National
MLTSS
Health Plan Association

July 31, 2026

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

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

Dear Administrator Oz,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the Medicaid Program; Community Engagement Requirement for Certain Individuals interim final rule with comment period (IFC).[1]

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.[2] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service (FFS) 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 MLTSS Association's member plans are prepared to serve as partners with CMS and states as the community engagement requirement, enacted in Section 71119 of Public Law 119-21, is implemented. As organizations that assume risk for and coordinate care for many of the individuals subject to the requirement, our members are deeply invested in an implementation approach that meaningfully carries out the statute while protecting continuity of coverage and access to care for the vulnerable populations they serve — including older adults, people with disabilities, and individuals who rely on LTSS to live safely and independently in their communities.

Our comments are broad in scope but focus on the areas where additional clarity would most improve implementation, particularly the accurate identification of individuals who qualify for the medically frail and caregiver exemptions. Our members hold some of the most comprehensive claims, encounter,

[1] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33,348 (June 3, 2026) (CMS-2454-IFC).
[2] 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.

assessment, and care management data available for these populations, and they administer person-centered assessments and service plans that document members' functional status and caregiving arrangements. The recommendations that follow are grounded in that experience and in a shared goal of implementing the statutory requirement in a way that is feasible for states, workable for plans and providers, and, above all, protective of the individuals for whom Medicaid serves as a lifeline, including older adults and individuals with disabilities.

Recommendations

1. **Clarify the role managed care organizations may play in supporting medical frailty exemption determinations.**

The IFC narrows the medically frail exemption by requiring not only that an individual fall within one of the five statutory categories, but also that the individual's condition significantly impairs their ability to meet the community engagement requirement. Making these determinations accurately depends heavily on data, including claims, encounter, assessment, and care management data that MCOs are uniquely positioned to hold for the populations they serve. At the same time, the conflict-of-interest safeguards at § 438.58 prohibit MCOs from determining whether a beneficiary satisfies the requirement. The IFC does not fully describe the supporting activities that remain permissible for plans, leaving states and plans uncertain about how MCO data and care management infrastructure may be used to support, rather than make, exemption determinations.

Recommendation: CMS should clarify that MCOs may support states in identifying and flagging individuals who are potentially medically frail, and should provide toolkits and other technical assistance reminding states of the options and flexibilities for permitting MCOs to conduct activities such as application and paperwork assistance. MCOs can support identification by applying state-defined criteria to claims, encounter, assessment, and care management data and surfacing candidates to the state or an independent entity for a determination consistent with the conflict-of-interest safeguards at § 438.58. Clear guidance from CMS on the boundary between permissible supporting activities and prohibited determinations is necessary, as is clarity around which activities can be included in capitation rates, what can count as in lieu of services (ILOS), and what can be included in the numerator of the MLR. This guidance would allow states to leverage plan data and reduce the risk that eligible individuals lose coverage because their medical frailty was not identified.

2. **Confirm that the receipt of Medicaid-funded LTSS is sufficient to establish the medical frailty exemption without additional documentation or assessment.**

Individuals receiving Medicaid-funded LTSS have, by definition, already been assessed as having significant functional limitations or as meeting an institutional level-of-care standard. These individuals' needs are documented through standardized functional assessments and person-centered service plans. Requiring these individuals, or the states and plans that serve them, to generate additional documentation or complete a separate assessment to establish medical frailty would be duplicative, would impose an unnecessary administrative burden, and would risk coverage loss for the population

least able to navigate additional procedural steps. The receipt of Medicaid-funded LTSS itself is reliable evidence of both a qualifying condition and the functional impairment contemplated by the IFC's interpretation of the exemption.

Recommendation: CMS should confirm that the receipt of Medicaid-funded LTSS is, on its own, sufficient to satisfy the medical frailty exemption, without any additional documentation or assessment. At a minimum, CMS should permit states to treat the receipt of Medicaid-funded LTSS as presumptive evidence of medical frailty for purposes of an ex parte exemption determination.

3. Allow a longer look-back period for "reliable information" and expand flexibilities for self-attestation of medical frailty.

The accuracy of ex parte medical frailty identification depends on the availability of data. However, several well-documented limitations — including gaps in coverage history for new applicants and recent enrollees, inconsistent provider coding, and the episodic nature of many qualifying conditions — mean that a short look-back window will fail to capture many medically frail individuals. A look-back period of at least 24 months would allow states and their plans to identify chronic and episodic conditions that may not appear within a narrower timeframe. Where data are unavailable or incomplete, self-attestation is an important safeguard against inappropriate coverage loss.

Recommendation: CMS should allow a longer look-back period for "reliable information" when verifying a medically frail exemption and should expand flexibilities for self-attestation of medical frailty where data are unavailable or do not fully capture an individual's condition. These flexibilities would reduce erroneous disenrollments while preserving the auditability CMS expects of state processes. Additionally, CMS should provide clear guidance and support simplified, standardized procedures that states can follow to demonstrate compliance with CMS standards for self-attestation.

4. Permit managed care organizations to leverage health plan data to verify and identify caregivers.

The IFC exempts parents, guardians, caretaker relatives, and family caregivers of a dependent child aged 13 and under or of a disabled individual from the Community Engagement requirement. For individuals who qualify as a specified excluded individual because they reside with and/or are related to a dependent child or disabled individual to whom they provide care, MCOs frequently already hold documentation of the caregiving relationship through functional assessments, person-centered service plans, and care management records, particularly where the care recipient is also a member.

Recommendation: CMS should confirm that assessments, person-centered service plans, and care management records may be leveraged to verify the exclusion of specified excluded individuals.

5. Provide additional guidance on reporting and ongoing monitoring.

The IFC establishes new reporting requirements and indicates that CMS will rely on existing data systems to monitor state implementation, but it leaves important questions about the scope, format, and frequency of reporting and about the role plans may play in supporting state reporting.

Recommendation: CMS should provide additional guidance on reporting and ongoing monitoring, including the specific data elements states will be expected to report, the role MCOs may play in supplying supporting data, and the associated timeframes, so that states and plans can operationalize these requirements in advance of the January 1, 2027, implementation date. CMS should also clarify how it envisions tracking and monitoring coverage impacts, including rates of procedural or administrative disenrollment and erroneous disenrollment of individuals who should be exempt. We note that CMS should also consider procedures for addressing higher-than-expected levels of procedural disenrollment.

Conclusion

The MLTSS Association stands ready to support CMS and states in implementing the community engagement requirement in a manner that is accurate and administrable, and that preserves coverage for eligible individuals. We believe the clarifications and flexibilities described above, particularly those concerning the use of plan data and care management infrastructure to identify exempt individuals, will help CMS and states apply the medically frail and caregiver exemptions accurately while reducing administrative burden and the risk of inappropriate coverage loss for the vulnerable populations our members serve. We appreciate the opportunity to comment on this interim final rule and welcome the opportunity to serve as a resource to CMS as it operationalizes these policy changes.

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

Sincerely,

Mary Kaschak

Chief Executive Officer