NATIONAL HEALTH COUNCIL

July 31, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals [CMS-2454-IFC]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) interim final rule with comment period (IFR) implementing Medicaid community engagement requirements for certain individuals. Because the IFR establishes the federal framework through which states will implement these new statutory requirements beginning in 2027, the NHC's comments focus on refinements that would help ensure the resulting state policies and processes are clinically appropriate, operationally workable, and protective of eligible individuals who rely on Medicaid coverage to access needed care.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, equitable, and sustainable health care. Made up of nearly 200 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC has previously encouraged CMS to implement the Medicaid provisions of the 2025 reconciliation law in a manner that minimizes administrative burden, supports eligible individuals in retaining coverage, and gives states clear and workable standards for implementation.[1] In our December 2025 Medicaid OBBBA implementation letter, the NHC emphasized that state systems must minimize the potential for errors in

[1] National Health Council, "NHC Medicaid OBBBA Implementation Letter," December 5, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-medicaid-obbba-implementation-letter/.

adjudicating Medicaid eligibility, that self-attestation should be available where appropriate, that exemption processes must be manageable and reasonable, and that beneficiaries will need meaningful assistance as states implement major eligibility and enrollment changes.[2] Those concerns remain central to the NHC's review of the IFR.

The NHC also recognizes that states have already begun preparing for January 1, 2027 implementation, including making policy, staffing, eligibility systems, outreach, training, and operational decisions based in part on preliminary guidance and the statutory text.[3,4] Stakeholders have indicated that aspects of the IFR may differ from the assumptions states used in that planning. To the extent the IFR requires states to revisit those decisions, particularly with respect to medically frail determinations, verification standards, outreach materials, notices, and eligibility worker training, the NHC encourages CMS to revisit whether the January 1 implementation date is realistic and to provide clear guidance and support so that operational changes do not increase the risk of eligible individuals being denied, disenrolled, or discouraged from appropriately applying for or utilizing coverage.

For individuals living with chronic diseases, disabilities, and other serious health conditions, Medicaid is far more than a source of insurance coverage. It provides access to physician services, specialty care, prescription drugs, behavioral health services, long-term services and supports, care coordination, and other services that are essential to maintaining health, independence, and quality of life. Even relatively brief interruptions in coverage can disrupt established treatment plans, impede access to medically necessary care, delay diagnostic testing or follow-up appointments, complicate disease management, and increase health and financial instability for patients and families. For some individuals, interruptions in coverage may also result in missed doses of ongoing therapies, delays in initiating treatment, avoidable disease progression, or worsening health outcomes.[5,6]

The NHC acknowledges that the IFR includes several procedural safeguards, including requirements related to verification, notices, appeals, outreach, and oversight, and

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[2] National Health Council, "NHC Medicaid OBBBA Implementation Letter."

[3] Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, "Informational Bulletin: Implementation of Medicaid Provisions in Public Law 119-21," December 8, 2025, https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf.

[4] Georgetown University Center for Children and Families, "Tracking Implementation of H.R. 1 Medicaid Work Reporting Requirements," accessed June 24, 2026, https://ccf.georgetown.edu/feature/tracking-implementation-of-h-r-1-medicaid-work-reporting-requirements/.

[5] Stephanie Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, April 12, 2021), https://aspe.hhs.gov/reports/medicaid-churning-continuity-care.

[6] MaryBeth Musumeci et al., "Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care," Commonwealth Fund, June 11, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.

recognizes multiple pathways through which individuals may demonstrate community engagement. At the same time, the inclusion of procedural safeguards does not, by itself, ensure that individuals can effectively use them. The ultimate impact of the rule will depend heavily on how states operationalize these requirements, how beneficiaries experience those systems, and whether CMS provides sufficient guidance and oversight to prevent eligible individuals from losing coverage because of administrative barriers rather than true ineligibility.

These risks are especially significant for individuals living with chronic diseases, disabilities, rare diseases, behavioral health conditions, and other serious or complex health needs.[7] Many patients experience fluctuating symptoms, episodic health limitations, intensive treatment schedules, ongoing caregiving responsibilities, variable work capacity, or complex interactions with the health care system, and these realities may not be fully reflected in administrative records, claims data, employment databases, education records, or other verification sources relied upon by states.[8,9,10,11,12,13] For some individuals, Medicaid-covered services, including home- and community-based services, personal care, behavioral health care, prescription drugs, transportation, and care coordination are what allow them to remain stable, live independently, manage their conditions, and participate in work, education, caregiving, or other qualifying activities when they are able to do so. As a result, implementation decisions regarding medically frail determinations, self-attestation, verification

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[7] National Health Council, "NHC Submits Letter to CMS on H.R. 1," February 23, 2026, https://nationalhealthcouncil.org/letters-comments/nhc-submits-letter-to-cms-on-hr-1/.

[8] American Cancer Society Cancer Action Network, "New Restrictions on Medicaid Eligibility Are Unreasonably Harsh and Will Be Life-Threatening for Cancer Patients," June 1, 2026, https://www.fightcancer.org/releases/new-restrictions-medicaid-eligibility-are-unreasonably-harsh-and-will-be-life-threatening.

[9] American Diabetes Association, "Statement from the American Diabetes Association on CMS's Medicaid Work Requirements Interim Final Rule," June 3, 2026, https://diabetes.org/newsroom/press-releases/statement-american-diabetes-association-cmss-medicaid-work-requirements.

[10] American Lung Association, "48 Patient Organizations Warn of Massive Coverage Losses Under New Medicaid Work Requirements," June 2, 2026, https://www.lung.org/media/press-releases/fy26-work-requirements-coalition-statement.

[11] National Alliance on Mental Illness, "New Medicaid Mandates Threaten Stability for Many People with Mental Illness," June 2, 2026, https://www.nami.org/press-releases/nami-statement-new-medicaid-mandates-threaten-stability-for-many-people-with-mental-illness/.

[12] National Kidney Foundation, "Medicaid Work Requirements Interim Final Rule Not Realistic for Dialysis Patients," June 3, 2026, https://www.kidney.org/press-room/medicaid-work-requirements-interim-final-rule-not-realistic-dialysis-patients.

[13] National Organization for Rare Disorders, "CMS-2454-IFC: Medicaid Community Engagement Requirement for Certain Individuals," explainer, June 2026, https://rarediseases.org/wp-content/uploads/2026/06/NORD_RANExplainer_CMS__2454_IFC_CERequirements_2026.pdf.

standards, reporting requirements, notices, appeals, system design, and oversight mechanisms will have significant implications for patient access to care.[14]

The NHC therefore encourages CMS to implement and oversee the community engagement framework in a manner grounded in a simple but critical principle: eligible individuals should not lose Medicaid coverage because of administrative barriers rather than true ineligibility. This principle is consistent with NHC's prior comments to CMS on Medicaid implementation, Medicaid access, Medicare Advantage data transparency, beneficiary communications, utilization management, and procedural protections, where the NHC has repeatedly emphasized that systems intended to support program administration must also be understandable, navigable, timely, and responsive to the needs of people with chronic diseases and disabilities.[15,16,17]

Summary of Recommendations

The NHC's recommendations focus on ensuring that implementation is clinically appropriate, operationally workable, and protective of eligible individuals who may otherwise lose coverage because of documentation challenges, system limitations, communication failures, or other administrative barriers rather than true ineligibility.

Specifically, the NHC encourages CMS to:

- Remove the IFR's "significantly impairs" standard under the medically frail exclusion, or, if CMS retains the standard, provide additional guidance to ensure that it is implemented broadly and consistently in a manner that recognizes the realities of chronic disease, disability, behavioral health conditions, and other serious or complex health needs and minimizes the risk of inappropriate coverage loss.
- Promote verification processes that rely on existing data whenever possible, minimize unnecessary documentation requirements, and preserve reasonable, straightforward opportunities for individuals to demonstrate eligibility, exclusions, exceptions, or compliance.

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[14] Medicaid and CHIP Payment and Access Commission, June 2026 Report to Congress on Medicaid and CHIP (Washington, DC: MACPAC, June 2026), https://www.macpac.gov/publication/june-2026-report-to-congress-on-medicaid-and-chip/.

[15] National Health Council, "NHC Comments RE 2026 Interoperability and Prior Authorization," June 15, 2026

[16] National Health Council, "NHC Comments on Response to the Medicare Program Request for Information on Medicare Advantage Data," May 29, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-response-to-the-medicare-program-request-for-information-on-medicare-advantage-data/

[17] National Health Council, "NHC Responds to Joint CMS-ASTP/ONC RFI on Improving Health Technology," June 16, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-responds-to-joint-cms-astp-onc-rfi-on-improving-health-technology/.

- Support implementation approaches that minimize procedural disenrollment by ensuring that notices, reporting requirements, and beneficiary communications are clear, timely, accessible, and understandable.
- Monitor how states operationalize community engagement requirements, exclusions, exceptions, and verification standards to identify implementation challenges, unintended consequences, and potential barriers to coverage retention.
- Encourage consistent administration of caregiver-related policies, including implementation of caregiver exclusions and outreach efforts directed toward individuals whose caregiving responsibilities may affect their status under the community engagement framework.
- Ensure that outreach, education, and beneficiary assistance activities are sufficient to help individuals understand their obligations, available exclusions and exceptions, reporting requirements, and appeal rights.
- Promote systems design, reporting processes, and operational workflows that are accessible, user-centered, and capable of accommodating individuals with disabilities, chronic conditions, limited English proficiency, limited digital access, or other barriers to navigating complex administrative processes.
- Evaluate whether reporting frequency, verification requirements, and re-verification practices are functioning as intended and whether they are contributing to unnecessary administrative burden or coverage loss among eligible individuals.
- Utilize monitoring, oversight, and public reporting activities to assess not only compliance with statutory requirements but also the real-world effects of implementation on access to coverage and continuity of care.
- Continue engaging patients, caregivers, providers, states, plans, and other stakeholders as implementation proceeds so that operational challenges can be identified and addressed before they result in inappropriate coverage loss.

CMS Should Strengthen Medically Frail and Health-Based Protections

For individuals living with chronic diseases, disabilities, behavioral health conditions, rare diseases, and other serious or complex health needs, the medically frail framework will be one of the primary mechanisms for ensuring that community engagement requirements do not apply in circumstances where a person's health status, treatment burden, or functional limitations make compliance inappropriate or impracticable. The NHC recognizes that the IFR establishes an exclusion pathway for individuals who are medically frail or otherwise have special medical needs and that CMS is implementing the statutory categories enacted by Congress. However, the NHC is deeply concerned that the practical scope of these protections will depend heavily on how states evaluate functional limitations, treatment burden, fluctuating conditions, documentation, and the relationship between a person's health needs and their ability to comply with community engagement requirements, and that, without additional guidance and safeguards, overly narrow or inconsistent implementation could place individuals with significant health needs at risk of avoidable coverage loss.

The IFR generally limits medically frail determinations to categories identified in statute and adds an emphasis on whether a disability or physical or behavioral health condition

significantly impairs an individual's ability to comply with community engagement requirements. The NHC recognizes CMS' interest in ensuring that state determinations are auditable, justifiable, and consistent with the rule, but remains concerned that the "significantly impairs" standard could lead states to apply subjective or overly narrow severity thresholds that do not adequately account for chronic, episodic, fluctuating, or treatment-intensive conditions.[18,19] Diagnostic codes and claims data may help identify the presence of a condition, but they may not capture its severity, functional impact, treatment burden, symptom variability, or the extent to which the individual can work, report, obtain documentation, respond to notices, or otherwise comply with recurring administrative requirements, particularly during periods when symptoms worsen or treatment intensifies.[20,21] As a result, states may need to create new standards, data logic, staff training, and provider documentation processes to connect condition severity and functional impact to community engagement compliance, and beneficiaries may face coverage risk if those processes are not clear, consistent, and accessible.[22]

The NHC therefore encourages CMS to ensure that implementation of the medically frail framework gives states sufficient flexibility to consider the full context of an individual's health status and related care needs, including treatment demands, symptom variability, functional limitations, and the practical ability to navigate program requirements.[23,24] These considerations are particularly important for individuals receiving ongoing treatment for chronic or complex conditions, because even relatively brief interruptions in Medicaid coverage may delay access to physician services, prescription drugs, ongoing therapies, behavioral health services, or other medically necessary care, potentially disrupting established treatment plans and continuity of care

Many individuals living with serious health conditions continue to work, attend school, volunteer, care for family members, or otherwise participate in their communities, and the ability to remain engaged during some periods should not be treated as evidence

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[18] Christopher Chen, Clara Filice, and Janelle White, "Implementing Medical Frailty Exemptions under HR 1," *JAMA Health Forum* 7, no. 5 (2026): e261808.doi:10.1001/jamahealthforum.2026.1808.

[19] Medicaid and CHIP Payment and Access Commission, *Functional Assessments for Long-Term Services and Supports* (Washington, DC: MACPAC, June 2016), https://www.macpac.gov/publication/functional-assessments-for-long-term-services-and-supports/.

[20] National Organization for Rare Disorders, "CMS-2454-IFC."

[21] Center for Health Law and Policy Innovation, "Work Requirements."

[22] National Kidney Foundation, "Medicaid Work Requirements."

[23] National Organization for Rare Disorders, "CMS-2454-IFC."

[24] Center for Health Law and Policy Innovation of Harvard Law School, "A Shift Between Congressional Intent and Implementation: Work Requirements," Health Care in Motion, June 2026, https://chlpi.org/news-and-events/news-and-commentary/health-care-in-motion/a-shift-between-congressional-intent-and-implementation-work-requirements/.

that medically frail protections are unavailable.[25,26] Individuals undergoing treatment for cancer, managing autoimmune diseases, living with serious mental illness, coping with progressive neurological disorders, recovering from major medical events, managing substance use disorder treatment, or living with rare diseases may experience periods of relative stability interrupted by disease flares, treatment complications, acute episodes, recovery periods, or intensified medical need, and these fluctuations may affect their ability to satisfy reporting, verification, or documentation requirements even when they do not meet formal disability standards or demonstrate permanent incapacity.[27,28] Patient organizations have also raised concerns that medically frail determinations could become too closely tied to an individual's ability to demonstrate incapacity rather than to the seriousness, complexity, treatment burden, or functional impact of an underlying condition.[29,30] The NHC therefore encourages CMS to ensure that an individual's ability to work or participate in other meaningful activities during periods of relative stability does not, by itself, disqualify them from medically frail protections.

The NHC also recommends that CMS distinguish medically frail status from formal disability determinations, including SSDI, SSI, or other disability-based eligibility determinations, and ensure that treatment burden plays a meaningful role in medically frail determinations. While a disability determination may serve as one indicator of health-related need, medically frail protections should not be limited to individuals who satisfy formal disability standards or can demonstrate permanent incapacity. Many individuals with serious health conditions do not qualify for disability benefits, may be in the process of applying for them, or may not identify as disabled. However, these individuals may still face recurring medical appointments, medication management requirements, treatment side effects, recovery periods, care coordination obligations, transportation challenges, or other care-related demands that affect their ability to consistently satisfy reporting or participation requirements.[31,32]

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[25] American Cancer Society Cancer Action Network, "New Restrictions on Medicaid Eligibility Are Unreasonably Harsh and Will Be Life-Threatening for Cancer Patients," June 1, 2026, https://www.fightcancer.org/releases/new-restrictions-medicaid-eligibility-are-unreasonably-harsh-and-will-be-life-threatening

[26] Blood Cancer United, "New Rule Could Strip Health Coverage from Cancer Patients Undergoing Treatment," June 1, 2026, https://bloodcancerunited.org/new-rule-could-strip-health-coverage-cancer-patients-undergoing-treatment.

[27] National Organization for Rare Disorders, "CMS-2454-IFC."

[28] Center for Health Law and Policy Innovation, "Work Requirements."

[29] American Cancer Society Cancer Action Network, "New Restrictions on Medicaid Eligibility."

[30] Blood Cancer United, "New Rule Could Strip Health Coverage."

[31] National Health Council, "NHC Medicaid OBBBA Implementation Letter."

[32] National Organization for Rare Disorders, "CMS-2454-IFC."

The NHC is further concerned that overly restrictive verification requirements may undermine the intended protections of the medically frail framework. Individuals who qualify for medically frail protections should not lose coverage because their condition is not readily reflected in administrative data sources or because they are unable to repeatedly obtain documentation for ongoing conditions. Claims data may be incomplete, delayed, or insufficient to capture disease severity, treatment burden, symptom variability, or functional limitations, and the absence of data should not be treated as evidence that an individual does not have a serious or complex medical condition.[33,34]

The NHC therefore encourages CMS to provide additional implementation guidance and oversight practices that recognize the complexity and variability of serious health conditions, promote consistent application across states, and ensure that medically frail protections remain accessible to the individuals they are intended to protect. In particular, the NHC asks CMS to clarify that medically frail status is not limited to a closed list of diagnoses and does not require an individual to demonstrate permanent incapacity, inability to work, or eligibility for disability benefits. If CMS retains the "significantly impairs" standard, it should provide clear direction on how states should evaluate severity and functional impact and require medically frail evaluation processes that account for treatment burden, disease management requirements, episodic conditions, fluctuating functional limitations, and appropriate clinical judgment, while avoiding rigid diagnostic or documentation standards that may exclude individuals with significant health needs.

CMS Should Preserve Meaningful Opportunities for Self-Attestation and Minimize Documentation Burden

The IFR establishes a verification framework intended to determine whether beneficiaries satisfy community engagement requirements or qualify for applicable exclusions and exemptions. The NHC recognizes the value of a data-first approach and supports CMS' general expectation that states rely on reliable information already available to them before requesting additional information from beneficiaries. Use of existing data can reduce administrative burden, improve efficiency, and minimize unnecessary documentation requests when the data are accurate, timely, complete, and relevant.

[33] Blood Cancer United, "New Rule Could Strip Health Coverage."

[34] American Kidney Fund, "American Kidney Fund Statement on Interim Final Rule's Work Reporting Requirements for Medicaid Beneficiaries," June 3, 2026, https://www.kidneyfund.org/article/american-kidney-fund-statement-interim-final-rules-work-reporting-requirements-medicaid.

However, administrative data sources alone may not provide enough information to accurately assess individual's circumstances.[35,36] Employment information may be delayed, claims data may not fully capture disease severity or treatment burden, educational enrollment records may not be updated in real time, caregiving responsibilities, community service, and other volunteer activities may not be documented in formal data systems.[37] For beneficiaries with variable work schedules, intermittent or seasonal employment, episodic health conditions, changing caregiving responsibilities, or temporary disruptions that may not be readily captured through automated verification systems, the absence of data should not be treated as evidence that an individual has failed to comply with program requirements or does not qualify for an exclusion or exemption.[38]

The NHC encourages CMS to reinforce the verification hierarchy established in the IFR. States should evaluate whether an individual qualifies as a specified excluded individual before assessing compliance with community engagement requirements or exceptions, and, once exclusion status is verified, the exclusion should take precedence even if the state has also collected information related to compliance. This hierarchy would reduce unnecessary compliance checks, limit duplicative administrative interactions, and help ensure that individuals who are not subject to the requirements are not exposed to avoidable reporting, verification, or documentation burdens.[39]

The NHC is concerned that the IFR's limits on self-attestation, particularly the transition beginning January 1, 2028, could increase documentation burden for beneficiaries, caregivers, providers, and state Medicaid agencies. The NHC understands that, in 2027, states may accept documentation or other information, including self-attestation, where reliable data are not available. Beginning in 2028, however, the rule appears to require documentation when reasonably available and to permit other information sufficient to verify eligibility when documentation does not exist or is not reasonably available. The rule also appears to limit medical frailty self-attestation to one opportunity during a period of enrollment. This distinction is important because the NHC does not understand the IFR to permit denial or termination solely because an individual cannot produce documentation where documentation does not exist or is not reasonably available. The NHC therefore encourages CMS to ensure that states implement this standard consistently.

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[35] U.S. Government Accountability Office, *Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19*, GAO-24-106883 (Washington, DC: GAO, July 2024), https://www.gao.gov/products/gao-24-106883.

[36] Stephanie Sugar, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, April 12, 2021), https://aspe.hhs.gov/reports/medicaid-churning-continuity-care.

[37] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[38] National Health Council, "NHC Medicaid OBBBA Implementation Letter."

[39] Medicaid and CHIP Payment and Access Commission, June 2026 Report to Congress.

The NHC recognizes CMS' interest in program integrity and reliable verification, and it does not oppose reasonable efforts to confirm eligibility, compliance, or exclusion status. The NHC's concern is that limiting self-attestation when data are unavailable or incomplete may create a gap between people who qualify for protections and people who can successfully demonstrate that they qualify, particularly for medically frail individuals, caregivers, people with fluctuating work arrangements, and individuals whose circumstances are not easily captured by claims data or administrative records.[40] For these individuals, delays in verification may also hinder access to medications, treating clinicians, behavioral health services, and other medically necessary care that depends on uninterrupted Medicaid coverage. Self-attestation need not replace reasonable verification processes, but it can serve as an important safeguard when reliable data are unavailable, incomplete, delayed, or otherwise insufficient to accurately reflect an individual's circumstances. The NHC encourages CMS to preserve meaningful opportunities for self-attestation and simplified verification while closely monitoring the effects of the January 2028 transition on coverage stability, appeals, provider burden, and procedural disenrollment.

The NHC is similarly concerned about the cumulative burden associated with documentation requirements. While individual requests for documentation may appear reasonable in isolation, repeated requests for verification can create significant challenges for beneficiaries, caregivers, providers, and state agencies alike, particularly when individuals living with chronic diseases or disabilities are required to obtain records from multiple providers, respond to duplicative requests for information, or verify circumstances that have already been established.[41,42] These requirements may also create unintended burdens for clinicians and health care providers, who should not be placed in the position of repeatedly generating documentation for conditions that are chronic, long-term, or already reflected in existing records. Excessive documentation requirements may consume clinical resources, increase administrative workload, and divert attention away from patient care without meaningfully improving program integrity.[43,44,45]

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[40] Georgetown University Center for Children and Families, "Federal Work Reporting Requirements under H.R. 1," accessed June 24, 2026, https://ccf.georgetown.edu/feature/federal-work-reporting-requirements-under-h-r-1/.

[41] Sugar et al., Medicaid Churning and Continuity of Care.

[42] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[43] American Cancer Society Cancer Action Network, "New Restrictions on Medicaid Eligibility."

[44] Blood Cancer United, "New Rule Could Strip Health Coverage."

[45] National Health Council, Exploring the Burden of Prior Authorization on Patients with Chronic Disease (Washington, DC: National Health Council, November 2023), https://nationalhealthcouncil.org/research-briefs/nhc-report-exploring-the-burden-of-prior-authorization-on-patients-with-chronic-disease/.

The NHC encourages CMS to consider the interaction between Medicaid verification requirements and other public benefit programs. Beneficiaries often participate in multiple programs simultaneously, each with its own reporting and documentation requirements, and when states already possess reliable information through Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), workforce systems, educational institutions, or other public programs, beneficiaries should not be required to repeatedly provide the same information through multiple administrative channels. Greater alignment across verification systems could reduce burden on beneficiaries while improving administrative efficiency.[46]

Ultimately, verification systems should support accurate eligibility determinations rather than create additional barriers to maintaining coverage. The NHC encourages CMS to clarify that missing, delayed, conflicting, or incomplete information should not be treated as evidence of noncompliance or ineligibility, that states should provide beneficiaries meaningful opportunities to submit additional information, resolve discrepancies, or otherwise demonstrate eligibility before coverage is denied or terminated, and that repeated documentation requirements for ongoing health conditions, caregiving responsibilities, and previously verified circumstances should be limited wherever possible. The NHC also recommends that CMS monitor—and address as needed in future rulemaking—the impact of verification requirements on procedural disenrollment, appeals, reinstatements, provider burden, and beneficiary access to coverage.

Community Engagement Requirements and Caregiver Exclusions Should Reflect Real-World Circumstances

The IFR establishes multiple pathways through which beneficiaries may satisfy community engagement requirements and accounts for participation through a variety of work, educational, training, service, seasonal, income-based, and combined activities. The NHC supports CMS' inclusion these pathways because work and community participation often occur through multiple channels rather than a single, uniform employment arrangement. This flexibility is particularly important for individuals who work variable schedules, hold multiple part-time jobs, engage in seasonal or temporary employment, pursue education or job training intermittently, volunteer in community settings, or combine several activities to meet personal, family, financial, or health-related obligations.[47,48]

While these provisions are an important aspect of the IFR, their effectiveness will ultimately depend on how they are implemented at the state level. The NHC encourages CMS to ensure that this implementation does not inadvertently favor traditional full-time employment over other pathways expressly recognized in the

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[46] National Health Council, "NHC Medicaid OBBBA Implementation Letter."

[47] U.S. Bureau of Labor Statistics, "Contingent and Alternative Employment Arrangements — July 2023," news release, November 8, 2024, https://www.bls.gov/news.release/conemp.nr0.htm.

[48] U.S. Bureau of Labor Statistics, "Multiple Jobholders by Selected Characteristics," Current Population Survey, last modified February 20, 2026, https://www.bls.gov/cps/cpsaat36.htm.

statute, and that educational enrollment, workforce training programs, volunteer activities, community service opportunities, seasonal employment, income-based alternatives, and combinations of qualifying activities are treated as equally valid means of satisfying the requirements rather than secondary alternatives. CMS should also clarify that other activities that support employment, education, community engagement, or independent living, including peer support, mentoring, coaching, and similar structured supports, may qualify where they are consistent with the statute and state implementation standards. This is especially important for individuals whose participation patterns may vary from month to month because of employment instability, caregiving responsibilities, changing educational schedules, treatment demands, disease flares, transportation challenges, and other life circumstances, as such variations do not necessarily indicate a lack of engagement or justify placing individuals at risk of coverage loss.[49,50]

Similar concerns arise with respect to caregiver exclusions. The NHC recognizes that the IFR includes caregiver-related exclusions from community engagement requirements and acknowledges that caregiving responsibilities may affect an individual's ability to satisfy community engagement obligations. However, caregiving often occurs in ways that do not fit neatly within formal administrative categories, and many caregivers provide substantial assistance to family members, household members, or loved ones without formal legal authority, paid caregiver status, or documentation that clearly captures the nature and extent of their responsibilities.[51,52] The NHC appreciates CMS' use of a broad caregiver framework and encourages CMS to make clear that caregiving relationships may include care provided to family members, household members, loved ones, friends, neighbors, or other individuals with whom the beneficiary has a caregiving relationship, consistent with applicable statutory and regulatory standards.

Caregiving responsibilities may also fluctuate over time, particularly when an individual is caring for someone with a chronic disease, disability, behavioral health condition, rare disease, or other serious health need.[53,54] A caregiver may spend substantial time coordinating appointments, managing medications, assisting with activities of daily

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[49] Georgetown University Center for Children and Families, "Federal Work Reporting Requirements under H.R. 1."

[50] Georgetown University Center for Children and Families, "State Implementation of Work Reporting Requirements," accessed June 24, 2026, https://ccf.georgetown.edu/feature/state-implementation-of-work-reporting-requirements/.

[51] AARP and National Alliance for Caregiving, Caregiving in the United States 2025 (Washington, DC: AARP, July 2025), https://www.aarp.org/pri/topics/ltss/family-caregiving/caregiving-in-the-us-2025/.

[52] National Alliance for Caregiving, *Rare Disease Caregiving in America* (Bethesda, MD: National Alliance for Caregiving, February 2018), https://www.caregiving.org/research/rare-disease-caregiving-in-america/.

[53] AARP and National Alliance for Caregiving, Caregiving in the United States 2025.

[54] National Alliance for Caregiving, Rare Disease Caregiving in America.

living, providing transportation, responding to disease flares, or supporting recovery following treatment, and these responsibilities may not be reflected in traditional documentation sources even though they can significantly affect an individual's ability to participate in work or other activities.[55,56] If individuals are required to produce documentation that does not exist, repeatedly verify longstanding caregiving arrangements, or satisfy narrow definitions that fail to reflect real-world caregiving relationships, eligible caregivers may lose access to protections intended for them.[57,58,59]

The NHC therefore encourages CMS to implement community engagement requirements and caregiver exclusions in a manner that reflects the realities of beneficiaries' lives, preserves the flexibility reflected in the IFR and permitted by statute, recognizes diverse forms of work and participation, and accounts for the fact that caregiving responsibilities often occur outside traditional administrative frameworks. The NHC further encourages CMS to clarify how states should evaluate variable work schedules, fluctuating participation, nontraditional caregiving relationships, shared caregiving arrangements, and caregiving activities that are not readily reflected in existing data sources, while encouraging states, to the extent permitted by law, to evaluate potential caregiver exclusion status before taking adverse action.

Reporting, Notices, Appeals, and Procedural Safeguards Should Minimize Procedural Disenrollment

The NHC is concerned that reporting requirements, verification activities, notices, appeals processes, and other procedural requirements may become primary drivers of coverage loss under the community engagement framework. Evidence from the unwinding of Medicaid continuous enrollment and prior state demonstrations involving Medicaid work requirements shows that eligible people can lose coverage when they are unable to successfully navigate administrative processes, respond to requests for

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[55] AARP and National Alliance for Caregiving, Caregiving in the United States 2025.

[56] National Alliance for Caregiving, Rare Disease Caregiving in America.

[57] AARP and National Alliance for Caregiving, Caregiving in the United States 2025.

[58] National Alliance for Caregiving, Rare Disease Caregiving in America.

[59] National Alliance for Caregiving, *Caregiving in a Diverse America: Beginning to Understand the Systemic Challenges Facing Family Caregivers* (Bethesda, MD: National Alliance for Caregiving, November 2021), https://www.caregiving.org/research/caregiving-in-a-diverse-america/.

information, or satisfy procedural requirements within prescribed timeframes.[60,61,62] More specifically, data collected during the unwinding indicate that large numbers of occurred for procedural reasons rather than confirmed ineligibility, underscoring the importance of clear notices, accessible response pathways, accurate eligibility systems, and timely opportunities to correct or supplement information.[63,64,65] As CMS implements the IFR, reducing the risk of procedural disenrollment should remain a central objective to avoid repeating these patterns of preventable coverage loss.

The IFR establishes a framework through which states will monitor compliance, verify information, issue notices, process appeals, and administer adverse actions. The NHC recognizes that these processes are necessary components of program administration, but their effectiveness will depend heavily on how they are operationalized and whether beneficiaries are provided with meaningful opportunities to understand requirements, respond to requests, correct errors, and maintain coverage when they remain eligible. Reporting requirements warrant particular attention because the frequency, timing, and alignment of reporting activities can significantly influence whether beneficiaries successfully maintain coverage. Even where individuals satisfy community engagement requirements or qualify for exclusions or exemptions, frequent, poorly aligned, or duplicative reporting obligations may increase the likelihood of missed deadlines, incomplete submissions, administrative errors, coverage churn, and disruptions in care.[66,67] When otherwise eligible individuals lose Medicaid coverage because of procedural barriers rather than substantive ineligibility, they may experience interruptions in access to prescription drugs, specialty and primary care, behavioral health treatment, and disease management, along with additional financial and

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[60] Benjamin Sommers et al., “Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care,” Health Affairs 39, no. 9 (2020): 1522–1530, https://doi.org/10.1377/hlthaff.2020.00538.

[61] Michael Karpman, Genevieve Kenney, and Jennifer Haley, Assessing Potential Coverage Losses among Medicaid Expansion Enrollees under a Federal Medicaid Work Requirement (Washington, DC: Urban Institute, March 2025), https://www.urban.org/research/publication/assessing-potential-coverage-losses-among-medicaid-expansion-enrollees-under.

[62] KFF, “Understanding Medicaid Procedural Disenrollment Rates,” June 2024, https://www.kff.org/medicaid/understanding-medicaid-procedural-disenrollment-rates/.

[63] Medicaid and CHIP Payment and Access Commission, State-Reported Medicaid Unwinding Data (Washington, DC: MACPAC, 2024), https://www.macpac.gov/publication/state-reported-medicaid-unwinding-data/

[64] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[65] KFF, “Medicaid Enrollment and Unwinding Tracker.”

[66] Sugar et al., Medicaid Churning and Continuity of Care.

[67] Medicaid and CHIP Payment and Access Commission, An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP (Washington, DC: MACPAC, October 2021), https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip/.

administrative burdens associated with reestablishing coverage. These risks are especially significant where reporting or verification occurs outside regular Medicaid renewal processes, or where beneficiaries managing chronic health conditions, caregiving responsibilities, unstable employment, variable or seasonal work, transportation barriers, limited English proficiency, cognitive limitations, or limited access to technology must navigate separate or repeated reporting cycles.[68,69]

The NHC is also concerned that verification activities occurring outside traditional Medicaid renewal processes may create additional opportunities for coverage loss among eligible individuals. CMS' materials indicate that states must verify compliance at application, and renewal, and may choose to conduct verification more frequently. If a state cannot verify compliance, it must provide notice and allow 30 calendar days for the individual to demonstrate compliance or that the requirement does not apply. This structure creates important procedural protections, but it also creates additional points at which beneficiaries may be required to respond to requests for information, submit documentation, understand new notices, or navigate state systems in order to maintain coverage.[70,71] For individuals living with chronic diseases, disabilities, behavioral health conditions, or other serious or complex health needs, these additional verification steps may be confusing, burdensome, or difficult to complete within required timeframes, particularly when health status, treatment schedules, functional limitations, transportation barriers, caregiving responsibilities, or limited access to technology affect a beneficiary's ability to respond.

This concern is heightened by the IFR's "unable to verify" process. When a state cannot verify an exclusion, exception, or compliance based on available reliable information, the notice of noncompliance and 30-day response period become critical safeguards. However, from a patient perspective, "unable to verify" should not function as a proxy for noncompliance, particularly when the underlying issue may be incomplete data, delayed records, unclear documentation standards, technology limitations, or a beneficiary's inability to obtain provider documentation within a short timeframe. The NHC encourages CMS to ensure that states treat these notices as opportunities to resolve uncertainty rather than as a pathway to termination for individuals who remain eligible or who may qualify for an exclusion or exception.

Notice, appeal, and correction processes are central to whether the IFR's procedural safeguards will work in practice. Beneficiaries cannot comply with reporting obligations, respond to verification requests, or exercise appeal rights if they do not understand

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[68] Georgetown University Center for Children and Families, "Are States Ready to Implement H.R. 1 and Medicaid Work Reporting Requirements?," September 4, 2025, https://ccf.georgetown.edu/2025/09/04/are-states-ready-to-implement-hr-1-and-medicaid-work-reporting-requirements/.

[69] Georgetown University Center for Children and Families, "Tracking Implementation of H.R. 1 Medicaid Work Reporting Requirements."

[70] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[71] Sugar et al., Medicaid Churning and Continuity of Care.

what is being asked of them. Notices should therefore be clear, accessible, and actionable, including by explaining why a it was issued, what information is required, how that information may be submitted, what deadlines apply, what consequences may result from a failure to respond, and how to obtain assistance.[72] This is especially important for beneficiaries experiencing housing instability, limited English proficiency, disabilities, chronic illnesses, caregiving responsibilities, behavioral health conditions, low literacy, or limited access to technology, who may encounter significant barriers when attempting to receive, understand, or respond to notices.[73,74]

Appeals and fair hearing rights provide an important safeguard against inappropriate coverage loss because even well-designed systems may produce incorrect determinations, incomplete records, administrative errors, or misunderstandings regarding a beneficiary's circumstances.[75,76] The NHC encourages CMS to evaluate notice and appeal protections from both an administrative perspective and from the perspective of beneficiary usability, because appeal rights are only effective if beneficiaries understand that they exist, know how to exercise them, and have sufficient time and support to do so.[77,78] Likewise, individuals should have meaningful opportunities to correct errors or submit additional information, particularly when serious health conditions or caregiving responsibilities that may affect their ability to respond quickly to complex administrative requests.[79,80] The NHC also recommends that reinstatement processes are timely, predictable, and accessible when individuals are subsequently determined to have satisfied community engagement requirements, qualified for an exclusion or exemption, or otherwise remained eligible for Medicaid coverage. In those circumstances, CMS should ensure that coverage is reinstated retroactively to the date of the procedural termination or other adverse action so that individuals do not experience gaps in coverage, unpaid claims, interruptions in prescription drug therapy, cancelled appointments, or disruptions in ongoing treatment resulting solely from administrative delays or procedural error.

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[72] Medicaid and CHIP Payment and Access Commission, Denials and Appeals in Medicaid Managed Care, chap. 2 in Report to Congress on Medicaid and CHIP (Washington, DC: MACPAC, March 2024), https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-2-Denials-and-Appeals-in-Medicaid-Managed-Care.pdf.accreport.pdf.

[73] MACPAC, Denials and Appeals in Medicaid Managed Care.

[74] National Health Council, "NHC Responds to Joint CMS-ASTP/ONC RFI."

[75] National Health Council, "NHC Responds to Joint CMS-ASTP/ONC RFI."

[76] MACPAC, Denials and Appeals in Medicaid Managed Care.

[77] MACPAC, Denials and Appeals in Medicaid Managed Care.

[78] National Health Council, "NHC Comments RE 2026 Interoperability and Prior Authorization."

[79] MACPAC, Denials and Appeals in Medicaid Managed Care.

[80] National Health Council, "NHC Comments RE 2026 Interoperability and Prior Authorization."

The NHC is also concerned that procedural terminations may make it difficult to distinguish between individuals who are substantively ineligible and those who have not completed an administrative requirement. States should separately track, monitor, and report procedural disenrollments, reinstatements, appeals outcomes, and other indicators that help distinguish coverage losses caused by administrative barriers from those resulting from actual changes in eligibility status. Such information will be essential for evaluating whether implementation is functioning as intended, whether the safeguards in the IFR are effectively protecting eligible beneficiaries, and whether state partners need additional guidance, technical assistance, or operational support.

Ultimately, procedural safeguards should be designed to preserve coverage for eligible individuals while supporting program integrity. Beneficiaries who remain eligible for Medicaid or who satisfy applicable community engagement requirements should not lose coverage because of missed notices, administrative errors, unclear instructions, documentation challenges, reporting confusion, or other procedural obstacles. The NHC therefore encourages CMS to minimize reporting frequency where possible, align reporting and verification activities with existing Medicaid eligibility processes, strengthen notice standards, preserve meaningful appeal rights, support rapid reinstatement when individuals are subsequently determined eligible, and continue monitoring procedural termination rates as a key indicator of implementation success.

Effective Implementation Requires Accessible Systems, Transparent Monitoring, and Robust Oversight

While much of the discussion surrounding community engagement requirements focuses on eligibility standards, reporting obligations, and verification processes, the policy's practical effects on beneficiaries will ultimately depend on how it is administered.[81,82,83] Reporting platforms, notices, call centers, verification processes, appeals systems, beneficiary communications, and other operational components will shape whether individuals can successfully comply with requirements and maintain coverage.[84,85,86] For that reason, implementation decisions that may appear administrative in nature can have significant consequences for beneficiaries living with

[81] National Health Council, "NHC Responds to Joint CMS-ASTP/ONC RFI."

[82] Margaret Kyle and Austin Frakt, "Patient Administrative Burden in the US Health Care System," Health Services Research 56, no. 5 (October 2021): 755–765, https://doi.org/10.1111/1475-6773.13861.

[83] MACPAC, June 2026 Report to Congress, 2–3.

[84] National Health Council, Exploring the Burden of Prior Authorization.

[85] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[86] MACPAC, June 2026 Report to Congress, 2–3.

chronic diseases, disabilities, behavioral health conditions, and other serious health needs.[87,88,89,90]

State operational readiness will be central to implementation success.[91,92] States may need to revise eligibility and enrollment systems, update applications and renewal forms, redesign outreach and notice materials, train eligibility workers, add staffing and call center capacity, and develop new processes related to medically frail determinations, verification, reporting, and oversight.[93,94,95] These implementation demands reinforce the importance of clear federal expectations and ongoing CMS engagement as states operationalize the community engagement framework.

The NHC is particularly concerned about individuals who may face additional barriers when interacting with administrative systems. Medicaid beneficiaries include individuals with disabilities, chronic conditions, behavioral health conditions, cognitive impairments, limited English proficiency, low health literacy, limited digital literacy, unstable housing situations, and varying levels of access to technology.[96,97] Accordingly, the NHC encourages CMS to promote a multi-channel approach to beneficiary interaction so that individuals can receive information, submit documentation, report compliance, request assistance, and exercise appeal rights through multiple pathways, including online systems, telephone support, mail, mobile-accessible platforms, and in-person assistance where appropriate. Accessibility should be viewed as a core component of implementation, and beneficiaries should not be disadvantaged because of technology

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[87] National Health Council, Exploring the Burden of Prior Authorization.

[88] Kyle and Frakt, “Patient Administrative Burden.”

[89] MACPAC, June 2026 Report to Congress, 2–3.

[90] GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations.

[91] Georgetown University Center for Children and Families, “Are States Ready to Implement H.R. 1 and Medicaid Work Reporting Requirements?”

[92] Georgetown University Center for Children and Families, “Tracking Implementation of H.R. 1 Medicaid Work Reporting Requirements.”

[93] MACPAC, June 2026 Report to Congress.

[94] Georgetown University Center for Children and Families, “State Implementation of Work Reporting Requirements.”

[95] Commonwealth Fund, “Medicaid Work Requirements,” accessed June 24, 2026, https://www.commonwealthfund.org/taxonomy/term/902.

[96] National Health Council, “NHC Responds to Joint CMS-ASTP/ONC RFI.”

[97] National Health Council, *Comments RE Request for Information; Health Technology Ecosystem (CMS-0042-NC)* (Washington, DC: National Health Council, June 16, 2025), https://nationalhealthcouncil.org/wp-content/uploads/2025/06/NHC-Comments-RE-CMS-Health-Technology-Ecosystem-RFI.pdf.

limitations, communication barriers, or difficulty navigating administrative processes.[98,99] In implementing this approach, the NHC also encourages CMS to account for geographic barriers, particularly in rural and other underserved areas where beneficiaries may face limited broadband access, longer travel distances, fewer in-person assistance resources, and reduced access to organizations or individuals that can help them navigate reporting and verification requirements. Similarly, system limitations, technology failures, inaccessible platforms, administrative errors, or other operational issues should not result in findings of noncompliance when beneficiaries have made reasonable efforts to satisfy applicable requirements.

The IFR's outreach requirements make these considerations particularly important because states will be responsible for communicating with beneficiaries before implementation, during enrollment, and throughout the operation of the program. States that developed outreach materials before publication of the IFR may need to revise those materials to reflect changes related to medically frail determinations, verification standards, qualifying activities, notices, and exclusions or exceptions.[100] The NHC encourages CMS to support the development of outreach materials that are accurate, accessible, plain-language, and consistent across communication channels.

Oversight and transparency will be equally important because states will retain substantial discretion regarding implementation. The NHC is concerned that implementation challenges may not become immediately apparent through traditional program monitoring mechanisms, particularly where beneficiaries experience confusion, inconsistent application of exclusions, procedural disenrollment, or barriers to accessing exemptions and protections. Monitoring should therefore focus not only on whether administrative processes exist, but also on how those processes affect beneficiary outcomes.

The NHC encourages CMS to develop a standardized framework for implementation monitoring and public reporting that allows meaningful comparison across states and helps distinguish coverage losses caused by administrative barriers from those resulting from actual changes in eligibility status. Particular attention should be given to procedural terminations, medically frail determinations, caregiver exclusion determinations, appeals outcomes, reinstatement rates, notice response rates, reporting completion rates, call center performance, system accessibility, disruptions in continuity of care, delays in prescription drug or treatment access, and other indicators that can help identify emerging implementation challenges.

The NHC also recommends that CMS evaluate implementation outcomes across different beneficiary populations, including individuals living with chronic diseases, disabilities, behavioral health conditions, limited English proficiency, and limited digital

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[98] National Health Council, "NHC Responds to Joint CMS-ASTP/ONC RFI."

[99] MACPAC, Denials and Appeals in Medicaid Managed Care.

[100] Georgetown University Center for Children and Families, "Tracking Implementation of H.R. 1 Medicaid Work Reporting Requirements."

literacy. Such monitoring can help identify whether certain populations are experiencing disproportionately high rates of procedural disenrollment or barriers to accessing exclusions and exemptions and can support timely corrective action where appropriate.[101,102]

Finally, the NHC encourages CMS to use good-faith waiver authority in a manner that recognizes genuine operational barriers to implementation. Where states face significant challenges related to funding, systems design, procurement, staffing, training, notices, outreach, medically frail determinations, or provider documentation processes, time-limited implementation flexibility may help prevent rushed operational decisions that increase the risk of inappropriate coverage loss. The NHC views good-faith waivers as a tool that may help support accurate, workable, and patient-centered administration of the community engagement framework, rather than as a substitute for implementation.

Conclusion

The NHC recognizes CMS' effort to implement the community engagement requirements established by Congress while incorporating safeguards related to verification, beneficiary communications, appeals, outreach, and oversight. The NHC views several aspects of the IFR as important components of implementation, including recognition of multiple community engagement pathways and the inclusion of exclusions and exemptions for certain populations. At the same time, the NHC remains concerned that implementation may create administrative barriers that place eligible individuals at risk of avoidable coverage loss, particularly where medically frail determinations, self-attestation limitations, documentation requirements, reporting processes, notices, appeals, and state systems do not fully reflect the realities of living with chronic diseases, disabilities, serious health conditions, and caregiving responsibilities.

The NHC encourages CMS to continue engaging patients, caregivers, providers, state Medicaid agencies, managed care organizations, and other stakeholders as implementation proceeds. The success of the community engagement framework will depend not only on compliance with administrative requirements, but also on whether eligible individuals can successfully maintain continuous access to coverage, medically necessary care, and ongoing treatment. Continued stakeholder engagement, robust oversight, and transparent monitoring of implementation outcomes will be critical to identifying challenges, supporting corrective action, and ensuring that the framework functions as intended in practice.

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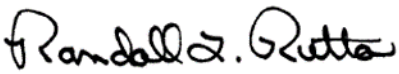
[101] MACPAC, June 2026 Report to Congress.

[102] Georgetown University Center for Children and Families, "Let's Start a Conversation about Data to Monitor the Impact of H.R. 1's Work Reporting Requirements," February 4, 2026, https://ccf.georgetown.edu/2026/02/04/lets-start-a-conversation-about-data-to-monitor-the-impact-of-h-r-1s-work-reporting-requirements/.

Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org, or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail. The NHC appreciates the opportunity to comment on this IFR and welcomes continued engagement with CMS on these issues.

Sincerely,



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