July 31, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Oz:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services's (CMS) interim final rule with comment period (IFC) on the community engagement (CE) requirement for certain individuals in Medicaid published on June 1, 2026. MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program.

MACPAC submits these comments on the IFC that implements and provides additional guidance regarding the CE requirement in Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act). The Commission's comments focus on enrollment and eligibility and draw primarily from the Commission's research and analysis of work and CE requirements through Section 1115 demonstrations, as well as our more recent work since enactment of this new requirement. The findings of our most recent analysis are reflected in the four principles that the Commission identified for implementing CE requirements and in our recommendation that CMS develop a transparent monitoring and evaluation plan for assessing CE implementation (MACPAC 2026a). The Commission's principles are:

- CMS should provide timely federal guidance and technical assistance to states;
- CMS and states should ensure that eligible individuals can gain and maintain coverage;
- CMS and states should prioritize efficiency when procuring, updating, and operating state information technology (IT) systems; and
- CMS and states should use timely monitoring and evaluation data to inform policy and operations.

The Commission's recommendation in the June 2026 report to Congress on implementing CE requirements in Medicaid calls on the Secretary to direct CMS to develop a transparent plan for monitoring and evaluating CE requirements (MACPAC 2026a). We acknowledge and appreciate CMS establishing the state reporting requirements outlined in the IFC to monitor eligibility and enrollment as

states implement CE requirements. In addition to this new reporting requirement, the Commission recommends that CMS adopt the other aspects of the Commission's recommendation by making these state-reported data publicly available in a timely manner and developing a transparent evaluation plan that, at minimum, assesses the effect of CE requirements on beneficiary employment and health, and state and federal administrative and program spending.

The Commission supports policies that advance the Medicaid statutory goals of efficiency, economy, quality, and access, including efforts to ensure that eligible individuals enroll in Medicaid and stay covered, and to minimize state and beneficiary burden. For example, the IFC highlights the importance of state use of ex parte processes, which automatically leverage existing data to facilitate Medicaid redeterminations without requiring information from beneficiaries. However, the Commission is concerned that the IFC will limit CMS's and states' ability to ensure eligible individuals gain and maintain coverage. The IFC establishes complex policies for identifying individuals subject to and excepted and excluded from CE requirements that states must implement by January 1, 2027. Notably, the IFC definition of medical frailty may create challenges for states to implement and for eligible beneficiaries to document their status. As such, we are concerned that these policies create administrative burden for states and beneficiaries, which is contrary to Medicaid's statutory goals and could curtail coverage of populations that the program aims to support.

Summary of key IFC provisions

For the first time, states will be required to condition Medicaid eligibility for certain applicants and current beneficiaries on participation in qualifying CE activities, pursuant to the 2025 Budget Reconciliation Act. To comply with CE requirements, applicable individuals must participate in 80 hours of work, a work program, community service, education, or a combination thereof or be enrolled in an education program at least half-time in a given month.[1]

The law established the framework for CE implementation, including state implementation timelines; compliance verification requirements; qualifying CE activities; individuals subject to, excepted, and excluded from CE; beneficiary outreach requirements; noncompliance procedures; and good faith effort exemptions. The law also delegates to the Secretary the authority to set certain standards and procedures described below. As required by law, CMS issued the IFC by June 1, 2026.

Applicable individuals. Applicable individuals are persons applying for or enrolled in the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as well as individuals applying for or enrolled in a Section 1115 demonstration that provides minimum essential coverage to individuals who are age 19–64, not pregnant, not dually eligible for Medicare, and not otherwise eligible for coverage under the state plan. Applicable individuals are subject to CE requirements. The IFC's definition of an applicable individual aligns with the statutory definition.

Mandatory exceptions and specified excluded individuals. Congress required the Secretary to establish standards for determining who is a specified excluded individual and to define medical frailty. The IFC details criteria for identifying individuals who are excepted or excluded from CE requirements, which has important policy and operational implications for determining if an individual is subject to CE and the appropriate eligibility review period. Individuals meeting the criteria for a mandatory exception are subject to CE requirements but deemed compliant for the month(s) in which they meet the criteria during the one- to three-month period before application (i.e., lookback period).[2] Specified excluded individuals, on the other hand, are not subject to CE requirements and states cannot apply a lookback period to these individuals.

CMS provides detailed criteria for each of the nine categories of specified excluded individuals, including defining individuals participating in substance use disorder (SUD) treatment and individuals considered medically frail.[3] The law identifies individuals who are medically frail or otherwise have special needs as specified excluded individuals and delegates to the Secretary the authority to define this category. The IFC expands on the statutory framework in the 2025 Budget Reconciliation Act by defining individuals considered medically frail as those with a physical, mental, or behavioral health condition that significantly impairs an individual's ability to comply with CE.

Frequency of renewals and option for more frequent verification. States are required to conduct six-month renewals for most populations enrolled in the expansion pathway, except for American Indians. For those enrolled in Section 1115 demonstrations, the six -month renewal only applies to demonstrations that provide minimum essential coverage to all individuals who would be eligible if the state adopted the expansion pathway under the state plan. States also have the option to conduct more frequent verification checks during the six-month renewal period. The IFC notes that if states elect to conduct more frequent checks, they should consider how the timing of these checks relate to the verification timing for the six-month renewal process and the feasibility of accessing timely data for each verification check.

Verification of compliance or exception or exclusion status. The 2025 Budget Reconciliation Act required the Secretary to establish standards and processes for using data to verify compliance, exception, or exclusion status without requiring individuals to submit additional information. The statute also gave states the option to not require an individual to verify information resulting in the individual being deemed as excepted from CE. The IFC specifies the types of data that are considered reliable sources of information and should be used to verify compliance before seeking additional information from the individual. Also, the IFC requires states to use the electronic data service established by the Secretary (i.e., federal data services hub) for verification of beneficiary status related to CE, or request CMS approval to use an alternative data source.[4] CMS indicates that when reliable sources of documentation are not available, states may require documentation or accept self-declaration under penalty of perjury in the absence of available information before January 1, 2028. Starting on January 1, 2028, the state must first require documentation when it is reasonably available, as defined by the IFC, from the individual. If no documentation is reasonably available, the state must establish a process to accept other information, and the processes vary based on whether the state is verifying compliance, deeming compliance, or verifying excluded individuals.

Beneficiary outreach. As required by the statute, the Secretary establishes standards for notifying individuals of CE requirements. The IFC describes requirements related to initial and periodic outreach to inform individuals of the CE requirements and permits states to use managed care plans to assist with some outreach activities. States are required to send the initial outreach in advance of state implementation to ensure these individuals are aware of the requirement to demonstrate CE, how to demonstrate compliance (including frequency of renewals), and requirements for qualifying for a mandatory exception or specified excluded individual status. Following the initial outreach, states are required to conduct outreach on a periodic basis for varying circumstances that may affect eligibility, including after eligibility determinations, at the time of renewal, and when states effectuate a short-term hardship or implement the short-term hardship option. The IFC does not define "periodic basis" as a specific frequency.

Noncompliance procedures. Congress required the Secretary to establish standards for notifying individuals whose compliance with CE requirements cannot be verified. The IFC details these procedures, many of which are consistent with existing regulations, with one notable difference. Existing rules at 42 CFR 435.916(b)(2)(B) require states to provide modified adjusted gross income (MAGI) beneficiaries with at least 30 calendar days from the date the agency *sends* the notice to respond. As required by the 2025 Budget Reconciliation Act, the IFC requires states to provide beneficiaries with 30-calendar days from the date the individual *receives* the notice to respond to a notice of noncompliance. In the IFC, CMS defines the date of receipt as five days following the date on the

notice unless the applicant or beneficiary can show that they did not receive the notice within this timeframe (42 CFR 435.558(c)(4)). However, the rule does not specify how an individual demonstrates that they did not receive the notice within the five-day period.

Monitoring. The 2025 Budget Reconciliation Act did not establish requirements for monitoring implementation of CE requirements. However, the IFC establishes new CE reporting requirements, as was recommended by the Commission in the June 2026 report to Congress. States must submit data to CMS in a timely manner and of sufficient quality. CMS requires states to include information on enrollment, applications and renewals, individuals subject to CE requirements, and any other information the agency will specify. However, the IFC does not specify whether these new data would be made publicly available.

Coverage for Eligible Individuals

Prior MACPAC work suggests that many applicable individuals will likely meet CE requirements or qualify for an exception or exclusion, and states will need to implement large system and programmatic changes to ensure that eligible individuals can gain and maintain coverage. MACPAC's analysis of 2023 National Health Interview Survey data found that 54.8 percent of all Medicaid-covered adults (age 19–64 years) work at least part time (32.0 percent full time and 22.8 part time). Of those who do not work, the majority reported not working due to health reasons or a disability, caring for family or household, and going to school (MACPAC 2025).

Other MACPAC research found that many children and youth with special health care needs (CYSHCN) enrolled in non-MAGI pathways as children enroll in the expansion pathway as an adult and could be subject to CE requirements (MACPAC 2026b). MACPAC's analysis of the Transformed Medicaid Statistical Information System (T-MSIS) data from 2017–2019 found that 13.5 percent of CYSHCN beneficiaries who transitioned without experiencing a gap in coverage enrolled in the expansion pathway as an adult. Among those who experienced a gap in coverage during this transition and re-enrolled within 12 months, 50.1 percent enrolled in an expansion pathway as an adult. Stable Medicaid coverage for CYSHCN is critical to ensuring continued access to their specialized care as they age into adulthood and transition to an adult model of care. Further, these beneficiaries represent a vulnerable population with ongoing health care needs, and the expansion pathway has played an important role in supporting their ability to maintain coverage as adults (MACPAC 2026b).

In the Commission's prior work on implementing CE requirements, states and stakeholders emphasized the need to prioritize operational efficiency to implement these new requirements and minimize coverage loss among eligible individuals, in particular, those who may qualify for an excluded status. Interviewees emphasized state use of ex parte verification to reduce administrative burden for beneficiaries and raised the importance of accepting self-attestation when data are not available to verify a beneficiary's compliance, exclusion, and exception status. Further, stakeholders raised the importance of sending outreach and education materials to beneficiaries and sending these materials through multiple modalities to improve beneficiary awareness of upcoming eligibility changes. MACPAC's prior research indicated that inadequate beneficiary outreach may have contributed to high numbers of beneficiary disenrollment because of unawareness of the new requirements and how to demonstrate compliance. Similarly, stakeholders emphasized the importance of states developing notices that are written in clear and plain language to promote beneficiary comprehension and urged states to use multiple means of communication to ensure information reaches targeted individuals (MACPAC 2026a).

Medical frailty

States will need to effectively and efficiently identify individuals who are medically frail, and thus excluded from CE requirements. According to the statute, medically frail individuals include those who are blind or disabled; have a substance use disorder; have a disabling mental disorder; have a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or have a serious or complex medical condition (§ 1902(a)(xx)(9)(A)(ii)(v)). The IFC adds another criterion for qualifying as medically frail, by requiring states to determine whether an individual's health condition significantly impairs their ability to meet CE requirements although such criterion is not specified in statute. States that began CE-related systems changes and implemented CE policies prior to the release of the IFC and its definition of medical frailty will now have to update programming. Also, we note that CMS has not provided clear guidance on how to evaluate this criterion, and state Medicaid programs do not have experience assessing whether an individual's condition impairs their ability to work. Therefore, the Commission is concerned with states' ability to implement the IFC's definition of medical frailty, the effect on individuals who may experience challenges documenting their status as medically frail, and the uncertainty that the updated definition introduces to overall program enrollment and spending.

In the IFC, CMS indicates that states should consider incorporating plain language screening questions on the Medicaid application to help individuals identify themselves as potentially qualifying for an excluded status, including those who may be medically frail or have special medical needs. In MACPAC's work on implementing CE requirements, some stakeholders suggested states could use the Medicaid application as a way to identify these populations. Prior MACPAC work highlights the role of the Medicaid application as an initial source for gathering information on individuals applying for Medicaid and the importance of using evidence-based questions that include descriptions of how the information will be used to ensure the collection of complete and accurate information (MACPAC 2024a, 2023a). Therefore, the Commission supports states incorporating clear and easily understood language in the application about the exceptions and exclusions to the CE requirement to ensure that applicants are aware of and can identify themselves as potentially qualifying for one of these categories.

Data sources. States will likely experience challenges verifying whether individuals qualify for the medical frailty exclusion using existing data sources. The IFC specifies that states are required to use reliable information to verify an individual's status as medically frail, including claims and managed care encounter data. However, known limitations with using claims and managed care encounter data, including the timeliness and completeness of the data and the lack of functional limitation assessments, are barriers to using the data for ex parte processes to determine whether an individual meets the medically frail criterion of the IFC. Due to typical claims lag, availability of up-to-date data will not always align with the timing of CE determinations. Under current federal regulations, providers have up to 12 months from the date of service to submit a claim to the state (CFR 42 CFR 447.45). In addition, reliability and completeness of claims data may limit state ability to identify individuals considered medically frail under the IFC. For example, a provider may inadvertently forget to include a diagnosis code or the excluding condition permitted by the IFC may not be able to be easily included on the claims form. While the ex parte process is effective and states have increased their ex parte rates following the unwinding of the public health emergency (PHE) (ex parte rates increased from 55.8 percent in April 2023 to 75.1 percent in June 2024), historically, states have used ex parte processes to obtain information needed to confirm income eligibility for individuals subject to MAGI counting rules (MACPAC 2024b, 2023b). MACPAC's examination of state use of ex parte renewal also found that states experience challenges using ex parte processes to verify eligibility factors such as assets or health and disability status (MACPAC 2023b). Determining whether an individual meets the rule's definition of medical frailty will require functional assessments, which extend beyond how states have previously implemented ex parte policies.

SUD. Individuals with SUD may qualify for exclusion from CE requirements in two ways: they are determined medically frail or they participate in SUD treatment. The IFC directs states to use available data sources to identify individuals with SUD who may be excluded from CE requirements. However, states may experience challenges in identifying individuals participating in SUD treatment using ex parte due to gaps in Medicaid coverage of SUD treatment services and challenges associated with sharing data related to this population. For example, MACPAC's research identified gaps in Medicaid coverage of the full continuum of clinical services for treating SUD (MACPAC 2018a). Further, prior work identified challenges associated with data sharing for individuals with SUD, due to confidentiality requirements established in 42 CFR Part 2 (Part 2) (MACPAC 2018b). The IFC notes that states should account for the data privacy laws related to individuals with SUD when sharing sensitive information to determine whether those individuals qualify for an exclusion. While the IFC does not provide additional guidance around this issue, it notes that CMS will work with HHS's Office for Civil Rights to provide states with technical assistance on the intersection of Part 2 and CE requirements. The Commission supports CMS's efforts to provide technical assistance to states on sharing these sensitive data and further encourages CMS to do so in a timely manner to ensure that states are appropriately implementing this exclusion and complying with confidentiality laws.

Diagnoses. Acknowledging that states may face challenges identifying individuals eligible for exclusions and exceptions, the IFC indicates that states must develop lists of diagnoses to facilitate identification and provides states the option to accept self-declaration, but places restrictions on its use. For example, CMS directs states to develop lists of diagnosis codes that can be used as a step for identifying individuals with conditions that lead to medical frailty, but has so far only provided states with limited parameters for developing the lists (e.g., the list can include diagnosis codes and must be auditable). States are required to share these lists with CMS, which may audit them as a part of its oversight activities. However, CMS has not yet issued guidance on such audit requirements. In addition, CMS allows for limited use of self-attestation (referred to in the IFC as self-declaration) for verifying individuals considered medically frail. Prior to January 1, 2028, if reliable information is not available, the IFC allows states to accept a self-declaration provided under penalty of perjury. Starting on January 1, 2028, if the state is unable to verify this exclusion status using reliable information, the state must first require the beneficiary or applicant to provide additional information. States are permitted to accept a self-declaration provided under penalty of perjury only if other documentation is not available. Further, this is only permitted once during the individual's period of enrollment.

Self-attestation. The Commission notes that the IFC's policy permitting limited use of self-attestation to establish exception or exclusion status from CE requirements, particularly for individuals considered medically frail, after January 1, 2028 is inconsistent with current Medicaid self-attestation policy. Existing rules permit states to enroll individuals based on self-attested information for certain non-financial eligibility factors with the option to conduct post-enrollment verification for most eligibility factors. Further, existing rules do not restrict the use of self-attestation to specified timeframes or to the number of times it can be used. Most states currently use self-attestation for at least some eligibility factors. As of 2020, 49 states accepted self-attestation for household composition, 40 for state residency, and 5 for income with post-enrollment verification (Brooks 2020). The IFC's self-attestation policy may contribute to delays in coverage or uninsurance for some individuals despite meeting specified criteria, including medical frailty. Given the Commission's interest in ensuring that eligible individuals can gain and maintain coverage, we encourage CMS to provide states with ongoing flexibility to use self-attestation or other appropriate tools to help states identify individuals who qualify for excepted or excluded status. State flexibility to allow individuals to self-attest to their compliance, deemed compliance, or exception status, is needed when data are not immediately available to verify their circumstances. In the Commission's prior work on CE, states and stakeholders raised the importance of accepting self-attestation, particularly for new applicants, for whom the state does not have claims or other information to determine compliance, exclusions, and exceptions. Additionally, individuals who satisfy CE requirements through qualifying activities outside traditional employment

and education, such as community service or non-traditional employment (e.g., babysitting) may experience challenges with providing the state with reliable information needed to verify compliance.

Ex parte processes

The IFC requires states to use ex parte processes at application and renewal to determine eligibility and compliance with CE requirements by using reliable information available to the agency without requiring additional information from the individual. To support the ex parte process at application, the IFC encourages states to consider incorporating plain language screening questions in Medicaid applications to help individuals identify themselves as caregivers or having medical frailty, as these individuals may not always identify themselves as qualifying for these exclusions. State use of ex parte is important for identifying and verifying compliance with CE and exclusions and exceptions, given its role in reducing state administrative burden and beneficiary burden associated with submitting additional information (CMS 2022, 2020). The Commission's prior work found that automating ex parte processing for renewals can free up staff time for other eligibility-related tasks, such as responding to new applications or processing renewal forms completed by beneficiaries whose eligibility could not be renewed on an ex parte basis (MACPAC 2023b).

Known implementation challenges. MACPAC's prior work examining ex parte processes in the context of the PHE unwinding highlighted factors critical for the effective use of ex parte and surfaced challenges that states experience. The Commission found ex parte processes require access to robust and variable data sources to confirm eligibility and integration with eligibility systems used for other human services programs (e.g. Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF)). States need to use many different data sources to verify Medicaid eligibility and make decisions about which data to use based on a number of factors, including the ease of use, the number of cases to which the data are applicable, and the specificity and recency of the data. Integration with other programs is also important for improving the specificity of the shared data. For example, when SNAP and Medicaid systems are not integrated, the Medicaid agency may receive only summary income information through a data sharing agreement, rather than details on the type of income and the household member who earned it, which are often needed to redetermine Medicaid eligibility (MACPAC 2023b). Similarly, as states incorporate new types of data sources into ex parte processes for CE determinations, states should consider the usability and specificity of the information and prioritize sources that can provide multiple types of information that may need to be verified to minimize the number of checks across multiple data sources.

In some cases, data sources used for ex parte determinations conflict with each other, and while establishing data hierarchies can help to resolve the differences, states experienced challenges doing so (MACPAC 2023b). These hierarchies allow states to determine the order in which electronic data sources are assessed to reduce checking multiple sources and potential mismatches. The hierarchy logic can be dynamic and prioritize data sources that are most useful based on the data types needed and only check additional sources when the first source is insufficient (CMS 2024a, 2022). We found that states have challenges determining these hierarchies due to variability in the timeliness of the data in these sources (e.g., quarterly wage data, annual income tax returns, income data collected by other agencies), which can make it challenging to compare data across sources, as well as the availability of data based on the types of eligibility information needed.

Additionally, our prior work identified ex parte renewal as particularly challenging for populations where eligibility is determined based on factors other than income. For example, beneficiaries whose eligibility is based on age or disability typically have additional factors of eligibility, such as asset limits and functional assessments. Limitations in the timeliness and availability of asset information in state asset verification systems often inhibit the use of ex parte renewals for non-MAGI beneficiaries. Further, states have challenges verifying health status or medical expense information, which is sometimes needed to verify eligibility for beneficiaries who have disabilities or

multiple chronic conditions (MACPAC 2023b). Challenges associated with ex parte verification will result in requiring the beneficiary to submit documentation. The Commission's work on implementing CE requirements highlighted the importance of states providing user-friendly online application and renewal portals for beneficiaries to report their CE compliance, mandatory exception, or exclusion status. Our research found that in states that implemented work and CE requirement demonstrations, administrative barriers to beneficiary reporting were among the most common reasons for non-compliance (ASPE 2021; Hill and Burroughs 2019).

The Commission also found that budget constraints can limit state updates to IT systems that are needed to improve their ex parte processes and the timeliness with which states can implement them. While states can request enhanced federal match by submitting an Advanced Planning Document (APD), those requests often require time to develop, and states must finance their share of the IT project or upgrade. Stakeholders we spoke to shared that gaining approval of APDs is a central component of their CE implementation, but that states have a limited window in which to make changes to their IT systems for on-time implementation. Some stakeholders shared concerns that CMS would not have adequate staff and resources to review and approve APD requests in a thorough and timely manner (MACPAC 2026a, 2026c, 2023b). In addition, all systems changes, even those that may be considered technically straightforward, require time and financial resources for planning, development, and testing to ensure that new programming does not negatively impact other system functions. We previously found that ex parte efforts are more likely to be hindered by limited resources and competing priorities than technological limitations (MACPAC 2023b).

During the PHE unwinding and in response to known challenges with ex parte processes, CMS provided regular technical assistance to states and published guidance on state requirements and options for verifying eligibility during an ex parte renewal. CMS outlined key data sources related to earned and unearned income, residency, and assets, and described opportunities to integrate with other eligibility systems. Further, given the unprecedented undertaking of states to conduct a large volume of renewals, CMS provided states with additional flexibilities, including a number related to ex parte renewals, to ensure that states could conduct timely renewals and ensure that eligible individuals could gain and maintain eligibility during this period by reducing the risk for procedural disenrollments (CMS 2024b).

Considerations for implementing ex parte for CE. Implementing CE requirements requires states to quickly update existing ex parte processes with new data sources to verify information that have not historically been needed for determining eligibility based on MAGI rules. States will need to update their IT systems to use data from federal, state, and local agencies to verify compliance with CE and adjudicated claims and encounter data for verifying certain specified exclusions, including medical frailty, participation in a drug addiction or alcoholic treatment and rehabilitation program, or other criteria (e.g., hospitalization). In addition, because the IFC requires states to use the federal data services hub for verification of beneficiary status related to CE, states that began CE-related systems changes before issuance of the IFC will likely need to implement new or additional changes to meet this requirement. Further, states will implement these changes while they work to address historical challenges with ex parte processes, including determining eligibility on factors other than income, which will be of particular importance for many individuals who may qualify for an exception or exclusion.

The Commission concurs with CMS on the importance of ex parte processes to reduce the burden on states and beneficiaries for purposes of establishing CE status. However, the Commission is concerned about states' ability to effectively deploy this tool without assistance from the agency given past challenges states have experienced, the number of IT systems changes needed to integrate new data sources, and the short implementation timeline. CMS should consider developing updated ex parte guidance that builds on the guidance developed during the PHE unwinding that focuses on the application of ex parte processes for CE implementation. The guidance could encourage states to implement existing eligibility processes that have been shown to improve ex parte renewals, including the strategic data hierarchies, and provide detailed examples of how states would implement these

hierarchies for verifying compliance with CE requirements and individuals who qualify for mandatory exceptions and specified exclusions.

Notices and outreach

The IFC establishes requirements for notices and outreach, which are important for ensuring that beneficiaries understand the CE requirements and actions required of them. These new requirements will prompt states to engage in programming changes, coordinate with other important eligibility notices, and conduct new beneficiary outreach and education. For example, states are required to conduct six-month renewals for those enrolled in the expansion pathway and have the option to conduct more frequent verifications during the six-month renewal period. If states are unable to verify compliance with the CE requirement during the renewals and more frequent verification checks, they are required to send beneficiaries a notice of noncompliance, which is similar to a request for information.

Approaches to improving beneficiary communication. MACPAC's prior research highlighted the importance of states sending beneficiaries clear and actionable notices through multiple modalities (e.g., paper, phone, and online) and providing beneficiaries with the appropriate number of days to respond. For example, beneficiaries can experience challenges with understanding notice language about next steps. Notices are often lengthy, not written at appropriate reading comprehension levels, and contain legal jargon (MACPAC 2022a). Beneficiaries also experience challenges with responding to notices within the short timeframes provided by states. MACPAC findings indicate that notices can get lost in the mail, may be sent to outdated addresses, and may take a longer time to arrive in rural areas. By the time a beneficiary receives a notice of noncompliance, they may have insufficient time to gather and return documents, such as paystubs or bank statements. While the use of electronic notices addresses some of these concerns, not all beneficiaries have access to or are comfortable using technology (MACPAC 2026a, 2022a, 2022b). The Commission's work found that outreach and notices should be written in clear and plain language to promote beneficiary comprehension (MACPAC 2026a). The PHE unwinding provides valuable lessons about effective strategies for reaching beneficiaries, including states partnering with managed care plans to obtain more current and reliable beneficiary contact information and to support community outreach efforts (MACPAC 2026a).

Given the important role of notices, the Commission made two recommendations in the June 2026 report to Congress. The first directed CMS to require states to provide notices to beneficiaries at least 60 days in advance of initiating the renewal to ensure that they had sufficient time to prepare. The second directed states to provide beneficiaries with a minimum of 30 days to respond. The goal of these recommendations is to ensure that beneficiaries received clear and actionable notices far in advance of the renewal so that they have sufficient time to prepare and gather the information needed to maintain coverage, if they remained eligible (MACPAC 2026a). Given our prior recommendations, CMS should specify that notices of noncompliance include information about how beneficiaries who receive notices later than five days after the date on the notice can demonstrate this and receive additional time to respond. Additionally, states may benefit from CMS guidance on allowable state and managed care plan outreach activities (e.g., text messaging, including through platforms such as WhatsApp) to raise awareness about CE requirements and collect needed information from beneficiaries.

CMS requests comments on the frequency of periodic outreach after states implement the CE requirement. Linking the periodicity of outreach with specific eligibility-related actions (e.g., determinations, renewals, state effectuating a short-term hardship) may help to mitigate beneficiary confusion from receiving multiple notices and help reduce state burden. The Commission supports providing states with flexibility in how they conduct outreach. The Commission also supports requiring states to conduct additional outreach if state-reported monitoring indicates a need for improved communication.

Monitoring and Evaluation

The Commission strongly supports the IFC's policies requiring states to monitor implementation of CE provisions and the impact of the CE requirement, which are consistent with Commission recommendations. The IFC's approach using existing data collection efforts to reduce state reporting burden (e.g., performance indicator (PI) data) is also consistent with the Commission's recommendation. The IFC notes the importance of monitoring efforts and data collection to ensure program integrity. We concur with the need to ensure high levels of program integrity in this and all aspects of the Medicaid program. The Commission's recommendation in the June 2026 report to Congress on implementing CE requirements in Medicaid calls on the Secretary to direct CMS to develop a transparent plan for monitoring and evaluating these requirements (MACPAC 2026a). Reflecting on previous state demonstrations and the PHE unwinding, our research underscored the importance of monitoring to identify and address issues that may contribute to coverage loss among eligible individuals. Because of the complexity of the policies the IFC requires states to implement for CE, the Commission is concerned that state implementation challenges may impede CMS's and states' abilities to ensure eligible individuals maintain coverage. Therefore, monitoring is needed to help CMS and states identify trends and areas requiring policy or operational adjustments to mitigate coverage loss among eligible individuals. Monitoring can also assist in identifying effective practices that other states may wish to replicate.

We note that the IFC does not implement all aspects of the Commission's recommendation. The Commission urges CMS to make these monitoring data publicly available in a timely manner to promote transparency, enable the identification and dissemination of effective practices, and support timely policy and operational improvements. We also encourage CMS to develop a transparent plan that outlines, at a minimum, the approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. A federally-led evaluation is needed because policies that make participation in CE activities a condition of Medicaid eligibility are relatively new and have not been widely evaluated. States that implemented Section 1115 work requirement and CE demonstrations projected and experienced substantial disenrollment, including of eligible beneficiaries (Sommers et al. 2020, HHS 2019). The Congressional Budget Office estimates that the number of people without health insurance will increase by 5.3 million by 2034 as a result of the CE policy, which further points to the need for a robust evaluation (CBO 2025a, 2025b). Further, evaluation is needed to assess state and federal administrative spending associated with implementing and maintaining CE requirements (GAO 2025). The Government Accountability Office (GAO) reported that implementing work requirements can result in added Medicaid administrative spending or activities such as needed changes to state eligibility and enrollment systems and additional beneficiary outreach. Further, the GAO estimated that administrative spending for previously implemented Section 1115 demonstrations with work requirements ranged from under $10 million to over $250 million in five states studied. Georgia had Medicaid administrative spending for its demonstration of $54.2 million from fiscal year 2021 through the second quarter of fiscal year 2025 (GAO 2025).

Conclusion

Thank you for the opportunity to comment on this IFC. The Commission appreciates CMS's efforts to promulgate rules for implementing CE requirements under the tight timeframe specified in the statute. The Commission is also pleased with the policy included in the IFC that requires state submission of monitoring data that will provide information regarding the status and success of CE implementation. We also acknowledge the tremendous amount of work states have done and have yet to do to support CE implementation.

However, the Commission is concerned that the short implementation timeline, complexity of policies, and scope of needed systems changes will impede states' ability to implement CE requirements in a timely way that ensures eligible individuals obtain and maintain coverage. Before January 1, 2027, states must implement multiple

complex CE policies, including integrating new reliable data sources to allow states to identify and verify an individual's compliance, exception, or exclusion status, while also implementing other policies mandated by the 2025 Budget Reconciliation Act, such as six-month eligibility redeterminations. The Commission is also concerned that certain IFC policies will limit CMS's and states' abilities to ensure eligible individuals obtain and maintain Medicaid coverage, especially those who are medically frail.

The IFC indicates a number of places where additional guidance is forthcoming, and our work indicates that timely technical assistance to states is necessary to support state implementation. We urge CMS to adopt the Commission's recommendation to publish monitoring data in a timely manner and establish a requirement for evaluating CE requirements. Please let us know if there is any further information MACPAC can provide to aid in your consideration of our comments.

Sincerely,

Verlon Johnson, MPA
Chair

Endnotes

[1] Individuals are also compliant with CE if they have a monthly income that is equal to or above the federal minimum wage requirement multiplied by 80 hours.

[2] Individuals qualify for a mandatory exception if they are: younger than age 19; dually eligible for Medicare; eligible through a mandatory pathway; a specified excluded individual; or incarcerated at any point during the 3-month period prior to the month.

[3] Specified excluded individuals are individuals meeting the criteria for any of the following categories: youth formerly in foster care; parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 years and younger or a disabled individual; medically frail or otherwise have special needs; pregnant or entitled to postpartum Medicaid coverage; American Indian or Alaska Native; veterans with a total disability rating; incarcerated; meeting TANF work requirements or receiving SNAP benefits and subject to SNAP work requirements; or participating in a drug addiction or alcohol treatment program.

[4] The electronic data service established by the Secretary contains multiple data sources with relevant reliable information for verification.

References

Brooks, T. 2020. Medicaid and CHIP Eligibility Verification Flexibilities Help States Keep up with Increased Application Volume due to COVID-19. Washington, DC: Center for Children and Families. https://ccf.georgetown.edu/2020/04/14/medicaid-and-chip-eligibility-verification-flexibilities-help-states-keep-up-with-increased-application-volume-due-to-covid-19/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Centers for Medicaid & CHIP Services informational bulletin regarding "Basic requirements for conducting ex parte renewals of Medicaid and CHIP eligibility." November 26, 2024. https://www.medicaid.gov/federal-policy-guidance/ downloads/cib11262024.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Centers for Medicaid & CHIP Services informational bulletin regarding "Extension of temporary unwinding-related flexibilities." May 9, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Ex parte renewal: Strategies to maximize automation, increase renewal rates, and support unwinding efforts. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2022-10/ex-parte-renewal-102022.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Center for Medicaid and CHIP Services informational bulletin regarding "Medicaid and CHIP renewal requirements." December 4, 2020. https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

Congressional Budget Office (CBO). 2025a. CBO's estimate of annual changes in the number of people without health insurance under Title VII, Public Law 119-21. Washington, DC: CBO. https://www.cbo.gov/system/ files/2025-08/61367-Uninsured-Data.xlsx.

Congressional Budget Office (CBO). 2025b. Summary: Estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to Title II of H. Con. Res. 14, relative to CBO's January 2025 baseline. Washington, DC: CBO. https://www.cbo.gov/system/files/2025-07/61570- pl119-21-2025Recon-CLB.xlsx.

Hill, I., and E. Burroughs. 2019. *Lessons from launching Medicaid work requirements in Arkansas*. Washington, DC: Urban Institute.https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas_3.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026a. Chapter 1: Implementing community engagement requirements. In *Report to Congress on Medicaid and CHIP*. June 2026. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2026/06/Chapter-1-Implementing-Community-Engagement-Requirements-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026b. Chapter 5: Children and youth with special health care needs transitions to adult coverage. In *Report to Congress on Medicaid and CHIP*. June 2026. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2026/06/Chapter-5-CYSHCN-Transitions-to-Adult-Coverage.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026c. State Medicaid enterprise systems. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2026/07/Issue-Brief-State-Medicaid-Enterprise-Systems-FINAL.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. *Access in brief: Adults' experiences in accessing medical care*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/07/Access-in-Brief-Adults-Experiences-in-Accessing-Medical-Care.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024a. Chapter 4: Medicaid demographic data collection. In *Report to Congress on Medicaid and CHIP*. June 2024. Washington, DC: MACPAC. https:// www.macpac.gov/wp-content/uploads/2023/03/Chapter-1- Medicaid-Race-and-Ethnicity-Data-Collection-and-ReportingRecommendations.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024b. *State reported Medicaid unwinding data*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/06/State-Reported-Medicaid-Unwinding-Data-Brief-Update.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023a. Chapter 1: Medicaid race and ethnicity data collection and reporting: Recommendations for improvement. In *Report to Congress on Medicaid and CHIP*. March 2023. Washington, DC: MACPAC. https:// www.macpac.gov/wp-content/uploads/2023/03/Chapter-1- Medicaid-Race-and-Ethnicity-Data-Collection-and-ReportingRecommendations.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023b. *Increasing the Rate of Ex Parte Renewals*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. *Beneficiary preferences for communication*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/01/Beneficiary-Preferences-for-Communication_MACPAC-Issue-Brief_Jan-2022.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. Letter from MACPAC to Administrator Brooks-LaSure regarding "Re: CMS-2421-P: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program application, eligibility determination, enrollment, and renewal processes." November 7, 2022. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/11/CMS-2421-Comment-on-NPRM.pdf.

Medicaid and CHIP Payment and Access Commission (MAPAC). 2018a. Chapter 4: Access to Substance Use Disorder Treatment in Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MAPAC). 2018b. Chapter 2: Substance use disorder confidentiality regulations and care integration in Medicaid and CHIP. In *Report to Congress on Medicaid and CHIP*. June 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Substance-Use-Disorder-Confidentiality-Regulationsand-Care-Integration-in-Medicaid-and-CHIP.pdf.

New Hampshire Department of Health and Human Services (HHS). 2019. Letter from Jeffrey A. Meyers to Calder Lynch regarding "Notice of temporary delay in implementation of community engagement requirement under waiver no. 11-W-00298/1." July 9, 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/granite-advantage-health-care-program/nh-granite-advantage-health-care-program-temp-delay-20190709.pdf.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2021. Medicaid demonstrations and impacts on health coverage: A review of the evidence. Washington, DC: ASPE. https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence.

Sommers, B.D., L. Chen, R.J. Blendon, et al. 2020. Medicaid work requirements in Arkansas: Two-year impacts on coverage, employment, and affordability of care. *Health Affairs* 39, no. 9: 1522–1530. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00538.

U.S. Government Accountability Office (GAO). 2025. Medicaid demonstrations: Information on administrative spending for Georgia work requirements. Report no. GAO-25-108160. Washington, DC: GAO. https://www.gao.gov/assets/gao-25-108160.pdf.