National
MLTSS
Health Plan Association

July 31, 2026

State Medicaid Directors
Cc: National Association of Medicaid Directors (NAMD)

RE: Implementation of Medicaid Community Engagement Requirements

Dear State Medicaid Directors,

The National MLTSS Health Plan Association (MLTSS Association) writes regarding your state's implementation of the Medicaid community engagement (CE) requirements. These requirements were established by Section 71119 of Public Law 119-21 and are interpreted in the Centers for Medicare and Medicaid Services (CMS)'s interim final rule with comment period (CMS-2454-IFC). We recognize the compressed timeline your agency faces ahead of the January 1, 2027 implementation deadline, and we write to offer both our partnership and a set of practical recommendations intended to protect coverage for eligible members while easing administrative burden on the state. The MLTSS Association requests that the state consider these recommendations as it finalizes its CE implementation plan, and we would welcome the opportunity to discuss them with your team in advance of the January 1, 2027 deadline.

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[1] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

Overview

The individuals our members serve are directly impacted by the implementation of the CE requirements. Many MLTSS enrollees will qualify for a mandatory exception or be a specified excluded individual. Yet the greatest risk in CE implementation is that eligible, exempt individuals will lose coverage for procedural reasons rather than because they failed to meet the requirement. The recommendations below, designed to reduce that risk, fall into five categories:

- Leveraging MCOs as implementation partners
- Minimizing verification frequency and look-back periods to reduce documentation burden
- Strengthening outreach notices and enabling parallel, multi-channel outreach by plans
- Publishing category-level outcomes data to monitor whether exempt members are being protected

[1] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

- Adopting the short-term hardship exceptions in full

Taken together, these recommendations would allow the state to meet its CE obligations while minimizing avoidable coverage loss among the medically frail, disabled, and caregiver populations our member plans serve. Additionally, our recommendations promote consistency across states, easing administrative burden for plans that operate in multiple markets and helping ensure comparable protections for members regardless of where they live.

Recommendations

1. Leverage MCOs as partners in CE implementation and ongoing operations

The interim final rule expressly indicates that states may delegate certain functions to their managed care plans, and it recognizes managed care entities as participants in outreach, education, and data sharing. While the rule's conflict-of-interest provisions appropriately reserve compliance and eligibility determinations to the state, they leave substantial room for states to rely on their MCOs for the member-facing work of CE implementation.

Managed care plans hold assets that are difficult and costly for a state to replicate, particularly on the timeline states are facing. Key MCO resources include:

- Current member contact information across multiple channels
- Established, trusted relationships with members and their caregivers
- Care managers who are already in regular contact with high-need enrollees
- Encounter and claims data that can help the state identify individuals who are likely exempt (for example, on the basis of medical frailty or disability)

For MLTSS populations in particular, plans hold the clinical and functional information most relevant to accurate exemption identification. Enlisting MCOs to support outreach, member navigation, exemption documentation, and data sharing will reduce improper terminations, lower the state's administrative cost, and improve the accuracy of the underlying determinations.

2. Adopt the least frequent reverification timing and the fewest months in the review periods

The CE interim final rule requires verification of compliance at application and at renewal, but makes more frequent periodic verification a state option. We urge states to verify at application and renewal only, which aligns with the annual renewal cycle. More frequent verification would include multiple (potentially overlapping) notices, more frequent documentation demands, and opportunities for procedural coverage loss, without materially improving program integrity for a population whose circumstances the state and plans already monitor.

Relatedly, the rule permits states to select the number of months an individual must demonstrate community engagement during a look-back period. States must include at least one month but can

select up to three months at application, and one or more months between renewals. We urge states to choose a single month in each review period. A shorter review period lessens the chance that eligible members are disenrolled over documentation gaps rather than genuine non-compliance. Each avoidable termination generates downstream costs in uncompensated care, reenrollment, and care disruption that fall on the state, plans, and providers alike.

3. Include member-centered content in outreach notices, and allow MCOs to conduct education and outreach in parallel — including by text and other electronic messaging

The CE interim final rule requires outreach notices to explain who is an applicable individual and who is excepted, the consequences of non-compliance, and how to report a change in status. To make that outreach effective, we recommend that notices, in plain and accessible language (including for individuals with disabilities):

- Clearly list every qualifying activity and the income-equivalent option, so members understand the many ways compliance can be met;
- Describe each exception and specified-excluded category, with concrete examples relevant to individuals with disabilities, and those who are caregivers or medically frail, and a simple path to request review of an exemption;
- Explain the short-term hardship exceptions and how to request one;
- Explain the 30-day period following a notice of non-compliance and exactly how and where to respond; and
- Inform members they can request assistance from their health plan, with plan contact information included.

Consistent with the rule's allowance for outreach by telephone, text message, website, and other commonly available electronic means, we ask that the state authorize its MCOs to conduct member education and outreach in parallel with the state's own outreach, and to use text messaging and other electronic messaging (subject to member opt-in and applicable consent requirements). Because members already know and trust their health plan, channeling parallel, multi-channel outreach through plans is one of the most effective ways to reduce avoidable coverage loss.

4. Publish outcomes data on CE implementation, broken out by exemption category

Transparency will be essential to identifying and correcting implementation problems quickly. We request that states publish and, where feasible, share with its contracted plans, data on the outcomes of CE implementation, disaggregated by exemption and exclusion category. Useful breakouts include the number of individuals identified as exempt under each category; the number disenrolled for non-compliance; the share of terminations that are procedural versus substantive; and reapplication and reinstatement rates.

Category-level data is what makes it possible to see whether individuals most likely to be exempt - particularly the medically frail and disabled individuals central to MLTSS - are in fact being protected, or

whether they are slipping through the verification process and losing coverage they are likely still eligible to keep. This transparency serves the state's own program-integrity and monitoring obligations and allows plans to target support where the data show it is most needed.

5. Elect the short-term hardship exceptions in full

The interim final rule makes the short-term hardship exceptions optional but provides that a state electing this option must adopt all of the statutory hardship circumstances rather than selecting among them. We strongly urge the state to elect these exceptions, which provide critical protection for members who cannot reasonably meet the requirement through no fault of their own. These exceptions are precisely the circumstances that disproportionately affect the medically complex individuals our plans serve. Declining the hardship option would leave those individuals exposed to loss of coverage for situations entirely beyond their control, raising the risk of interrupted care and higher downstream costs.

Partnership moving forward

The MLTSS Association appreciates the efforts of state Medicaid agencies to ensure appropriate compliance with relevant statutes while maintaining appropriate member protections. Our members are ready to be active partners in operationalizing this policy change, and we welcome the opportunity to serve as a resource to your agency throughout the CE implementation process. Our plans' operational experience and member relationships are assets the state should put to use as CE implementation moves forward.

If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak

Chief Executive Officer