Advancing High Performance Health

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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: [CMS-2454-IFC] Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz:

On behalf of AMGA, I appreciate the opportunity to comment on the Medicaid Program; Community Engagement Requirement for Certain Individuals interim final rule.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA recognizes CMS' responsibility to ensure that Medicaid is administered in accordance with statutory requirements and to promote the program's long-term sustainability. We support efforts to encourage active and thoughtful beneficiary participation in Medicaid and to improve program integrity within Medicaid. However, we are concerned that the community engagement requirement in the interim final rule would impose a significant burden on beneficiaries and providers without full consideration of its potential impact on beneficiary coverage, access to care, and provider burden.

Accordingly, AMGA is pleased to offer the following recommendations:

- **Beneficiary Coverage and Access to Care:** AMGA urges CMS to enhance safeguards to minimize procedural coverage losses and ensure Medicaid beneficiaries maintain continuous coverage. AMGA also urges CMS to create a system to track and publicly report data on coverage losses, procedural disenrollments, and measures of healthcare access.
- **Medical Frailty Exclusion and Provider Burden:** AMGA urges CMS to reduce unnecessary burden associated with the medical frailty exclusion, including by extending the duration of the exclusion for beneficiaries who qualify. AMGA also urges CMS to issue standardized guidance and technical support to states and providers regarding medical frailty criteria, documentation, and verification.
- **Elongate Implementation Timeline and Transitions:** AMGA urges CMS to slow the implementation process to account for the complexity of the new requirement and to take into consideration other Medicaid policy changes concurrently underway. At a minimum, CMS should provide at least an additional 12 months of transition time and establish evaluation checkpoints before subsequent implementation phases take effect.

Our detailed comments follow.

Beneficiary Coverage and Access to Care

AMGA is concerned that the interim final rule would result in significant coverage losses for Medicaid beneficiaries, disrupting access to care and posing operational and financial difficulties for multispecialty medical groups and integrated care systems. Although CMS estimates that the community engagement requirement will cut federal and state Medicaid costs, most of these savings are based on expected decreases in enrollment rather than on better health outcomes or improved care delivery.

CMS projects that the community engagement requirement will reduce Medicaid enrollment by 2.3 million individuals in fiscal year (FY) 2027 (accounting for implementation occurring in the second quarter of the fiscal year) and 3.1 to 3.3 million individuals annually thereafter, resulting in an estimated $350.3 billion reduction in federal Medicaid spending and a $41.6 billion reduction in state Medicaid spending over 10 years. CMS attributes these savings primarily to reduced enrollment rather than changes in per-enrollee spending. Specifically, CMS attributes nearly 43% of projected coverage losses (6.4 of 15 percentage points) to procedural disenrollment rather than actual failure to satisfy the community engagement requirement.

Conversely, the Congressional Budget Office (CBO) estimates that 18.5 million adults each year will be subject to the community engagement requirement and will need to regularly demonstrate compliance or prove that they qualify for an exemption.[1] The CBO also estimates that, by 2034, 2.9 million adults subject to the community engagement

[1] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

requirement will lose federal Medicaid coverage, and 2.8 million additional adults will lose coverage because the requirement will add steps to the application process.[2] CBO estimates that the community engagement requirement will increase the number of people without health insurance by 5.3 million.[3]

CMS' estimates underscore that the interim final rule would implement the community engagement requirement in a manner that is far more restrictive than Congress intended. The projected coverage losses are not limited to individuals who fail to satisfy the requirement; rather, CMS' own estimates indicate that a substantial amount of disenrollments would result from procedural barriers and administrative complexity, which is a critical distinction. A requirement intended to promote beneficiary engagement should not operate primarily as a mechanism for eligible individuals to lose coverage because they are unable to navigate new reporting, documentation, or verification processes. Such an outcome would be inconsistent with Medicaid's core purpose and would create avoidable disruptions in access to care. These same procedural and administrative burdens also fall on healthcare providers, who must dedicate additional staff time to help at-risk patients navigate, document, report, and verify their eligibility so that providers can receive appropriate payment for services already provided and services yet to be provided. Accordingly, CMS should adopt alternative implementation policies that better align with the statutory objective, preserve coverage for eligible beneficiaries, reduce the risk that procedural or systems-based barriers become the primary driver of coverage loss, and account for the added administrative costs these requirements impose on providers.

Coverage disruptions affect both Medicaid beneficiaries and their providers. When beneficiaries lose coverage, they often delay or forgo preventive and specialty health services, increasing the risk of preventable complications and poorer health outcomes. Providers are also impacted, especially when uninsured patients seek necessary care. As uninsured patients seek care, multispecialty medical groups and integrated care systems may experience an increase in uncompensated care and bad debt, as well as a greater need for financial assistance programs.

This risk is not theoretical. A recent AMGA member survey found that medical groups and health systems are already absorbing significant financial strain from other Medicaid funding reductions enacted this year: 38% have already eliminated patient services, 21% have already closed or restructured facilities, and 50% have already furloughed or laid off staff, with even larger shares anticipating further cuts. These findings indicate that multispecialty medical groups and integrated care systems have little remaining margin to absorb the additional uncompensated care that would result from procedural coverage losses under the community engagement requirement. Layering new coverage losses onto an already-strained delivery system increases the likelihood that providers

[2] https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf
[3] https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

will be forced to make further reductions in services, staffing, or facilities—compounding, rather than isolating, the impact of this rule.

As one respondent to AMGA's survey explained, "Medicaid was already a challenging payer to engage with due to low/no margins. With the new Medicaid cuts, we will lose even more money per patient and are no longer able to offset that loss with commercial payers or value-based care." Another respondent similarly noted that "[s]hifting the needle from poorly compensated care to uncompensated care will impact almost every service line." These accounts reflect a broader dynamic in which multispecialty medical groups and integrated care systems are being asked to do more with less: Providers are expected to maintain access and quality even as reimbursement is reduced and the pool of insured patients shrinks. CMS should account for this cumulative financial pressure in evaluating the coverage and access impacts of the community engagement requirement.

AMGA urges CMS to enhance safeguards to reduce procedural coverage losses and maintain coverage continuity for Medicaid beneficiaries who are eligible and who should be enrolled seamlessly in the program. We also urge CMS to establish and make publicly available a monitoring and reporting system to track coverage losses, disenrollments, and measures of healthcare access. These measures would help CMS, states, and providers identify unintended consequences of the community engagement requirement early on and minimize disruptions to coverage and care continuity during implementation.

Medical Frailty Exclusion and Provider Burden

AMGA is concerned that the medical frailty exclusion in the interim final rule would impose a substantial burden on providers. Although states are responsible for determining eligibility for the medical frailty exclusion, multispecialty medical groups and integrated care systems will play a significant role in helping Medicaid beneficiaries establish and maintain eligibility for exclusion from the community engagement requirement.

CMS defines medical frailty at Section 435.554(c)(5)(i) "to include an individual: who is blind or disabled (as defined in Section 1614 of the Act); with [a substance use disorder (SUD)], with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more [activities of daily living (ADL)]; or with a serious or complex medical condition (which is defined at §435.554(c)(5)(i)(E))." CMS further defines a medically frail individual at §435.554(c)(5)(i) "as an individual whose physical, mental, or other behavioral health condition *significantly impairs the individual's ability to comply with the community engagement requirement in this subpart*."

AMGA urges CMS to remove the phrase "*significantly impairs their ability to comply with the community engagement requirement*" from the interim final rule because it would make it more difficult for individuals with serious health conditions to obtain the

Medicaid coverage Congress intended. The medical frailty definition already identifies categories of conditions that, by their nature, warrant exclusion from the community engagement requirement; CMS should not require beneficiaries, states, and providers to prove the practical effect of those conditions on compliance. Conditioning the exclusion on an individualized assessment of whether a person can meet an engagement-related requirement would transform a clinical eligibility determination into a burdensome, non-standardized evaluation that is not well-suited to state Medicaid agencies or providers. Such a standard would be difficult and costly for states to operationalize, would invite inconsistent determinations, and may place new documentation and verification burdens on providers without producing a corresponding programmatic benefit.

States have flexibility to determine which conditions qualify for the exclusion; however, the rule requires states to verify both that an individual has a qualifying condition or diagnosis and that the condition significantly impairs the individual's ability to comply with the community engagement requirement. To verify that an individual qualifies for the medical frailty exclusion, states must use all reliable data available, including adjudicated claims and encounter data from the preceding 12 months, before requesting information from the individual.

Historically, states have not used medical frailty determinations to assess whether a beneficiary is capable of complying with a community engagement-related requirement. With the introduction of the medical frailty determination, many states would need to create new policies, workflows, and verification systems to evaluate not only whether an individual has a qualifying medical condition, but also whether that condition impairs the individual's ability to comply with the community engagement requirement. In the absence of clear federal standards and state processes for making this determination, states may look to physicians and other clinicians to provide documentation or attestations regarding a beneficiary's functional capacity, work ability, or ability to satisfy engagement-related requirements. These determinations may extend beyond the typical scope of clinical practice and would impose new documentation, coordination, and administrative responsibilities on provider offices. These burdens could be especially difficult for small and independent practices, including those in rural and medically underserved areas, which may have limited administrative staff and fewer resources to respond to repeated verification requests. The administrative burden also may be significant for integrated systems of care serving large Medicaid populations and coordinating care across multiple specialties and care settings. Without clear, consistent standards for identifying medical frailty and verifying the exclusion, implementation is likely to vary across states, increasing the risk of inconsistent determinations, unnecessary provider burden, and avoidable coverage disruptions for medically frail beneficiaries.

Accordingly, AMGA urges CMS to reduce unnecessary administrative burden by allowing beneficiaries who qualify for the medical frailty exclusion to attest to their exclusion status for four years beyond the existing one-year period, for a total of five years.

Extending the duration of the exclusion would allow for continuity of care and coverage for beneficiaries while states work with stakeholders to develop and implement meaningful processes to assess medical frailty in a way that neither unfairly burdens providers nor results in unnecessary loss of coverage for the medically frail. At a minimum, CMS should permit states to apply a longer exclusion period for beneficiaries with chronic, disabling, serious, or complex conditions that are unlikely to materially improve within a one-year period.

In addition, AMGA urges CMS to provide technical assistance and standardized guidance to states and providers regarding the application of the medical frailty criteria, documentation expectations, and verification processes to promote consistent implementation and minimize unnecessary administrative burden.

Elongate Timeline and Transition Periods

AMGA is also concerned that CMS' proposed implementation timelines do not fully account for the size and complexity of the new community engagement requirement. Sudden implementation of the new requirement could cause major disruptions to the healthcare system before policymakers can fully grasp the impact on patient access and care.

AMGA recommends that CMS adopt an implementation process with realistic timelines, while considering other major changes to the Medicaid program happening simultaneously, including but not limited to significant decreases in Medicaid payment and financing flexibilities. Additionally, CMS should consider the impact of other Medicaid policy changes concurrently underway.

AMGA's member survey confirms that this concurrent strain is already materializing: 62% of responding organizations anticipate having to take further staffing or administrative actions, and 63% anticipate further changes to programs and initiatives, such as population health and social drivers of health investments, in response to Medicaid funding changes already underway. Implementing the community engagement requirement on the same timeline as these other disruptions increases the risk that CMS will be unable to distinguish the effects of this rule from the cumulative effects of concurrent Medicaid policy changes—undermining CMS' own ability to evaluate the requirement's impact.

Providers are simultaneously adapting to numerous changes to Medicaid program administration, including provider tax limitations, which only add to the burden across the payer continuum. At a minimum, CMS should offer an additional 12 months of transition time beyond the initial proposals in the interim final rule. This approach would enable CMS, states, providers, and beneficiaries to better understand the real-world effects and any unintended consequences of implementing the community engagement requirement.

Conclusion
AMGA appreciates the opportunity to comment on the interim final rule. While we recognize CMS' efforts to encourage beneficiary engagement and strengthen the Medicaid program, we urge the agency to consider the potential unintended consequences of the community engagement requirement on beneficiary continuity of coverage, as well as the additional burdens placed on states and providers. We encourage CMS to adopt additional safeguards to minimize coverage losses, reduce administrative burden, and allow for a longer implementation period.

We thank CMS for the opportunity to submit these comments. Should you have questions, please contact Darryl M. Drevna, AMGA's senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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