June 30, 2026
Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Re: Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz,

On behalf of Advocates for Community Health (ACH), a nonpartisan, nonprofit membership organization comprised of 55 community health center members in 22 states that serve over 4 million patients, we are writing to express our concern with the Centers for Medicare & Medicaid Services' (CMS) Interim Final Rule (IFR): Community Engagement Requirement for Certain Individuals. While ACH recognizes CMS's efforts to provide implementation guidance through this IFR, we urge the agency to consider modifications that reduce unnecessary administrative provider burden and preserve continuity of coverage for eligible Medicaid beneficiaries.

Background

Community health centers serve over 34 million patients, and Medicaid is the primary source of coverage for more than half of those individuals. Health centers routinely serve on the front lines of care for underserved and rural communities, delivering high-quality, comprehensive, and affordable primary and preventive care. In addition to providing care, health centers often serve as trusted enrollment, outreach, navigation, and care coordination partners, working directly with Medicaid beneficiaries to apply for coverage, maintain eligibility, and navigate complex administrative requirements. As a result, health centers often see on the ground impacts of policy changes first and are uniquely positioned to understand the challenges beneficiaries may face under the IFR requirements.

For health centers and other safety net providers, widespread coverage losses can disrupt access to primary, preventive, behavioral health, and chronic disease management services and require additional staff time to help patients regain coverage. Combined with additional administrative responsibilities, coverage disruptions are likely to increase uncompensated care, creating financial strain for the nation’s health centers and further stressing the entire health care safety net that millions of Americans rely on today. Therefore, ACH urges CMS to consider the following recommendations:

1. **Remove the Impairment Requirement Associated with “Serious or Complex” Medical Conditions**

The IFR recognizes five statutory medical frailty categories, including individuals with a "serious or complex medical condition," and allows states flexibility to define which specific diagnoses may qualify within that category in order to determine whether an individual can be exempted from community engagement requirements.[1] In addition, the IFR directs states to *also* evaluate whether the condition impairs an individual's ability to satisfy community engagement requirements.

This latter requirement goes beyond statutory intent. H.R. 1 included an exemption for serious medical conditions without further requirements, and given the plain language of the text, it is safe to assume that Congress intended for this exemption to be implemented as written. If an individual has a serious or complex medical condition, it is presumed that your ability to work is impaired.

The requirement to confirm impairment creates new documentation and verification burdens for patients, providers, and state Medicaid agencies. This will make it more difficult for individuals to qualify for and maintain the exemption based on a qualifying condition, without any discernible benefits for patients, states, or the taxpayer.

While states may be able to verify some aspects of eligibility and compliance through existing electronic data sources, such as income, participation in other public benefit programs, or certain medical diagnoses, identifying individuals who qualify for the "serious or complex medical condition" medical frailty category may require additional review and clinical judgment. Then, the impairment verification requirement introduces yet another layer of complexity beyond identifying the qualifying diagnosis itself. Determining the extent to which a condition affects an individual's ability to engage in work or other qualifying activities often requires additional assessment, which is unduly burdensome for both patients and providers.

ACH is concerned about how these requirements would be implemented in practice at community health centers. Rather than only confirming the presence of a qualifying diagnosis, health center staff may be expected to complete additional documentation and make individualized assessments regarding a patient's functional impairment. These activities fall outside the routine delivery of clinical care, are generally not reimbursable,

[1] While the IFR requires states to verify that all medically frail individuals both meet one of the five statutory categories and have a condition that significantly impairs their ability to comply with the community engagement requirement, ACH is particularly concerned about implementation of the “serious or complex medical condition” category. Unlike the other medical frailty categories, this provision requires states to develop new eligibility standards and make individualized, case-by-case clinical determinations regarding both qualifying conditions and functional impairment. These types of assessments cannot be automated or consistently verified through existing electronic data sources, increasing administrative complexity and documentation burdens.

and require clinicians and staff to devote valuable time and resources to non-billable administrative activities instead of direct patient care. Health centers continue to face persistent workforce shortages, particularly in rural and underserved areas, while caring for medically complex patients, often with limited resources. Requiring clinicians and staff to complete additional eligibility-related assessments and documentation would divert scarce clinical capacity away from patient care and further strain an already overextended workforce.

Further, the IFR provides limited guidance regarding how providers are expected to operationalize these verification assessments in practice. ACH is concerned that the absence of clear provider expectations, documentation standards, and standardized processes will create uncertainty for health centers as they establish internal workflows, determine who is responsible for completing assessments, and implement new documentation and review processes.

ACH is also concerned about how these requirements will impact patients undergoing cancer treatment, managing serious chronic illnesses like cystic fibrosis or multiple sclerosis, or experiencing behavioral health or cognitive conditions may experience fluctuating symptoms and functional limitations that are not easily reflected in claims data. Similarly, this challenge is particularly evident for patients with conditions such as multiple sclerosis or Crohn's disease, where periods of remission may alternate with acute flare-ups that significantly affect an individual's functional capacity. As a result, a patient may be able to participate in work or other qualifying activities at certain times but not others, making it difficult for a single clinical assessment or existing claims data to accurately reflect the patient's ongoing ability to comply with community engagement requirements.

ACH therefore urges CMS to remove the impairment requirement associated with the serious or complex medical condition category and allow states to determine eligibility for this exclusion based on the presence of a qualifying condition. This will ensure medically vulnerable individuals and their providers are not subject to administratively burdensome verification procedures, while also making it less likely that a patient who otherwise qualifies for an exemption would lose their health coverage, a catastrophic outcome for someone with a chronic illness.

2. **Allow Continued Use of Self-Attestation for Medical Frailty Reverification**

Beginning January 1, 2028, the IFR limits the use of self-attestation for medical frailty determinations. While individuals may be permitted to self-attest when initially establishing eligibility for this exclusion, states generally must rely on available data sources or supporting documentation for future reverifications rather than accepting another self-attestation.

ACH is concerned that limiting self-attestation after an initial medical frailty determination will create barriers for individuals with serious conditions whose health circumstances are not easily captured through existing data sources. As beneficiaries go through renewal and reverification processes, some may be required to obtain provider documentation or other evidence to demonstrate continued eligibility for the exclusion, even when their underlying diagnosis has not changed. Again, this is particularly significant for eligible individuals with complex, fluctuating, and/or episodic conditions. It also increases the risk that these beneficiaries experience delays or coverage disruptions while attempting to demonstrate eligibility, which could have a serious impact on their health and well-being.

Health centers are likely to face additional demands to help patients comply with the new community engagement requirements, including assisting with documentation, verification, and ongoing reverification activities, all of which require staff time and resources that would otherwise be devoted to patient care. In practice, health center staff may be expected to help patients understand eligibility requirements, complete forms, gather supporting documentation, coordinate with clinicians to obtain medical attestations, and respond to repeated requests for verification. These activities are generally non-billable and may require clinicians to devote portions of patient visits to eligibility-related documentation rather than clinical care. Requiring health centers to absorb these new administrative responsibilities would further strain an already stretched primary care workforce, reduce availability, and ultimately limit timely access to care.

Given these challenges, ACH urges CMS to allow continued use of self-attestation for medical frailty reverification when reliable state data are unavailable. Ensuring this flexibility would help reduce administrative burden on beneficiaries, providers, and state Medicaid agencies while minimizing the risk of coverage delays or disruptions.

3. Limit Medical Frailty Reverification Burdens

The IFR requires states to periodically reverify that individuals continue to qualify for the medical frailty exclusion. States must conduct reverification at least every 12 months, although they may choose to do so more frequently, including at renewal.

While the IFR establishes a 12-month reverification standard, the interaction between reverification, renewal timing, and limits on self-attestation may create additional administrative complexity for patients and providers. Beginning in 2028, an individual who initially qualifies for a medical frailty exclusion through self-attestation may need to undergo a more formal verification process at their next Medicaid renewal, which CMS notes could occur as soon as six months later. As a result, some beneficiaries may have to go through a verification process sooner than the 12-month reverification cycle suggests, depending on when their renewal occurs. This may increase administrative burden for medically vulnerable individuals by requiring additional documentation, review, or provider involvement within months of their initial determination, which in turn could lead to medically vulnerable individuals inadvertently losing the health insurance coverage that helps them manage their condition.

Health centers and other providers are also likely to experience increased demands to assist patients with reverification activities. Providers recognize the imperative importance of ensuring their patients have the health insurance coverage they need, but this is another administrative burden for already overburdened staff who would otherwise be engaged in patient care activities. ACH urges CMS to maintain an annual reverification process for medical frailty that avoids policies that require beneficiaries to undergo additional verification within months of an initial determination.

Conclusion

ACH is deeply concerned that implementation of the Medicaid community engagement requirements, as outlined in this interim final rule, will significantly hinder patient access to care and cause many otherwise eligible patients to lose their Medicaid coverage. The unnecessarily complex administrative processes included therein also threaten the overall stability of the health care safety net.

ACH respectfully urges CMS to reduce unnecessary administrative barriers by removing the impairment requirement associated with the “serious or complex medical condition” medical frailty category and by minimizing provider and patient burden related to the medical frailty attestation and verification processes. These changes would help preserve access to coverage for eligible individuals while supporting less burdensome implementation of community engagement requirements.

Thank you for your consideration. We welcome discussion of these comments and direct you to contact me and/or Stephanie Krenrich, Senior Vice President of Policy and

Government Affairs, at skrenrich@advocatesforcommunityhealth.org for additional information.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health