July 31, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-2454-IFC. Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz:

On behalf of the 23,000+ physician and medical student members of the Massachusetts Medical Society (MMS), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) interim final rule (IFR), which provides direction to states implementing Medicaid community engagement requirements under Public Law 119-21.

The MMS has long opposed Medicaid work requirements because experience has shown that they cause eligible individuals to lose coverage for procedural reasons; disrupt access to medically necessary care; impose substantial administrative burdens on beneficiaries, state Medicaid agencies, and clinicians; and, do little to increase employment. For patients with serious medical, behavioral health, and substance use conditions, the resulting loss of coverage threatens continuity of care, access to treatment, and health outcomes.

Although CMS must implement the statute enacted by Congress, the IFR departs from Congress's intent in ways that will predictably increase otherwise avoidable coverage loss and unnecessarily burden patients, physicians, and state Medicaid agencies. The IFR relies on verification systems that often do not exist, imposes documentation and functional assessment requirements that Congress did not enact, and shifts responsibility for complex eligibility assessments onto patients and treating clinicians. Rather than minimizing administrative burden, the IFR will require many eligible beneficiaries to obtain additional documentation solely to maintain coverage, increasing the likelihood that medically frail and otherwise eligible individuals lose Medicaid for procedural rather than substantive reasons.

Congress expressly excluded medically frail individuals from the work and community engagement requirement in order to protect people with significant health care needs from losing Medicaid coverage. The IFR substantially narrows that statutory protection by requiring individuals who satisfy the standards for one of Congress's medical frailty categories to prove an additional functional impairment standard that appears nowhere in the language of the statute. As a practical matter, this new requirement will reduce states' ability to rely on *ex parte* verification, increase requests for physician documentation, interfere with patient care, and create avoidable procedural coverage losses among the individuals Congress intended to protect.

The IFR also restricts access to the good-faith-effort exceptions that Congress established to give states more time to develop the systems and processes necessary for implementation. Finally, the IFR's documentation requirements assume a speed of obtaining and completeness of third-party records as well as access to administrative and procedural assistance that bear little resemblance to real-world conditions.

Collectively, these provisions establish a framework that is operationally unworkable with existing systems and that will predictably cause eligible individuals, including medically frail individuals Congress intended to protect, to lose coverage—not because they are substantively ineligible, but because they cannot navigate documentation and verification systems that are not built for the reality of their lives.

Accordingly, we urge CMS to: (1) restore the medical frailty exclusion to the categorical protection Congress established by treating a qualifying diagnosis, condition, or status as sufficient, while preserving self-attestation and minimizing documentation burdens placed on beneficiaries and clinicians; (2) grant states good-faith-effort exceptions according to the standard Congress enacted; and, (3) revise the verification and assistance provisions to reflect the practical realities of obtaining third-party records and securing timely assistance from state agencies. The comments that follow explain the legal, operational, and clinical basis for adopting these minimum safeguards and identify the specific revisions necessary to protect eligible individuals from avoidable coverage losses.

I. Medical Frailty Exclusion

The medical frailty exclusion is the principal safeguard Congress established to ensure that individuals with significant health care needs do not lose Medicaid coverage because of the work requirement. Congress expressly excluded medically frail individuals from the work requirement and identified five categories of qualifying diagnoses, conditions, and statuses, reflecting its judgment that these individuals should retain access to Medicaid without having to satisfy additional work-related eligibility criteria.

The IFR adds a new eligibility criterion that is not found in the statute. Rather than recognizing that an individual who falls within one of the statutory medical frailty categories qualifies for the exclusion, the IFR requires individuals to demonstrate that their condition significantly impairs their ability to comply with the work requirement. **This additional impairment standard substantially narrows the protection Congress enacted by conditioning the exemption on a functional assessment that Congress did not require.**

The practical consequences are significant. Medicaid claims, encounter data, electronic health records, and other objective sources generally document diagnoses, treatment history, and clinical status—not an individual's ability to comply with the work requirements. As a result, the impairment standard substantially limits states' ability to identify medically frail individuals through *ex parte* verification using reliable information already available to the agency. Instead, it requires patients to obtain additional documentation and physicians and other treating clinicians to perform individualized functional assessments that they do not routinely conduct as part of clinical care. The predictable result is that individuals Congress intended to protect will lose

Medicaid coverage, not because they fail to satisfy the statutory definition of medical frailty, but because they cannot satisfy an additional documentation and verification requirement imposed by the Rule. These unnecessary administrative requirements also divert physician time away from patient care and risk interfering with the physician-patient relationship.

Medical frailty verification processes must also not depend primarily on physicians or other clinicians. Overreliance on clinicians to furnish verification paperwork would force patients to schedule appointments solely to obtain eligibility documentation, further constraining an already limited supply of appointments and compounding the administrative burdens that drive physician burnout. It would also divert scarce clinical time from patient care to paperwork, which would be especially harmful for Medicaid patients, who often have multiple complex medical, behavioral health, and social needs that must be addressed within a single encounter.

Beyond clinicians' limited capacity to absorb this additional non-clinical workload, clinician-gated verification could also undermine the therapeutic and clinical relationship on which effective care depends. Patients must be able to speak candidly with their clinicians about the most difficult and personal aspects of their lives, including pain, fatigue, psychiatric symptoms, cognitive limitations, substance use, trauma, and caregiving responsibilities. If patients believe that their continued health coverage may depend on what they disclose—or how their clinicians document those disclosures—they may feel less free to speak openly, chilling communication and eroding the trust necessary for effective diagnosis, treatment, and care planning. These harms are particularly difficult to justify when states already possess, or can readily obtain, the relevant information from other qualified sources.

1. **Eliminate the impairment standard and treat a qualifying diagnosis, condition, or status within a statutory medical frailty category as sufficient to establish the exemption.**

CMS should eliminate the impairment standard and recognize that reliable evidence establishing that an individual falls within one of the statutory medical frailty categories is sufficient to establish the medical frailty exemption. Congress anticipated that CMS would more fully define 'medical frailty,' but it clearly intended that individuals who fall into one of the medical frailty categories explicitly identified in statute would be exempt from work and community engagement requirements without having to demonstrate that their condition impairs their ability to comply with the requirements. Specifically, the structure of the statute demonstrates that Congress deliberately limited functional impairment language to only one statutory category while omitting similar language from the remaining categories.[1] Reading an impairment requirement into every category effectively adds an eligibility criterion that Congress did not enact.

Eliminating the impairment standard would better align the Rule with the statutory text and Congress's intent, facilitate *ex parte* verification using existing objective data sources, reduce unnecessary administrative burden on patients, physicians, and state Medicaid agencies, and minimize avoidable procedural coverage loss among medically frail individuals. Individuals who

[1] See section 1902(xx)(9)(A)(ii)(V)(dd) of the Social Security Act (42 U.S.C. 1396a(xx)(9)(A)(ii)(V)(dd)) (providing that medically frail individuals include individuals "with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living").

are described in one of the statutory medical frailty categories should not lose or be denied Medicaid coverage because they are unable to obtain documentation supporting a functional assessment that Congress never required.

2. **Convene physicians, disability experts, and states to develop a consensus framework for identifying medical frailty that impairs compliance with community engagement requirements.**

The IFR requires states to determine whether medically frail individuals' conditions, diagnoses, or circumstances impair their ability to comply with work requirements but does not define the level or type of impairment that satisfies that standard. Without clear guidance, states will develop their own criteria for determining when medical frailty is severe enough to establish the exemption. That approach will produce inconsistent, subjective, and insufficiently evidence-based determinations across states.

Alternatively, states may shift these judgments entirely to clinicians, asking them to determine—without validated criteria or clear standards—whether a patient is too impaired to meet the requirement. That would place clinicians in the untenable position of making eligibility determinations that could later be audited, second-guessed, or used to challenge the basis for an exemption. It may also create pressure to err against granting protection, even when a patient has serious clinical limitations. The result will be uneven access to the exemption for people with similar conditions and limitations, depending largely on where they live and how their state chooses to interpret an undefined federal standard.

To support consistent and clinically sound exemption determinations, CMS should work with physicians, disability experts, states, and other relevant stakeholders to develop a clear, evidence-based framework for granting medical frailty exemptions. CMS should ground that process in clinical expertise, disability expertise, and state eligibility-system experience, drawing on clinicians' understanding of health and function, disability experts' understanding of real-world participation barriers, and states' experience administering eligibility systems. The framework should direct states to consider a broad range of clinical, functional, and practical factors when granting exemptions and emphasize that individuals may qualify not only when medical frailty prevents them from satisfying the community engagement requirement, but also when it limits their ability to navigate the administrative processes required to demonstrate compliance or establish an exemption.

3. **Work with states to identify diagnoses, conditions, and clinical statuses that are sufficient in themselves to establish the medical frailty exemption.**

Certain conditions so clearly impair physical or cognitive functioning that states should, at a minimum, be permitted to treat reliable evidence of the diagnosis or status itself as sufficient evidence that the individual cannot reasonably satisfy an 80-hour monthly community engagement requirement. These include, among others, conditions that substantially limit mobility, strength, stamina, or cognition; permanent or progressive conditions; and statuses involving dependence on medical equipment, intensive treatment, or substantial daily assistance.

Requiring an additional individualized showing in these circumstances goes beyond what the statute contemplates and would do little to improve program integrity. Instead, it would create avoidable churn for states, unnecessary documentation burdens, and a heightened risk that medically frail individuals will lose coverage because they cannot navigate a redundant verification process. Accordingly, if CMS retains the added impairment requirement, it should permit states to identify at least a subset of diagnoses, conditions, and clinical statuses for which credible evidence of the diagnosis or status is alone sufficient to establish the medical frailty exemption, without requiring a separate individualized determination that the individual is too impaired to comply.

4. **Preserve self-attestation for medical frailty exemptions while states build reliable *ex parte* verification systems.**

The MMS strongly supports the IFR's direction that states verify compliance, deemed compliance, and exclusions—including medical frailty status—on an *ex parte* basis whenever possible, using reliable information available to the state without requiring information from the individual. When states have accurate and complete data, *ex parte* verification reduces paperwork, limits unnecessary documentation requests, and protects eligible individuals from avoidable coverage losses. In practice, however, most states today lack the infrastructure necessary to make *ex parte* determinations, particularly in the context of medical frailty exemptions.

The IFR directs states to use adjudicated claims or encounter data as the anchor for these determinations. Such data, however, have multiple shortcomings, the first of which is timing. Claims and encounter records pass through several steps before reaching states: clinicians submit claims, plans process them, and states receive, accept, and validate the data. Existing state policies expressly permit substantial delays between each of these steps. Encounter data can be even more difficult to access for patients with behavioral health conditions or SUDs. In some states, behavioral health services are carved out of the Medicaid managed care benefit and administered through a separate behavioral health plan. In others, the Medicaid managed care organization remains responsible for the benefit but delegates its administration to a subcontracted or sub-capitated behavioral health organization. Under either arrangement, encounter data generally pass through an additional entity before reaching the Medicaid agency, increasing the risk of delayed, incomplete, or inconsistent reporting. SUD treatment records are harder still to access: federal confidentiality protections generally prohibit their disclosure without the individual's consent, placing them beyond the reach of *ex parte* verification unless a state establishes lawful legal and operational pathways for obtaining them.

The limitations of existing data systems do not diminish the value of *ex parte* verification. Rather, they underscore the need for CMS to give states sufficient time and flexibility to build, test, and refine integrated, operational data systems. Until those systems are functional, CMS should allow states to continue accepting self-attestation of medical frailty after January 1, 2028, whenever reliable information is unavailable, incomplete, delayed, restricted by privacy law, or inaccessible to the Medicaid agency. Requiring full verification before states have functional *ex parte* systems in place would increase administrative burden and procedural disenrollment without improving program integrity.

5. **Require states to build *ex parte* systems that aggregate information from multiple reliable data sources.**

Even when claims and encounter data are timely, complete, and accurate, states will need to look across multiple encounters and other sources to determine whether an individual qualifies for a medical frailty exemption. A single claim will rarely contain all the information relevant to that determination because clinicians appropriately code only for the conditions and services evaluated or managed during a given visit. They do not list every chronic condition, secondary diagnosis, prior hospitalization or surgery, functional limitation, or aspect of a patient's social history on every claim. That is not a documentation gap; it reflects how the coding and billing system is designed to work. Claims data are encounter-specific records of services furnished for billing purposes, not comprehensive longitudinal assessments of a patient's medical, functional, and social circumstances.

To illustrate the stakes, consider a 58-year-old enrollee with long-standing, poorly controlled type 2 diabetes. Over several years, his disease has produced multiple complications that directly affect his ability to satisfy or prove compliance with a community engagement requirement: diabetic peripheral neuropathy that causes pain and numbness in his lower extremities, increases his risk of falls, and limits his ability to stand, walk, or remain on his feet for sustained periods; diabetic retinopathy that has caused substantial vision loss, making it difficult to perform many work-related tasks; end-stage kidney disease requiring frequent dialysis appointments that interfere with a regular work schedule; a partial foot amputation that further limits mobility and reliable travel to a work site; and major depression that impairs concentration, sleep, and motivation.

Taken together, these details present a picture of an individual who clearly meets the criteria for a medical frailty exemption. He has qualifying conditions, and those conditions impair his ability to stand, walk, see, concentrate, maintain stamina, and travel reliably. The same limitations would increase the burden of compliance itself, which may require traveling to appointments solely to obtain documentation and navigating complicated administrative processes. Yet the information needed to reach this conclusion is dispersed across multiple record systems: claims and encounter data from his primary care physician, nephrologist, endocrinologist, surgeon, and ophthalmologist; social work and case management notes; and psychiatric records held by his managed care plan's behavioral health subcontractor. Each record may be complete and accurate within its own scope, but none captures the combined effect of his diagnoses, complications, treatment burden, functional limitations, and social circumstances.

Without the capacity to combine information across multiple sources, states will fail to identify many patients like this one—patients whose eligibility for a medical frailty exemption becomes apparent only when their circumstances are considered in total. CMS should therefore require states to develop *ex parte* systems and processes capable of aggregating, reconciling, and synthesizing information from multiple encounters, payers, care settings, benefit programs, and other reliable sources. This change would allow states to assess eligibility based on a fuller picture of the individual's circumstances and reduce the risk that relevant information is overlooked or considered in isolation.

6. **Permit states to establish medical frailty exemptions *ex parte* based on the totality of reliable information rather than requiring individualized assessments in every case.**

Beyond building systems that can aggregate information from multiple sources, states must also have clear authority to act on what that information collectively shows. As illustrated above, certain combinations of diagnoses, treatment history, prescription drug records, utilization patterns, and other reliable information may strongly indicate both that an individual has a qualifying condition and that the condition impairs the individual's ability to satisfy the community engagement requirement. CMS should expressly clarify that, when the totality of reliable information supports those conclusions, states may grant an exemption without conducting a separate individualized assessment or requiring additional information in every case.

This clarification is essential to the operational viability of the *ex parte* provisions. If states must conduct an individualized assessment even when reliable information already supports an exemption determination, *ex parte* review would cease to function as a means of establishing the exemption and would instead serve only as a screening mechanism for identifying individuals who require further review. That would defeat both CMS's stated objective and Congress's intent to use information already available to states to establish exemptions without imposing unnecessary paperwork burdens on individuals. Permitting states to rely on reasonable inferences drawn from the totality of information would preserve appropriate safeguards while allowing *ex parte* review to function as intended.

7. **Adopt a continuing-status policy for permanent, irreversible, and progressive conditions.**

Beginning in 2028, states must verify medical frailty exemptions for individuals who self-attest at their next redetermination and must reverify those exemptions at least annually thereafter. For conditions that are permanent, irreversible, or progressive, a universal 12-month reverification cycle serves little clinical or administrative purpose. Instead, it requires patients to repeatedly obtain documentation for conditions already known to the state, clinicians to complete duplicative paperwork, and state agencies to process that paperwork. Individuals with permanent conditions may also have little recent utilization data to rely on *ex parte*, which pushes them into a manual reverification process each year to reproduce documentation confirming facts the state has already established.

CMS already recognizes the continuing-status principle elsewhere in the IFR: for veterans with a permanent disability status, states must rely on the Department of Veterans Affairs' determination that the condition is unlikely to improve and may not reverify that status once verified. The same principle should apply to all medical frailty exemptions. Where reliable information or clinical documentation establishes that an individual has a permanent, irreversible, or progressive condition satisfying the medical frailty exclusion under the state's criteria, states should record that status and refrain from annual reverification unless the individual reports a change in circumstances or the state receives information that the condition or its functional consequences have materially changed.

8. Permit states to consider information older than 12 months when it establishes a permanent, irreversible, or progressive condition.

The IFR prohibits states from considering information older than 12 months when verifying medical frailty or other special medical needs, based on CMS's concern that older information may fail to reflect an individual's current condition. That concern may apply when a state must assess facts that can reasonably change over time, such as current treatment status, symptom severity, or functional limitations. It should not prevent states from relying on older information to establish the existence of a permanent, irreversible, or progressive condition.

CMS should amend the IFR to permit states to consider information older than 12 months, especially when that information establishes a diagnosis or condition that is unlikely to change, such as spinal cord injury, congenital intellectual disability, limb loss, or advanced neurodegenerative disease. Requiring individuals with such conditions to obtain a new appointment or submit duplicative documentation would impose unnecessary burdens on patients, clinicians, and states without improving the accuracy of the determination. It would also increase the risk that individuals with the most serious and enduring conditions lose coverage simply because they cannot re-document what the record already establishes.

II. State Operational Readiness and the Good Faith Effort Exemption

Experience with state work requirement demonstrations and the Medicaid unwinding has shown that procedural barriers, rather than substantive ineligibility, drive many coverage losses among Medicaid-eligible individuals. To avoid repeating those outcomes, CMS should implement community engagement requirements in a manner that accounts for the practical limitations of existing state data systems and gives states sufficient time and flexibility to develop and operationalize reliable verification processes.

1. Apply the good faith effort exemption as Congress intended to give states time to build reliable verification systems.

The IFR treats *ex parte* verification as the primary safeguard against individuals losing coverage for procedural reasons. That safeguard depends on the premise that states can access current, activity-specific records for work, education, community service, caregiving, and excluded categories such as participation in a SUD treatment or rehabilitation program. In practice, states lack access to much of this information today.

Work hours. The IFR directs states to verify work hours using the same information they use to verify income, but income verification and hours verification are not interchangeable. CMS itself acknowledges that income data "often will not show hours," but we are concerned that the agency underestimates the operational consequences of that gap. States have spent decades developing Medicaid income-verification systems, and those systems still require manually submitted pay stubs, employer letters, W-2s, or other records in many cases. Even when income data are available, they generally show the amount and source of earnings, not the number of hours worked in a particular month. As a result, many states will need to create new processes to verify information that their current income data systems were never built to capture.

Those limitations apply even to traditional wage employment, where employer records and earnings data are more likely to exist. Verification will be even more difficult for unpaid, in-kind, self-employed, seasonal, and other nontraditional work, where there may be no employer record, wage report, or standardized documentation source. Caregiving presents a particularly complex case. The IFR excludes certain family caregivers from the community engagement requirement, while allowing other caregiving hours to count as unpaid work toward the 80-hour threshold. To apply those rules correctly, states will need to develop processes to determine the caregiving relationship, the age or disability status of the person receiving care, whether the caregiver resides with that person, and the hours of care provided in the month under review.

Educational program enrollment. The IFR encourages states to verify educational enrollment through state university systems, third-party vendors, or Hub-based educational data, if CMS makes such data available. These sources, however, do not provide a complete or currently operational verification pathway. State university systems generally exclude private institutions, many community-based programs, and other nontraditional education and training settings. The gaps are even more pronounced for GED and high school equivalency programs, technical and vocational schools, and adult education programs. For these settings, applicants and enrollees will likely need to manually submit documentation, and because many institutions take weeks to process transcript and enrollment-verification requests, students may be unable to obtain the required records within the IFR's 30-day cure period, creating an additional source of procedural coverage losses.

Community service and work-program participation. Community service and work-program participation are even less likely to be captured through automated data sources. Community service organizations vary widely in staffing and administrative capacity, and many lack formal attendance-tracking systems capable of generating records that can be used for Medicaid verification. For work-program participation specifically, the IFR notes that qualifying programs vary by state and that, because the Medicaid definition of work program aligns with the definition used for the Supplemental Nutrition Assistance Program (SNAP), states should consult SNAP agencies to identify what data sources SNAP uses.

The MMS strongly supports leveraging existing benefit-program systems where reliable data are available. However, alignment between program definitions does not in itself create an operational data pipeline. SNAP systems often rely on manual verification processes and are unlikely to capture the monthly hourly data Medicaid agencies need to verify compliance. In addition, many states do not currently have the interoperable systems needed to support automated cross-program data sharing and will need time and resources to build them.

Congress recognized existing limitations in state infrastructure, which is why it created a temporary good faith effort exemption and directed the Secretary, when evaluating exemption requests, to consider the actions a state has taken toward compliance; any significant barriers to compliance, including those related to the funding, design, development, procurement, or installation of necessary systems; and the state's detailed plan and timeline for achieving full compliance. The gaps described above are precisely the types of barriers Congress identified.

The MMS urges CMS to administer the exemption according to that statutory standard by withdrawing the language stating that approvals of good faith effort exemptions are expected to

be limited to states that experience "extraordinary, severe, or unexpected issues" that hinder implementation. Nothing in section 1902(xx)(11) of the Social Security Act imposes that heightened threshold. The statute recognizes that foreseeable implementation barriers—including systems changes, eligibility-process redesign, staffing needs, and data-sharing infrastructure—may support a good-faith-effort exemption when a state is making meaningful efforts toward implementation. CMS should not narrow that standard by limiting approvals to extraordinary circumstances.

To ensure states use these exemptions appropriately, CMS should rely on the oversight mechanism Congress specified: quarterly progress reports, backed by the Secretary's authority to terminate an exemption when a state fails to report or ceases making good-faith efforts. That approach protects program integrity while giving states the planning certainty needed to build reliable systems. It also promotes responsible stewardship of taxpayer dollars. A state compelled to implement community engagement requirements before its systems are ready will default to manual, error-prone processes that generate improper disenrollments, appeals, reinstatements, and rework—administrative churn that costs far more than building reliable infrastructure once. Administering the exemption as written by Congress would allow states to implement the statute accurately the first time, at lower cost, and with fewer procedural coverage losses.

2. **Require states to demonstrate operational readiness for each verification category and address unresolved gaps through the good faith effort exemption or broad acceptance of "other information."**

Section 435.557(b)(2)(iii)(B) prohibits a state from denying or terminating eligibility solely because an individual cannot produce documentation that does not exist or is not reasonably available. Documentation is not reasonably available to an individual when establishing compliance requires the person to obtain records manually from multiple employers, schools, community service organizations, work programs, or other third parties and assemble and submit those records within the 30-day cure period. The fact that the information may exist somewhere in the records of one or more third parties does not make it reasonably available to the applicant or beneficiary within the timeframe the IFR provides.

CMS reinforces this principle throughout the IFR by emphasizing *ex parte* verification as the principal safeguard against procedural coverage losses. The MMS strongly supports that approach. When states can obtain and use reliable information without requiring action from the individual, *ex parte* verification reduces paperwork, avoids unnecessary documentation requests, and protects eligible individuals from losing coverage because of administrative barriers rather than a failure to satisfy the substantive requirement.

That safeguard, however, works only if states have operational systems capable of obtaining the information necessary to verify each qualifying activity, deemed-compliance category, and exclusion. Simply identifying a potential data source does not establish that the necessary information is reasonably available to the state. Wage data, for example, may show earnings without showing hours worked. Enrollment data may confirm registration without establishing credit hours, attendance, or participation status. A state may identify another agency, employer, school, or community organization as a potential source without having established the data-

sharing agreements, system interfaces, matching processes, staffing, or procedures necessary to obtain and use the information within the applicable eligibility timeframe. Until a state can retrieve, combine, and use all the information necessary to make the relevant determination, it does not have a functional *ex parte* verification pathway for that category.

CMS should therefore direct each state, through its verification plan supplement, to demonstrate operational readiness for every qualifying activity, deemed-compliance category, and exclusion. The supplement should specify, for each category, the information needed to make the determination; each proposed data source; what that source does and does not contain; the frequency of updates and currency of the data; and the process by which the state will automatically obtain, match, combine, and apply the information. States should further explain how they will handle missing, delayed, stale, or conflicting data, and show that they can retrieve and use the necessary information within the applicable timeframe.

Where a state cannot make this showing, CMS should require it to address the resulting gap in proportion to its severity. Should the gaps be broad enough to preclude reliable implementation of the community engagement requirement via *ex parte* processes, the state should request a temporary good faith effort exemption, which CMS should approve whenever the statutory standard is satisfied. Where the gaps are confined to particular qualifying activities, deemed-compliance categories, or exclusions, CMS should require the state to accept a signed individual attestation as sufficient "other information" under Section 435.557(b)(2)(iii) for those categories until a reliable *ex parte* pathway exists. Such an attestation should suffice until the state demonstrates that it can retrieve and use all information necessary to verify the category within the applicable eligibility timeframe.

A system that depends on beneficiaries to navigate fragmented, unreliable, manual documentation processes cannot be considered operational. States must either build the infrastructure to conduct reliable *ex parte* verification—accepting individual attestations in the interim—or seek the additional implementation time Congress made available through the good faith effort exemption.

III. Verification, Notice, and Beneficiary Protections

When state records do not establish compliance or an exclusion, applicants and beneficiaries must have a meaningful opportunity to obtain and submit supporting documentation and obtain assistance in identifying and resolving missing or incomplete information before coverage is denied or terminated. The recommendations below address each of these protections.

1. Extend the mailed-notice receipt presumption to give applicants and beneficiaries adequate time to respond to noncompliance notices.

CMS should extend the mailed-notice receipt presumption from 5 to 14 days and clarify that, when an applicant or beneficiary demonstrates later delivery, the statutory response period begins on the date of actual receipt.

Section 1902(xx)(6)(A)(i) of the Social Security Act gives applicants and beneficiaries 30 calendar days after receiving a noncompliance notice to demonstrate compliance or establish an exclusion. Under the IFR, that 30-day period begins five days after the date printed on the notice. For many

individuals, 30 days will not provide enough time to receive and understand a mailed notice, determine what information is required, obtain documentation—often from multiple third parties—and submit it to the state before losing coverage. Because Congress established the 30-day response period in statute, however, CMS cannot extend it through regulation. CMS can, however, adopt a more realistic presumed receipt date that accounts for circumstances that may delay delivery or an individual's ability to retrieve and review the notice, including mail delays, address changes, housing instability, hospitalization, acute illness, and travel.

We recommend that CMS should extend the presumed receipt date from 5 to 14 days after the date printed on the notice and begin the response period on the date of actual receipt when a notice arrives later. These changes would better reflect actual delivery conditions, preserve the full response period Congress provided, and give individuals a meaningful opportunity to obtain and submit third-party documentation before losing coverage.

2. **Preserve coverage while third-party verification is pending.**

CMS should preserve coverage when an applicant or beneficiary has timely requested documentation from a third party but has not yet received it. As a general matter, individuals should not lose coverage because of administrative barriers or delays outside of their control. Demonstrating compliance with community engagement requirements may require records from employers, schools, community service organizations, or other outside entities. Delays by those entities are beyond the individual's control and should not result in a procedural termination.

Section 435.557(b)(2)(iii)(B) of the IFR prohibits a state from denying or terminating eligibility solely because an individual cannot produce documentation for an exemption other than medical frailty that does not exist or is not reasonably available. Documentation that an individual has requested but that a third party has not yet provided is, as a practical matter, not reasonably available during the cure period. CMS should therefore clarify that proof of a timely request is sufficient to preserve eligibility while the documentation remains pending and that a state may not terminate coverage solely because the third party has not yet responded.

Although individuals may later regain coverage through the reconsideration process, unnecessary procedural terminations create avoidable administrative burden and disrupt access to care. CMS should ensure states do not terminate coverage when the only barrier to verifying eligibility is administrative delay outside the individual's control.

3. **Direct states to offer eligibility assistance during accessible hours and through accessible channels.**

CMS should direct states to make eligibility assistance available at times and through channels that applicants and beneficiaries can realistically use. Timely access to eligibility assistance often determines whether an individual can resolve a verification issue before losing coverage. In many states, that access is constrained by long call center wait times, assistance lines and offices open only during standard business hours, few online messaging options, and no scheduled callback function.

CMS documented these barriers during the unwinding of continuous enrollment. In letters to 16 states, the agency warned that long call center wait times and high abandonment rates were impeding equitable access to assistance and the ability of individuals to apply for or renew Medicaid coverage. To avoid repeating these failures under the community engagement requirement, CMS should direct states to make eligibility assistance available at times and through channels that applicants and beneficiaries can realistically use. This includes offering two-way portal messaging, scheduled callback options, and extended or weekend phone and in-person hours, particularly in the initial years of implementation. These practices would help individuals correct incomplete submissions and resolve case-specific questions before coverage is denied or terminated and would also improve program efficiency by preventing unnecessary appeals, reinstatements, and reapplications arising from issues that timely access to assistance could have resolved.

4. **Encourage states to create a single process for submitting and tracking documentation, while preserving multiple accessible submission channels.**

CMS should encourage each state to maintain a single system that houses attestations, supporting documentation, the status of pending third-party verification, and final eligibility determinations. Within that system, every applicant and beneficiary should have a single authoritative case record that follows the individual across plan changes and transitions between managed care and fee-for-service coverage. While applicants and third parties should retain the ability to submit documentation through multiple channels, including online, by mail, by phone, and in person, every submission should flow into that same record.

Without a single system for submitting and storing documentation and determinations, applicants and third parties will have to navigate disparate submission processes, creating confusion and avoidable churn when enrollees move between plans. In addition to jeopardizing coverage, every redundant request and erroneous termination would impose costs on taxpayers by consuming staff time, increasing appeals volume, and requiring re-enrollment processing.

5. **Require states to accept documentation directly from authorized third parties.**

CMS should require states to allow authorized third parties to directly submit verification documentation on behalf of applicants and beneficiaries. Many records needed to verify compliance with community engagement requirements will be held by third parties, such as schools and employers, and states should not require applicants and beneficiaries to obtain the documentation themselves and resubmit it to the state. That additional step creates avoidable delays, increases administrative burden, and heightens the risk that documentation is lost or received after the response period has expired.

CMS has clear authority to require states to accept direct third-party submissions. Section 1902(xx)(5) of the Social Security Act directs states to establish processes for verifying community engagement, and the IFR implements that mandate at § 435.557(b)(4) by requiring states to allow the individual, a household or family member, or an authorized representative to submit verification information through any modality states use to accept applications. Directing states to

accept authorized submissions directly from record-holding third parties falls within that same authority.

States could readily facilitate direct third-party submission through secure, case-linked upload links. Direct submission would improve accuracy; reduce burden on applicants, beneficiaries, and third parties; and help prevent coverage losses caused by delayed or lost third-party documentation.

6. Strengthen public transparency regarding implementation outcomes.

The MMS appreciates CMS's decision to require comprehensive implementation reporting under Section 435.562. The monitoring framework provides CMS with valuable internal oversight tools. The rule, however, does not commit CMS to publicly sharing what it learns. Nothing in § 435.562 specifies that the resulting report will be released publicly, on what schedule, or broken out by the demographic and eligibility categories that would allow advocates, researchers, and regulators to identify which populations are bearing the burden of procedural denials. The MMS urges CMS to complete the monitoring framework CMS has already built by making the output public.

To maximize the value of that framework, CMS should publicly release regular community engagement implementation reports that distinguish procedural from substantive disenrollments, identify state-level *ex parte* verification rates, and enable CMS to work collaboratively with states to implement corrective actions before widespread coverage losses occur. These data should be used to identify outlier states and require corrective action. A state with unusually high procedural denials, low *ex parte* verification rates, high medical frailty denial rates, or large month-over-month coverage shifts should submit a corrective action plan, expand outreach, simplify documentation, improve assistance channels, or pause terminations until the problem is corrected. CMS should also publish best practices drawn from states that achieve high *ex parte* verification and low procedural disenrollment rates.

Conclusion

MMS physicians share the goal of making patients healthier. A healthier America, however, cannot be built by stripping health coverage from the people who most rely on it. For tens of millions of Americans, Medicaid is the only route to a physician, a diagnosis, a prescription, or a treatment plan, and by imposing additional restrictions on coverage and unrealistic expectations on states making coverage determinations, the IFR will close that route for many of the individuals the statute was intended to protect.

The MMS therefore urges CMS to revise the IFR to avoid compounding the well-documented harms of work requirements. With respect to medical frailty, that means giving full effect to the categories Congress established, without imposing extra-statutory functional requirements that will predictably exclude eligible individuals and burden the physician-patient relationship. On verification, it means aligning documentation requirements with the information states can reliably obtain, allowing states to rely on older records for permanent, irreversible, and progressive conditions, giving states sufficient time and flexibility to build the necessary infrastructure, and permitting a broad range of qualified professionals to verify medical frailty. On beneficiary assistance, it means ensuring beneficiaries can easily submit documentation and third-party

records, while ensuring that beneficiaries can obtain help through accessible channels and outside standard business hours. And where the systems necessary for implementation are not yet in place, it means administering the good faith effort exemption Congress created for precisely that circumstance—to prevent avoidable coverage losses, unnecessary churn, and the taxpayer waste that churn produces. The Administration's goal of a healthier America depends on it.

The MMS appreciates the opportunity to provide these comments and remains available as a resource should CMS require additional information or expertise. If you have any questions, or if you would like to talk further, please reach out to Casey Rojas, MMS' Federal Relations Director, at (781) 434-7082 or by email at CRojas@mms.org.

Sincerely,

Rebecca Brendel, MD, JD

President, Massachusetts Medical Society