July 31, 2026

The Honorable Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Post Office Box 8016
Baltimore, Maryland 21244-8016

Via Electronic Submission

RE: CMS-2454-IFC "Medicaid Community Engagement Requirement for Certain Individuals" Interim Final Rule

Dear Administrator Oz,

Local Health Plans of California ("LHPC") is the statewide trade association representing all 17 of California's public and not-for-profit community-based health plans, which collectively cover 70% of the state's Medi-Cal managed care enrollees or nearly 9 million Californians. California's local health plans play a vital role in delivering health care to low-income and vulnerable populations through the state's Medicaid program (Medi-Cal in California). Local health plans are mission-driven and locally accountable entities whose primary purpose is to serve the Medi-Cal population in their communities.

LHPC is concerned that where rule significantly deviates from previous guidance, implementation of community engagement requirements will lead to avoidable coverage losses among Medi-Cal enrollees who remain eligible for coverage but are unable to navigate new reporting, documentation, or verification processes. Our members have deep experience conducting member outreach, supporting continuity of care, and partnering with the state during major eligibility transitions. However, plans need timely guidance and reliable data sharing to help members understand requirements, document exclusions or exceptions, and avoid inappropriate disenrollment.

Given the truncated timeline for implementing these consequential policy changes, LHPC requests that CMS phase in components of the rule that states could not reasonably have planned for based on prior guidance and technical assistance. We also recommend that CMS reconsider requirements that create unnecessary administrative complexity. The recommendations below describe the operational and implementation barriers that support these requests.

I. **We appreciate that CMS provided public comment on this interim final rule but request consideration for implementation flexibility.** LHPC appreciates the opportunity to comment on the Interim Final Rule with Comment Period. Given the scope of the policy changes from prior informal and verbal guidance, the short implementation timeline, and the significant operational impacts for states, managed care plans, providers, and beneficiaries, CMS should carefully consider stakeholder feedback. CMS should also provide states with implementation flexibility, technical assistance, and sufficient time to design processes that protect eligible individuals from inappropriate loss of coverage.

II. **LHPC is deeply concerned that modifications to the definition of medical frailty will result in administrative disenrollment for the most vulnerable members.** Many Medi-Cal members have complex physical health, behavioral health, cognitive, functional, or social needs that may make it difficult or impossible to meet or document community engagement requirements. CMS should direct states to use administratively simple pathways for identifying medical frailty, relying primary on diagnoses codes in the near term. We acknowledge that utilization history, functional limitations, disability-related needs, receipt of long-term services and supports, serious mental illness, substance use disorder, high-risk pregnancy or postpartum complications, homelessness, and other indicators of clinical or functional vulnerability can all inform whether a condition renders an individual unable to meet community engagement requirements. However, it will take significant time to identify existing data sources and gaps, develop logic, and test before such a methodology could be relied on for purposes of coverage determination. Absent a data solution, we anticipate the burden of verification will land largely on providers and significantly increase administrative burden for those serving Medicaid patients.

    a. ***CMS should remove subjective impairment tests and rely on diagnosis codes for at least the first 24 months of implementation.*** LHPC is concerned that requiring a separate determination that a condition "significantly impairs" an individual's ability to comply would impose burdens on providers, eligibility workers, plans, and members and could lead to inconsistent results for individuals with similar diagnoses. CMS should instead allow states to rely on diagnosis codes to identify medically frail individuals ex parte while providing states adequate time to develop systems to identify impairment using existing clinical data.

    b. ***CMS should require stakeholder-informed tiering and automatic exemptions over the next 18 months.*** CMS should encourage or require states to obtain input from plans, providers, disability advocates, consumer organizations, counties, and other stakeholders to identify conditions and circumstances that should qualify for automatic or presumptive exemption. For conditions that are permanent, long-term, or evident from available data, states should be permitted to rely on diagnosis codes, encounter data, claims, functional assessments, or existing program

eligibility determinations without requiring beneficiaries to submit duplicative documentation.

c. ***CMS should account for claims lag and recurring verification burdens.*** Claims and encounter data may not capture recent diagnoses or treatment because provider billing and encounter submission can lag substantially. CMS should require or encourage states to use at least a 24-month lookback for claims and encounters and to supplement those data with plan screening tools, care management records, disease registries, disability determinations, and other reliable sources. For lifelong, chronic, or episodic conditions such as HIV, substance use disorder, disabling mental disorders, and serious or complex medical conditions, CMS should permit permanent or long-term exclusion designations rather than requiring repeated annual reverification.

III. **LHPC supports the exclusions articulated under the caregiver exemption, however CMS should apply the caregiver exemption broadly and minimize documentation burdens.** The caregiver exemption includes parents, guardians, and family caregivers, reflecting the diversity of family and caregiving relationships. However, we do have concerns that the regulatory language narrows statutory definition of eligible care recipients to exclude individuals with chronic health conditions, disabilities, or functional limitations. CMS should allow states to accept self-attestation of caregiving responsibilities unless the state has reliable information demonstrating that the attestation is inaccurate. There are very limited instances where caregiving can be identified through standardized reliable data sources. Requiring formal proof of caregiving would create barriers for families whose care arrangements are informal, fluctuate over time, or involve individuals who are not connected to a formal service system.

IV. **LHPC supports CMS' approach to recognizing additional pathways for applicable individuals to demonstrate compliance, however there are operational barriers for consideration.** Large scale system changes are necessary to implement the changes to demonstrate compliance and related calculations. The methodology for converting credits into hours inadvertently creates an arbitrary coverage cliff. Taken alone or in combination with other qualifying activities, the calculation of educational credits will leave many members falling just shy of the 80-hour requirement. Coverage decisions could hinge on hundredths of an hour, creating coverage less on a technicality when we understand CMS's policy intent is to encourage meaningful engagement. We recommend CMS round calculated community engagement hours up to the nearest whole hour to simply administration and prevent coverage loss for negligible shortfalls as opposed to meaningful failure to meet the requirement.

V. **CMS should require permanent auditable self-declaration where documentation gaps are predictable and persistent.** LHPC urges CMS to require states to accept auditable self-declarations when reliable electronic data is unavailable and documentation does not ordinarily exist or is not reasonably available. This protection is especially important for unpaid caregiving, substance use disorder treatment and recovery, functional limitations, pending disability determinations, and other circumstances that may not generate an institutional paper trail. Self-attestation should remain available beyond the first year of implementation and should not be limited to a single use during an individual's enrollment period when the underlying condition or circumstance persists.

VI. **We support CMS's requirement for states to first use reliable data, however CMS should more broadly permit self-attestation and align verification with existing data sources.** Verification policies should be designed to prevent eligible individuals from losing coverage because of paperwork, technology access, language access, disability access, or other administrative barriers. While we strongly support the requirement for states to first use available data sources before requesting information directly from beneficiaries, we urge CMS to permit self-attestation where existing reliable data sources are insufficient to consistently verify compliance with the requirements, whether an individual is excluded, or qualifies for an exception. For example, there are no existing reliable and standardized data sources for community service. This puts additional administrative burden on members, local organizations, and county eligibility teams to manually process disparate verification documentation.

VII. **CMS's eligibility framework may limit the effectiveness of Short-Term Hardship Exceptions by requiring individuals to demonstrate compliance before a hardship exception can be applied.** For broad-based exceptions, such as a declared emergency or high unemployment, the order or operations creates unnecessary administrative processing. Moreover, the one-month lookback period for inpatient care does not reflect the realities of acute medical events and will delay Medicaid coverage for members experiencing them. As written, a member hospitalized in January would not be eligible for the short-term hardship exemption because that member did not meet the exemption criteria in December. The regulatory language does not reflect the intent of the policy for members in inpatient settings to qualify for the exception during the time it's needed.

VIII. **CMS should apply good-faith exemptions broadly and provide model implementation guidance.** Given the compressed implementation timeline, concurrent eligibility changes, county and state system constraints, and unresolved operational questions, CMS should apply a broad and permissive standard for good-

faith effort exemptions and delay requests. CMS should also provide model notices, submission standards, verification plan templates, and technical assistance that states can adapt. Where states lack timely data systems, tested member portals, clear documentation standards, or sufficient plan-facing guidance, CMS should allow additional implementation time to reduce avoidable procedural terminations.

IX. **CMS should require timely public reporting and monitoring of community engagement outcomes.** CMS should require states to publicly report implementation data on a timely basis so policymakers, plans, advocates, and community partners can identify coverage losses and operational problems early. Reporting should include applications, renewals, processing timelines, individuals subject to the requirement, compliance pathways, exceptions and exclusions, ex parte verification rates, procedural versus substantive terminations, reconsiderations, reinstatements, and disenrollment reasons. To the extent feasible, CMS should require data to be stratified by geography, age, race, ethnicity, language, disability status, and other factors necessary to assess whether implementation is creating inequitable barriers to coverage.

For these reasons, LHPC urges CMS to finalize implementation policies that preserve Medicaid coverage, reduce administrative burden, and ensure that exemptions and verification processes are simple, accessible, and responsive to the needs of low-income Californians. LHPC looks forward to continued engagement with CMS, the State of California, and other stakeholders to support implementation approaches that protect eligible Medi-Cal members and promote continuity of care.

Sincerely,

Linnea Koopmans
Chief Executive Officer
Local Health Plans of California