement requirement. CMS provides no guidance on how a clinician may begin to make such a determination. Some clinicians may decide the administrative, and potential legal, risks are too great and stop participating in Medicaid altogether. Finally, CMS does not state whether such documentation is a covered activity for which those providers can bill Medicaid, further increasing the burden on them.

In one specific example, the nation's federally qualified health centers (FQHCs) are anticipating a great deal of additional administrative work, given the coordinated care and wraparound services their patients receive and that a large proportion of FQHC patients are covered by Medicaid. Many centers will dedicate their financial counselors, enrollment specialists, care coordinators, and other clinical staff to support patients throughout the process. Staff may have to help patients understand eligibility requirements, determine whether they qualify for medical frailty or other exclusions, complete forms, gather supporting documentation, coordinate provider attestations, and respond to ongoing verification and reverification requests. These

[9] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33434 (June 3, 2026).

activities generally fall outside reimbursable care services for FQHCs, requiring health centers to absorb the associated staffing and administrative costs and divert capacity away from direct patient care.

CMS made no effort to analyze the burden on health care providers in its regulatory impact analysis, such as the time they will spend on documentation and potential foregone income for non-billable activity. CMS also fails to estimate the impact on other patients who cannot get appointments because their providers are spending time on these new documentation requirements.

Burden on States and Localities

This second requirement places significant burden on state and local eligibility and verification systems. Recent court filings have documented that CMS was working with states on how to determine medical frailty based on medical claims data or health care provider documentation with no reference to a second prong of the requirement. At the last minute, on or around May 6, 2026, CMS abruptly told states to disregard previous guidance.[10] States only learned of this additional requirement on June 1, when the interim final rule was released to the public.

In late May, several states wrote to CMS expressing their concerns about potential changes to the guidance they had received. These letters and emails are outlined in recent court filings, including from California on May 27, Virginia on May 28, Massachusetts on May 29, and Maine also on May 29. These communications outlined the significant burden that the new requirement would place on states.

For example, the Maine Medicaid Director Michelle Probert wrote "We have no workable path to operationalize a provider certification or employability determination by January 1, 2027." The Deputy Director of the California Department of Health Care Services Yingjia Huang wrote, "A pivot toward a manual, documentation-based assessments would require California to completely reengineer our currently developed systems, workflows, and staffing – even, potentially, requiring provider or eligibility worker certifications that would seem to upend this data-driven approach and transform medical frailty to a largely manual, paper-based system that we have not been planning for." Virginia Medicaid Director Steve Ford wrote, "Tying medical frailty to work capacity could potentially require document-based verification and individualized assessments, creating substantial new administrative barriers for eligible individuals, including new paperwork requirements, provider certifications, and delays in processing eligibility and

[10] Complaint, *Commonwealth of Massachusetts, et al., v. Mehmet Oz, M.D., et al.,* Case No. 26-12962 https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/06/Massachusetts-v.-Oz_2026.06.29_COMPLAINT.pdf

exemptions."[11] Nevertheless, CMS moved forward with this new requirement and released the interim final rule on June 1.

Due to the lack of definition and the burden on applicants and beneficiaries, on providers, and on states and localities, CMS should stick to the statutory definition of medical frailty and eliminate the requirement that an individual be significantly impaired in complying with the community engagement requirement to be considered medically frail.

At the very least, CMS should adopt the Social Security Administration's Compassionate Allowances List for conditions that automatically meet the medical frailty standard in all states, including significant limitation in complying with the community engagement requirement.[12] States should be allowed to develop similar additional lists of conditions and diagnoses that so obviously meet the standard that additional documentation of impairment in meeting the community engagement requirement is not required.

Verification and Reverification

Data Sharing

We generally support requirement for states to use ex parte verification of compliance, deemed compliance, and status as a specified excluded individual first, without requiring additional documentation from the individual. We appreciate that CMS made clear that this requirement applies not just at renewal, but any time verification is required and that CMS encourages states to share data among state agencies. CMS should include Tribes and Urban Indian Organizations among these entities. Tribes and Urban Indian Organizations are trusted health care partners and can assist states in properly implementing the exclusion for American Indians. Specifically, they can identify patients who they know to be specified excluded individuals and prevent disenrollment based on misclassification or other procedural issues. Doing so aligns with unwinding practices in previous years.

We appreciate that CMS has recognized the role that managed care plans and other partners in the Medicaid system can play in sharing data to meet these requirements. CMS should encourage states to build on the experiences of the public health unwinding and flag for Medicaid managed care organizations when members are coming up for review, are found noncompliant, or are disenrolled (with reason codes). States Medicaid agencies should bring their managed care entities into data sharing arrangements with other state agencies, such as TANF/SNAP, incarceration, and labor as a key partner in helping eligible enrollees stay enrolled.

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[11] Declarations, *Commonwealth of Massachusetts, et al., v. Mehmet Oz, M.D., et al.,* Case No. 26-12962 https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/06/Massachusetts-v.-Oz_2026.06.29_DECLARATIONS-RE-MOTION-FOR-PRELIMINARY-INJUNCTION.pdf

[12] Social Security Administration, *Compassionate Allowances*, https://www.ssa.gov/compassionateallowances/index.htm. Accessed June 28, 2026.

However, we are concerned that, based on the vague new standard for medical frailty, it is unclear to us how such data can reliably demonstrate an individual's capacity to fulfill the community engagement requirements. The lack of detail from CMS leaves us in an uncertain environment about what information we may be asked to collect or provide.

Re-Verification
We support the policy that does not permit states to require reverification of conditions that do not change, including a permanent disability determination by the VA. We recommend that CMS treat other disabilities and medical conditions that do not improve in the same manner and not allow states to require reverification.

CMS should adopt a similar framework for other statuses that do not change, specifically people with developmental disabilities and people with substance use disorder (SUD). Developmental disability is a lifelong disorder that begins before age 22.[13] Once a state has determined that an individual has a developmental disability, it should be able to treat them the way it treats permanently disabled veterans and non-reverify that status. For individuals with SUD, CMS has a defined SUD to exclude those in stable recovery for 5 or more years. This means that once a state has verified that an individual has an SUD, it should not need to reverify that status for 5 years. CMS should treat people with SUD similar to how it treats former foster care youth and provide a period of time where reverification is unnecessary.

Finally, we note that the preamble uses slightly different language when discussing veterans with a permanent disability rating and American Indians. For veterans, the preamble says that states "must not" reverify a permanent disability status.[14] However, for American Indians, another status that does not change, it says that sates "do not need" to reverify.[15] In addition to adding the categories above, CMS should clarify that states must not reverify American Indian status, as it is a status that does not change and would only create opportunities for coverage loss through paperwork errors.

Self-Attestation
We oppose the time limit of self-attestation to an exemption or exclusion. The text of the statute provides states with the option to "elect not to verify information" regarding exemptions or exclusions and does not place a time limit on this option.

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[13] Developmental Disabilities and Bill of Rights Act, PL 106-402, https://acl.gov/sites/default/files/about-acl/2016-12/dd_act_2000.pdf
[14] 33405
[15] 33403

CMS has gone beyond the statute to limit self-attestation for most categories to only calendar year 2027 and for medical frailty status to once per enrollment period starting in 2028. The only justification that CMS provides for this once-per-enrollment limitation is that requiring documentation will "motivate individuals to access care."[16] People with the conditions and diagnoses listed under medical frailty do not need additional motivation to access the health care that is often the difference between life and death, necessary for mitigation of pain and suffering, and provides them with the care they need to continue to live full lives. However, additional and unnecessary documentation burdens will use up the valuable time of patients and clinicians that could be used providing actual health care.

The limitation on self-attestation is another area where CMS has imposed a new and extra-statutory burden on state and local eligibility systems and where states communicated their concerns with CMS. California communicated that it relied on CMS' Minimum Viable Product guidance from December of 2025 that permitted states to rely on self-attestation and California has built a system that is in the final phases of development and testing. Maine emphasized the statutory basis at 1902(xx)(3)(A) and long-standing use of self-attestation in Medicaid at 42 CFR §435.952. Massachusetts and Virginia also emphasized their reliance on CMS guidance and the great operational challenge that would be created by abandoning self-attestation. [17]

Caregivers and Care Recipients

We appreciate that CMS recognizes the privacy rights of a care recipient. However, the system that CMS has created, especially in the absence of self-attestation, is puzzling. CMS says that states must collect sufficient information to substantiate that the person receiving care meets the definition of disability and lists a "statement or screening tool" that the state must use to verify that the person receiving care meets the definition of a disabled individual if the care recipient does not consent to sharing their information.

Without self-attestation, these requirements create a bit of a paradox. For minors over age 14, where a parent is likely to be the one seeking a caregiver exclusion, it is unclear who is able to attest to the child's disability status if not the parent. For adult care recipients, it is unclear how an individual would complete a "statement or screening tool" if they are unable to attest to their own caregiving status. Perhaps CMS intended for caregivers to be able to attest to the disability status of the care recipient but not to their own caregiving, but that is not made clear in the preamble.

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[16] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33406 (June 3, 2026).

[17] Declarations, *Commonwealth of Massachusetts, et al., v. Mehmet Oz, M.D., et al.,* Case No. 26-12962 https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/06/Massachusetts-v.-Oz_2026.06.29_DECLARATIONS-RE-MOTION-FOR-PRELIMINARY-INJUNCTION.pdf

The paradox created by these policies provides another reason why CMS should adhere to the statute as written and allow for self-attestation without a time limit.

Medical Frailty

In addition to our concerns about the burden on providers, beneficiaries, and the entire system regarding the medical frailty standard, we are also concerned about the requirement that states only use claims or encounter data from the past 12 months to determine whether an individual is medically frail or has other special medical needs. Many disabilities and serious health conditions do not change or improve, and documentation of these conditions may be several years old. Obtaining appointments with specialists can take months. Health care providers that treat people with serious conditions are already overburdened with paperwork. People with disabilities already struggle to obtain the documentation and information they need from their medical providers. A 12-month limitation places an additional burden on enrollees to make an additional appointment, and place additional burden on the health care system, to repeat information that they and their doctors already know, to meet CMS's satisfaction. As discussed above, this burden is multiplied by the additional requirement created by CMS that health care providers somehow document that an individual is significantly limited in complying with the work requirement.

Short-Term Hardship Exceptions

We appreciate the inclusion of short-term hardship exceptions from the community-engagement requirement as included in the statute. However, the timeline that CMS has chosen to apply to these exceptions means that they might not be as useful as Congress intended.

Under the hierarchy described in the rule, individuals eligible for a short-term hardship exception are applicable individuals. This means that, at the time of application, states must look at their compliance with or exception from the community engagement requirement in the month prior to submitting the application. For example, an individual experiencing a medical event that requires inpatient hospitalization would not be eligible for Medicaid until the month *after* the hospitalization (at least initially) occurs.

While the statute requires the individual to proactively request certain short-term hardship exceptions, CMS should encourage states to use reliable information available to the state to the maximum extent possible to flag enrollees who may be eligible for such exceptions.

Inpatient Hospitalization or Equivalent

We appreciate the inclusion of §435.555(d)(1)(ii)(E), allowing for short-term hardship events for individuals receiving noninstitutional services that, but for receipt of such services, would likely

result in the individual receiving services in an institution. The inclusion of this provision recognizes CMS's decades of work to provide services in individuals' homes and communities and the successful provision of those services to individuals who meet institutional level of care. This provision creates two important protections for people with disabilities. First, it avoids a perverse incentive that would require a person experiencing a medical event to be required to seek institutional care. Second, it provides an important backstop for people who should be specified excluded individuals or enrolled through a separate pathway.

We also support CMS's decision not to limit such services to those delivered through a 1915(c) waiver and let states determine which services they provide to those with an acuity level similar to those that receive services in one of the institutions listed in the statute. CMS is correct that developing a comprehensive list at the federal level would be nearly impossible and would inevitably leave out some services.

Separately, we are concerned about the burden on inpatient facilities and providers of a similar acuity to provide documentation of services for short-term hardship exceptions. This potential documentation burden was not accounted for in the regulatory impact analysis.

Travel Outside of Community
We appreciate the inclusion of an exception if an individual or their dependent must travel outside of their community to receive medical services. We also appreciate that CMS has left up to the states how to define "community." Given the diversity in size and geography of the states, such a determination is appropriately left up to the state.

Together, the exceptions for inpatient treatment and travel for a dependent leave out an important situation: when a dependent requires inpatient treatment in the local community. Such an event is likely to disrupt the ability of a parent or caretaker to comply with community engagement requirements. CMS should acknowledge this situation and include it as a short-term hardship exception.

Good Faith Exemptions

As we have previously communicated, we continue to support the ability for states to get exemptions for up to one year. CMS notes in the preamble that it expects to only provide six-month exemptions. We see no reason for CMS to arbitrarily limit the exemptions provided to states when the statue clearly allows for exemptions up to 12 months. The length of the exemption should be determined based on an analysis of each state's individual circumstances.

Managed Care Implications

In the preamble, CMS describes the important role of managed care companies in conducting outreach and education, data sharing, and referral to services. However, additional guidance is needed on the permissible activities and specific functions MCOs can perform, in order to best support their members in outreach and navigation.

Plans are working diligently to support their members and state partners in implementation. The preamble and additional CMS policy direction has made clear that plans' work in supporting community engagement implementation may generally not be included in capitation payments. However, these new operational roles will require significant plan resources. Additionally, major programmatic changes often lead to significant, and unforeseeable shifts in member acuity, as seen in the recent unwinding from the COVID-19 Public Health Emergency. As such, updated CMS rates guidance addressing the potential for large changes in member acuity, as well as plans' new administrative functions, would help to support sound rate-setting.

Outreach and Notice Requirements

We appreciate that CMS is requiring states to conduct outreach using at least two modalities, including regular mail and one additional modality. CMS should strongly encourage states to use all modalities available to them. An individual receiving a piece of physical mail, an email, and a text message would not be too much outreach from a state for such a critical and confusing change to their health insurance.

Further, states would be better able to leverage their partnerships with managed care organizations if they had clarity on the application of the Telephone Consumer Protection Act. CMS should work with the Federal Communications Commission to explicitly clarify that managed care plans may contact enrollees by phone and text message about community engagement requirements.

For more information contact Paulo Pontemayor at ppontemayor@chausa.org.

Sincerely,

Advocates for Community Health
America's Essential Hospitals
American Academy of Family Physicians
American Academy of Pediatrics
The American College of Obstetricians & Gynecologists
American Dental Education Association

American Network of Community Options and Resources
American Nurses Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Easterseals, Inc.
LeadingAge
National Association of Pediatric Nurse Practitioners
National Council of Urban Indian Health
National Health Care for the Homeless Council