July 31, 2026

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

Re: Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule (CMS-2454-IFC)

Dear Administrator Oz:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (BHN), we appreciate this opportunity to offer comments on the Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule (CMS-2454-IFC).

The PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 66 member organizations committed to a higher value health system built on a foundation of whole-person primary care. (See PCC's Shared Principles of Primary Care — signed by nearly 400 organizations — which define our vision.) In 2022, the PCC and a diverse set of organizations launched the Better Health – NOW campaign to realize bold policy change needed to assure high-quality primary care in every American community to improve the nation's health.

Primary care is the one component of the health care delivery system where increased supply is consistently associated with improved population health outcomes, reduced

costs, and fairer results.[1] [2] Primary care is responsible for managing chronic diseases, coordinating with specialists and overseeing care transitions. Evidence indicates that maintaining an ongoing primary care relationship is crucial for improving population health outcomes; nearly all adults (95.5%) with a usual source of primary care received preventive services for chronic conditions, compared to 67.6% of those without such a relationship.[3] For individuals with chronic diseases, having a usual primary care source is associated with a nearly 54% decrease in overall health care costs and a 20% reduction in the risk of hospitalization.[4]

If the United States is to successfully address the challenges posed by endemic physical and mental chronic disease, primary care access is truly indispensable. Nowhere is this truer than for Americans eligible for Medicaid.

Medicaid is the nation's largest public health insurance program and a primary source of comprehensive primary care coverage for millions of low-income and underserved individuals. Under the law, Medicaid is the pathway to accessing comprehensive primary care and preventive services.[5] Ensuring access to Medicaid is essential for providing comprehensive primary care for everyone and reducing health disparities across populations.[6]

Given Medicaid's central role in supporting preventive and comprehensive services, policies that disrupt Medicaid coverage have the potential to adversely affect access to care, health outcomes and the broader health care system, such as increasing uncompensated care. The PCC is concerned that the Interim Final Rule may contribute to avoidable coverage losses and barriers to care and offer the following recommendations to promote coverage continuity and minimize unnecessary disenrollment.

In summary, the PCC and our Better Health – NOW partners believe that proceeding with implementation of this IFR risks significant administrative disruption and coverage losses driven by implementation barriers rather than statutory eligibility criteria. In this circumstance, CMS should withdraw and reissue the IFR in a manner that is more consistent with Medicaid's statutory aim and requirements. We further recommend the following:

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[1] Sanjay Basu et al., "Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015," *JAMA Internal Medicine* 179, no. 4 (February 18, 2019): 506, https://doi.org/10.1001/jamainternmed.2018.7624.

[2] Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* 2012 (January 1, 2012): 1–22, https://doi.org/10.6064/2012/432892.

[3] Yalda Jabbarpour et al., "Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease," *Milbank Memorial Fund*, June 1, 2026, https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/.

[4] ibid

[5] Diane Alexander and Molly Schnell, "The Impacts of Physician Payments on Patient Access, Use, and Health," *National Bureau of Economic Research*, July 1, 2019, https://doi.org/10.3386/w26095.

[6] Aaron Parzuchowski et al., "Evaluating the Accessibility and Value of U.S. Ambulatory Care Among Medicaid Expansion States and Non-expansion States, 2012–2015," *BMC Health Services Research* 23, no. 1 (July 3, 2023): 723, https://doi.org/10.1186/s12913-023-09696-x.

- Delay the implementation deadline from January 1, 2027 until at least January 1, 2028 across all states
- Provide states the flexibility to identify medically frail individuals whose circumstances may not fit within the five federally prescribed categories.
- Remove the requirement that individuals with a serious or complex medical condition must demonstrate functional impairment to qualify for a medical frailty exclusion and instead permit states to determine eligibility for this medical frailty exclusion category based solely on the presence of a qualifying serious or complex medical condition.
- Remove the exclusion of individuals in recovery for more than five years from the medical frailty exclusion for SUD.
- Maintain an annual reverification process for medical frailty.
- Encourage states to adopt a 1-month application look-back period.

DETAILED COMMENTS

Implementation Timeline

CMS Description: States are required to implement Medicaid community engagement requirements by January 1, 2027. CMS established implementation expectations, including outreach, systems readiness, verification processes and reporting requirements that states must have in place before implementation.

PCC/BHN Response: The PCC opposes setting a January 1, 2027, implementation deadline. Implementing the community engagement requirements will require states to adjust eligibility, enrollment, reporting and verification systems, a significant administrative undertaking. Without sufficient time to develop and test these systems, eligible individuals may lose Medicaid coverage due to administrative barriers, disrupting access to primary care and preventive services.

The IFR requires states to develop systems that can verify work, education, community service and income; identify individuals eligible for statutory exclusions and exceptions; issue notices of noncompliance; process satisfactory showings; and report extensive implementation data to CMS. States must also conduct outreach and beneficiary education and coordinate implementation across Medicaid agencies, workforce agencies, contractors and managed care organizations. Currently, approximately 55 percent of Medicaid enrollees are entirely unaware that work requirements will be a condition for eligibility starting in January 2027.[7] Additionally, 27 percent have heard

[7] Andrew Reed, "What 70 Million Medicaid Recipients Don't Know About Their Coverage," The Health Management Academy, June 4, 2026, https://hmacademy.com/blog/medicaid-enrollee-awareness-survey-2026.

about it but remain unsure of the specifics.[8] Successful implementation of these requirements will require coordinated planning across multiple state agencies and external partners, extensive information technology development and testing, workforce training and comprehensive beneficiary and clinician education. Given the wide scope of these operational changes, states need time to ensure systems are accurate, interoperable and capable of administering the new requirements without creating further unnecessary barriers to coverage. The complexity of these requirements raises concerns about whether all states can adequately test and operate these systems before January 2027.

Arkansas, the first state to implement a Medicaid work requirement in 2018, disenrolled more than 18,000 beneficiaries during the first several months of implementation due to system errors, unreachable notices and confusion about reporting procedures. This coverage loss did not result in increased employment. Rather, affected individuals were unaware of the reporting requirements or had difficulty navigating the reporting process, despite being employed or otherwise potentially eligible to retain coverage.[9] [10]

From a primary care perspective, continuity of Medicaid coverage is essential to maintaining access to primary care, preventive services, prescription medications and chronic disease management. The Oregon Health Insurance Experiment found that Medicaid coverage increased access to care, utilization of preventive services and financial security among beneficiaries.[11] Consequently, procedural disenrollments stemming from implementation challenges could undermine access to primary care, even for individuals who ultimately satisfy the community engagement requirements.[12] The current implementation timeline increases the risk that eligible beneficiaries will experience avoidable coverage disruptions due to inadequate eligibility systems, verification processes, or administrative errors, rather than changes in eligibility. Even temporary gaps in coverage can disrupt established patient-clinician relationships, delay needed treatment, reduce use of preventive services and ultimately compromise health outcomes. Providing states with additional time to develop and implement these systems would help minimize procedural coverage losses and better protect continuity of care.

Definition of Medical Frailty

CMS Description: The IFR defines medical frailty as a mandatory exclusion from the Medicaid community engagement requirement for individuals whose physical, mental, or behavioral health condition significantly impairs their ability to meet the work

[8] ibid

[9] Benjamin D. Sommers et al., "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs* 39, no. 9 (September 1, 2020): 1522–30, https://doi.org/10.1377/hlthaff.2020.00538.

[10] ibid

[11] Katherine Baicker et al., "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine* 368, no. 18 (May 2, 2013): 1713–22, https://doi.org/10.1056/nejmsa1212321.

[12] ibid

requirement. To qualify, an individual must not only experience a substantial functional limitation, but also fall within one of five categories established by CMS:

1) Blind or disabled, as defined under section 1614 of the Social Security Act

2) An individual with a substance use disorder

3) An individual with a disabling mental disorder

4) An individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living

5) An individual with a serious or complex medical condition.

Eligibility is based on both the individual's diagnosis and the extent to which the condition limits their ability to participate in community engagement activities.

The IFR also establishes a more standardized federal definition of medical frailty by limiting states to these five categories. States may not create additional categories of medically frail individuals beyond those specified in the rule.

PCC/BHN Response: Establishing a medical frailty exclusion to protect individuals whose health conditions substantially impair their ability to satisfy the community engagement requirement is a clear requirement of the law; however, the PCC strongly encourages CMS to provide states with greater flexibility to identify medically frail individuals whose circumstances may not fit neatly within the five federally prescribed categories.

Primary care routinely cares for patients with multiple chronic conditions, fluctuating illnesses and complex functional limitations that may substantially impair their ability to participate in community engagement activities, even when they do not fall squarely within a predefined category. States should retain discretion to recognize additional medically frail individuals based on clinical evidence and clinical judgment.

Self-Attestation for Medical Frailty

CMS Description: CMS establishes a limited self-attestation pathway to verify medical frailty when a state cannot verify an individual's condition using existing data. To qualify as medically frail, an individual must have a physical, mental, or behavioral health condition that significantly impairs their ability to comply with the community engagement requirement.

Individuals may qualify as medically frail if they fall within one of five categories:

1) Blind or disabled, as defined under section 1614 of the Social Security Act

2) An individual with a substance use disorder (excluding individuals in recovery for more than five years)

3) An individual with a disabling mental disorder

4) An individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living

5) An individual with a serious or complex medical condition.

However, under the IFR, a diagnosis alone is insufficient. States must evaluate whether the severity and current impact of the individual's condition substantially limits their ability to meet the work requirement.

The "serious or complex medical condition" category is one of several pathways through which an individual may qualify as medically frail. CMS defines a serious or complex medical condition as one that is life-threatening, seriously disabling, causes significant pain or functional impairment, requires frequent monitoring or coordination across multiple specialties, affects multiple organ systems, or otherwise requires intensive medical management.

Through 2027, states may rely on self-attestation, but beginning in 2028, self-attestation is limited to one use when reliable state information is unavailable. At future renewals, states must rely on available state data or supporting documentation rather than repeated self-attestation.

PCC/BHN Response: The IFR requires states to verify that all medically frail individuals meet one of the five statutory categories AND have a condition that significantly impairs their ability to comply with community engagement. We believe that the addition of this functional impairment requirement will significantly impair the ability to comply and goes beyond the statute.

The PCC is especially concerned about the implementation of the "serious or complex medical condition" category. Unlike other frailty categories, this requires states to establish new eligibility standards and conduct individualized, case-by-case clinical assessments to determine qualifying conditions and functional impairments. These evaluations cannot be automated or verified consistently through existing electronic data sources, which increases administrative complexity and the workload for documentation. Therefore, the PCC urges CMS to remove the requirement that individuals with a serious or complex medical condition must demonstrate functional impairment to qualify for a medical frailty exclusion. CMS should permit states to determine eligibility for this medical frailty exclusion category based solely on the presence of a qualifying serious or complex medical condition, as the law intended, to

reduce administrative complexity while ensuring timely access to care for individuals with significant health needs.

The PCC is concerned that the need to confirm impairment could add extra documentation and verification burdens for patients, primary care clinicians and their teams and state Medicaid agencies. Requiring clinicians and beneficiaries to document not only the existence of a qualifying medical condition but also the extent to which it impairs daily functioning creates an unnecessary administrative burden, introduces additional eligibility determination challenges and increases the risk that medically vulnerable individuals will experience delays or inappropriate exclusion denials.

Determining whether a serious or complex medical condition limits an individual's ability to meet the requirements requires individualized clinical judgment that cannot be comprehensively assessed through electronic data sources or claims data alone. For instance, individuals undergoing certain treatment, managing severe chronic illnesses, or living with behavioral health or cognitive conditions may experience symptoms and functional limitations that fluctuate over time and are not accurately captured in administrative data.

This requirement would place additional administrative demands on already strained health care clinicians while requiring medically vulnerable beneficiaries to obtain and submit additional documentation. Together, this increases the risk of delayed eligibility determinations, procedural coverage losses and interruptions in access to primary and specialty care for individuals with significant health needs – without achieving the intended goal of increasing employment.

Similarly, the PCC is also concerned that CMS narrows the statutory medical frailty exclusion by categorically excluding individuals who have been in recovery from substance use disorders (SUD) for more than five years. The statute does not establish any temporal limitation for individuals with SUD, yet the IFR imposes a fixed five-year cutoff without providing a clear clinical or statutory justification.

Therefore, the PCC urges CMS to remove the exclusion of individuals in recovery for more than five years from the medical frailty exclusion for SUD. Recovery is not a binary clinical state, and individuals may continue to require medication-assisted treatment, behavioral health services, or experience functional limitations well beyond five years. This categorical restriction risks denying medically vulnerable individuals' access to the medical frailty exclusion based on an arbitrary timeline rather than an individualized clinical assessment, undermining the statute's intent to protect individuals whose health conditions limit their ability to comply with community engagement requirements.

Medical Frailty Reverification

CMS Description: CMS requires medical frailty status to be reverified at least every 12 months but also permits states to conduct reverification more frequently. States must first attempt reverification using reliable information available to the state, including

adjudicated claims and encounter data from the preceding 12 months, before requesting documentation from beneficiaries.

Beginning January 1, 2028, states may not rely on repeated self-attestation and instead must use available state data or supporting documentation to confirm continued eligibility for the medical frailty exclusion – not just the diagnosis, but the impact of the diagnosis on the ability to work.

PCC/BHN Response: The interaction between reverification, renewal timing, and self-attestation limits will pose challenges for patients. Rather than policies that force beneficiaries to verify their status again just months after an initial check, we encourage CMS to rely on attestation or other sources that are necessary. In the event that CMS implements any twelve-month standard, it should, at a minimum, not permit states to adopt a shorter standard.

The proposed rule arbitrarily limits medical claims data to data adjudicated in the preceding 12 months. This limitation ignores the realities of Medicaid claims processing, where there is often a significant lag between the time of patient service provision, the time when a provider submits a claim for payment, and the time a state Medicaid agency processes and pays a claim for that service.

Starting in 2028, those who initially qualify for a medical frailty exception through self-attestation might need more formal verification at their next Medicaid renewal, which CMS indicates could occur as soon as 6 months later. Consequently, some beneficiaries may undergo verification before the 12-month cycle, depending on their renewal date.

This increased frequency could increase administrative burdens for medically vulnerable individuals, requiring extra documentation, review or clinician involvement shortly after their initial determination.

Additional reverification requirements would also shift additional and substantial administrative responsibilities to primary care practices, as clinicians and staff are - asked to complete medical documentation, respond to eligibility requests and help patients maintain coverage. Primary care clinicians are already facing increasing administrative demands and regulatory complexity that divert time and resources away from direct patient care and contribute to workforce burnout.

These burdens have significant financial consequences for primary care practices. Research shows that increased Medicaid administrative requirements reduced physician practice revenue by about 18 percent over a one-year period, as practices devoted more uncompensated physician and staff time to paperwork rather than to billable patient care.[13]

[13] Abe Dunn et al., "A Denial a Day Keeps the Doctor Away," *National Bureau of Economic Research,* July 1, 2021, https://doi.org/10.3386/w29010.

Reduced revenue is not just clinician pay – it is a fiscal reality that renders continued Medicaid participation less financially sustainable, particularly for small, independent, rural, and safety-net practices, leading to further erosion in Medicaid participation by clinicians. As participation declines, Medicaid beneficiaries face greater difficulty accessing primary care, including longer wait times, fewer available appointments, and increased reliance on costly emergency departments for care that could otherwise be delivered in outpatient settings.

To the extent it is constrained to establish any time-based standard, CMS should maintain a single reverification process for medical frailty across states. This would avoid or mitigate duplicative administrative requirements, preserve limited clinical resources for patient care, and provide beneficiaries with a more predictable and less burdensome process for maintaining Medicaid coverage.

Technology should be used first to identify individuals not subject to the requirement, individuals who qualify for an exclusion and individuals whose compliance can be established electronically. A failed electronic match should trigger outreach and human review, not automatic termination. Without such an approach, we are concerned a substantial portion of eligible individuals both within the Medicaid expansion population and categorically eligible populations (including children, disabled, pregnant women and medically needy) will be denied access to coverage and care.

Short-Term Hardship Categories

CMS Description: The IFR permits states to adopt an optional short-term hardship exception for individuals temporarily unable to meet Medicaid's community engagement requirement. If a state elects this option, affected beneficiaries are deemed compliant for the duration of the hardship period.

The rule identifies four qualifying hardship categories:

1) Receipt of institutional or similarly intensive medical services, including inpatient psychiatric care and select high-acuity community-based services

2) Residence in an area affected by a federally declared emergency or disaster

3) Residence in a county experiencing high unemployment

4) The need for an individual or their dependent to travel outside the community for an extended period to receive treatment for a serious or complex medical condition.

States may adopt the short-term hardship option, but they cannot selectively implement specific hardship categories. If a state opts for the exception, it must make all four hardship categories accessible to eligible individuals. However, unemployment-related hardship requires a separate request from the state and approval from CMS before it can be activated in a specific county or locality.

PCC/BHN Response: The PCC supports CMS's inclusion of optional short-term hardship categories for individuals subject to Medicaid community engagement requirements. These protections recognize that temporary health, economic, and community circumstances can create legitimate barriers to meeting reporting and engagement requirements, even for individuals who remain actively connected to the health care system. The hardship categories for institutional or intensive medical services, travel for treatment of a serious or complex medical condition, residence in areas affected by disasters or emergencies and residence in areas experiencing high unemployment help prevent unnecessary coverage disruptions for individuals facing circumstances beyond their control.

For individuals with behavioral health conditions, these protections are especially important. Primary care practices serve as the front door to mental health and substance use disorder treatment for millions of Americans, especially in rural and underserved communities where specialty behavioral health clinicians are scarce.[14] Integrated, whole-person primary care improves access to behavioral health services and helps address longstanding gaps in treatment availability, particularly in communities facing clinician shortages.[15]

Additionally, rural populations face significant access challenges, including clinician shortages, limited availability of specialty care and the need to travel long distances to receive necessary services.[16] These challenges are often even greater for individuals seeking specialty behavioral health treatment. Patients receiving inpatient psychiatric care, intensive outpatient treatment, substance use disorder services, or specialty mental health care may face temporary barriers to meeting community engagement requirements, even while remaining actively engaged in treatment and recovery.

Continuity of coverage is essential to the successful and effective treatment of all patients. Policies that minimize avoidable coverage loss will help ensure that patients can continue to receive the primary care and behavioral health services necessary to maintain their health and well-being.

The PCC encourages CMS to simplify pathways for activation, particularly where credible data demonstrates need, so that hardship exceptions can function as a practical safeguard against procedural disenrollment.

Application Look-Back Period

[14] Primary Care Collaborative, "Behavioral Health Integration" PCC, September 16, 2024, https://thepcc.org/policy/behavioral-health-integration/.
[15] Amie A. Pollack et al., "The Primary Care Investment Guide," PCC, December 18, 2025, https://thepcc.org/wp-content/uploads/2026/01/REPORT-Primary-Care-Investment-Guide-2025.pdf.
[16] Alison Huffstetler et al., "Closing the Distance in Rural Primary Care," *PCC*, November 24, 2025, https://thepcc.org/reports/closing-the-distance-in-rural-primary-care/.

CMS Description: The application look-back period applies to new applicants seeking Medicaid coverage. States may require applicants to demonstrate compliance with the community engagement requirement for a period before enrollment. CMS limits the application look-back period to 1, 2, or 3 consecutive months prior to application.

The IFR requires states to specify the timeframe in State Plan materials and gives states flexibility to determine how compliance is demonstrated and verified, including through data sources, attestation, and documentation.

PCC/BHN Response: The PCC urges CMS to encourage states to adopt the shortest permissible application look-back period. A one-month review period provides a sufficient assessment of an individual's current compliance with the community engagement requirement while minimizing unnecessary administrative burden for beneficiaries, state agencies, and physicians. Longer look-back periods require individuals and their chosen source of primary care to document compliance over multiple months, increasing reporting and verification requirements without necessarily yielding a more accurate assessment of an individual's present circumstances.

The PCC is concerned that longer application/renewal look-back periods may increase the risk of procedural coverage denials among otherwise eligible individuals. Because application look-back periods are used to assess compliance with community engagement requirements before enrollment, extending the review period increases the likelihood that individuals may be unable to provide documentation for every month under review, even when they are currently meeting program requirements.

Adopting the shortest permissible one-month look-back period for applications would better support continuity of coverage, reduce administrative complexity, and ensure that eligibility determinations are based on an individual's current circumstances, while still advancing the goals of the community engagement requirement.

Community Engagement Attestation & Verification

CMS Description: CMS directs states to assess and verify whether an applicable individual has met the community engagement requirement, qualifies for a mandatory exception or meets the criteria for a specified exclusion. States must first attempt to verify this information using available electronic data sources and other reliable information before requesting documentation from the individual. Applicants and beneficiaries may attest to qualifying community engagement activities, exceptions or exclusions through Medicaid applications, renewals and other eligibility processes.

The verification requirements apply at application and renewal and may also be used during more frequent compliance reviews, if the state elects to do so. When compliance cannot be verified through available data sources, states may request additional information from the individual. Before determining noncompliance, states must review all available information and verify whether the individual has demonstrated community engagement or qualifies for an exception or exclusion.

PCC/BHN Response: The PCC encourages CMS to collaborate with states to implement verification systems effectively and efficiently, share best practices, and continue to negotiate discounted vendor arrangements.[17] By prioritizing verification through existing data systems, the rule can help reduce unnecessary administrative burden on Medicaid beneficiaries and physicians, while providing states with a consistent process for determining compliance, exceptions and exclusions under the community engagement requirement.

Successful implementation of these provisions will require states to develop and maintain sophisticated eligibility and verification systems that integrate multiple electronic data sources. Robust technical assistance is essential to support state investments in eligibility infrastructure and system modernization, helping states implement the verification framework consistently while minimizing reliance on manual processes that increase administrative burdens for beneficiaries and clinicians.

Primary care physicians spend nearly half of their office day on electronic health record (EHR) and administrative tasks, while only 27 percent of their time is spent in direct face-to-face patient care.[18] Many physicians also spend an additional 1 to 2 hours each evening completing administrative work.[19] By reducing unnecessary documentation requirements and supporting more streamlined eligibility processes, such as using existing electronic data sources, the verification framework may help minimize administrative barriers that can disrupt coverage and access to care.

Whenever possible, states should rely on existing electronic data sources rather than physician certification or beneficiary-submitted documentation. Leveraging existing verification systems reduces the administrative burden on beneficiaries, clinicians, and state agencies alike and allows the primary care team to devote more time to direct patient care.

If and when CMS does implement these requirements, we anticipate substantial disruption of primary care access overall and, in particular, value-based payment arrangements. To mitigate the negative effects, primary care practices and health centers should not be financially penalized for eligibility changes, reporting failures, state or vendor errors, attribution inaccuracies, retroactive coverage changes, administrative delays or treatment disruption caused by coverage loss.

CMS should prohibit or strongly discourage inclusion of community-engagement-related coverage gaps in provider downside-risk calculations, shared-savings reconciliation, total-cost-of-care benchmarks, quality penalties, attribution evaluations,

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[17] CMS, "Fact Sheet: Pledges From Medicaid Technology Companies to Support Community Engagement Implementation and Related Medicaid System Improvements," *CMS*, February 3, 2026, https://www.cms.gov/newsroom/fact-sheets/fact-sheet-pledges-medicaid-technology-companies-support-community-engagement-implementation-related.

[18] Primary Care Collaborative, "Simplifying Value-Based Primary Care by Reducing Administrative Burdens," March 2026, https://thepcc.org/wp-content/uploads/2026/03/Simplifying-VBPC-by-Reducing-Admin-Burdens-PCC-March-2026.pdf.

[19] ibid

or network decisions. Plans should not recoup payment when providers delivered medically necessary services in good faith while systems showed the patient as eligible.

Should CMS and states fail to forestall these practice level impacts, we are alarmed at the potential impact on practice and health center viability. Any resulting practice closures would affect not just the Medicaid expansion population, but other categorically eligible individuals including children, disabled individuals, and medically needy eligibility.

Beneficiary Outreach & Notices

CMS Description: CMS mandates that states begin outreach at least 3 months prior to implementation and maintain outreach at key points, including application, renewal, changes in circumstances, activation of hardship exceptions, before hardship exceptions expire, prior to losing medically frail or excluded status and whenever CMS raises compliance concerns.

PCC/BHN Response: The IFR appropriately recognizes that clear, repeated communication is essential to successful implementation. However, written notices alone are not sufficient to ensure beneficiary awareness and understanding.

Primary care clinicians often have longstanding, trusted relationships with Medicaid beneficiaries and are well-positioned to reinforce awareness of the community engagement requirement and to direct patients to appropriate state resources. At the same time, responsibility for beneficiary education, eligibility determinations, and compliance with the community engagement requirement should remain with states and Medicaid agencies.

The PCC encourages CMS and states to engage trusted community partners, including willing primary care practices and community health centers (CHCs), as part of a broader beneficiary outreach strategy. It is vital that outreach efforts do not create new documentation, reporting, or administrative responsibilities for primary care practices, which already face a substantial administrative burden.

CMS should encourage states to develop outreach materials and referral resources that primary care practices and CHCs may share with patients during routine clinical encounters. Providing standardized educational materials, referral information, and points of contact for enrollment assistance would enable clinicians to help patients maintain coverage without requiring practices to administer or verify compliance with the community engagement requirement. This approach leverages the trusted patient-clinician relationship, preserves the state's responsibility for implementation and minimizes unnecessary burden on frontline providers.

Enhanced Federal Matching Funds (90/10 and 75/25)

CMS Description: CMS confirms that states may claim a 90% federal match for approved design, development, and installation costs, and a 75% federal match for approved operational costs. States must obtain CMS approval of an Advance Planning Document (APD) before incurring costs and must comply with Medicaid Enterprise System requirements to receive enhanced funding.

PCC/BHN Response: The PCC supports CMS's decision to make enhanced federal matching funds available to states implementing the community engagement requirement. The availability of 90 percent Federal Financial Participation for eligibility and enrollment system development can help states modernize Medicaid eligibility infrastructure while minimizing state fiscal burden. Enhanced federal support for system upgrades, data exchanges, reporting functions, and beneficiary-facing tools will be critical to efficiently implementing new requirements and reducing the risk that administrative complexity disrupts beneficiary access to coverage.

The Medicaid program was established to provide essential care. CMS's actions - which promote rules that erode low-income individuals' ability to access necessary services - contradict the program's fundamental goal. Losing health coverage due to this policy will likely increase healthcare system expenses and lead to worse health outcomes.

Nonetheless, the PCC and our Better Health - NOW campaign appreciate this opportunity to provide comments on the Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule (CMS-2454-IFC) and look forward to working with the CMS team to ensure the primary care community's perspectives are fully considered and that Medicaid beneficiaries continue to have access to high-quality, comprehensive primary care. Please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org, with any questions regarding our comment letter and policy suggestions.

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative