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

**COMMENT RE: MEDICAID PROGRAM: COMMUNITY ENGAGEMENT REQUIREMENT FOR CERTAIN INDIVIDUALS (CMS-2454-IFC)**

Dear Administrator Oz,

On behalf of the National Association of Counties (NACo) and the National Association of County Human Services Administrators (NACHSA), we write to express concern over the Administration's interim final rile (IFR) implementing Medicaid community engagement requirements. NACo represents the nation's 3,069 county, parish and borough governments, and NACSHA represents county human services directors and administrators responsible for administering public assistance and social service programs at the local level. Given our role in several states performing Medicaid eligibility determinations, as well as serving as providers of last resort across health care systems nationwide, counties are concerned that the IFR will lead to unnecessary coverage loss for Medicaid-eligible residents while imposing significant new uncompensated care costs. As key intergovernmental partners with the states and federal government in the administration and financing of the Medicaid program, counties urge the Centers for Medicaid and Medicare Services (CMS) to substantially revise the IFR to more closely align with the statutory language of H.R. 1 (PL 119-21).

Seven Medicaid expansion states delegate the administration of Medicaid eligibility and enrollment to counties: California, Colorado, Minnesota, North Carolina, North Dakota, Ohio, and Virginia. In New York and New Jersey, the state shares these responsibilities with the counties. For counties in these nine states, H.R. 1's establishment of community engagement requirements within the Medicaid program already represents a substantial and costly increase in program administration. In anticipation of the January 1, 2027 implementation deadline, impacted counties have been actively engaged in designing and operationalizing new business processes, statewide automation updates, guidance materials, staff training, beneficiary notices, and broader implementation strategies. However, in absence of federal implementing regulations, states and counties made many system design decisions (such as changes to eligibility rules and workflows) to meet the implementation deadline without adequate information by relying on a plain-language reading of H.R. 1 as well as informal guidance provided CMS.

Against this backdrop, counties are concerned that the IFR goes beyond H.R. 1's statutory medical frailty exclusion by requiring that a qualifying medical condition also "significantly impairs" an individual's ability to work. Although states are instructed to use diagnoses, encounter information, claims data, and other reliable medical information to identify medically frail individuals, the requirement to also establish the condition's impact on an individual's ability to work makes it more difficult to rely on these existing data sources for identifying and exempting eligible individuals. States are unlikely to be able to create comprehensive lists of diagnosis and procedure codes that capture not only the existence of a serious or complex medical condition, but also whether that condition substantially limits an individual's ability to work. Assessing an individual's ability to work generally requires a case-by-case evaluation that may depend on factors such as education, employment history, and other personal circumstances. Compounding these challenges, the IFR does not clearly define what constitutes a "significant" impairment, creating uncertainty and inconsistency in how the standard may be applied.

The IFR's departure from the plain reading of the statute will require additional staff capacity to reprogram eligibility systems, redo outreach notices, manage new verification workflows, process documentation of exemptions and hardship exceptions, issue and track noncompliance notices and manage substantial coordination across public assistance and workforce systems, beneficiaries, providers, employers, and volunteer coordinators. These operational demands will be extremely costly and difficult to implement by January 1, 2027 – risking significant paperwork and systems errors that could result in unnecessary coverage losses among individuals who are in compliance with the community engagement requirement. Significantly limiting the option for Medicaid enrollees to self-attest (self-report) their medical condition starting in 2028 will further burden program participants, health care providers and the county eligibility workforce.

The IFR's narrowed definition of medical frailty will also likely increase the number of people who are denied or lose health coverage due to the community engagement requirement, exacerbating counties' concerns about rising uncompensated care costs. When eligible individuals are unable to meet community engagement requirements and lose Medicaid coverage, they do not disappear from the health care system — they seek care through county hospitals, community health centers and safety-net providers, who are often required to provide care regardless of ability to pay. Most states mandate counties to provide some level of health care for low-income, uninsured or underinsured residents – care that is often not reimbursed and falls directly to counties. In 2024, approximately 27 million individuals still lacked health insurance, which results in uncompensated care costs for counties upwards of $20 billion annually. Nationwide, over 900 county-supported hospitals—2/3 of which are in rural or small counties—are the providers of last resort, providing care to all patients regardless of their ability to pay. As coverage losses grow, the financial pressure

on county-supported health infrastructure will likely increase, particularly in communities with higher rates of low-income residents.

We urge you to recognize counties as essential partners in Medicaid service delivery and substantially revise the IFR to minimize the additional administrative burden and coverage losses facing counties and their residents. We look forward to continuing our work together as intergovernmental partners to enhance the Medicaid program and ensure that counties can effectively serve our residents. If you have questions, please contact Eryn Hurley at ehurley@naco.org and Rachel Mackey at rm@paragonlobbying.com.

Sincerely,

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National Association of Counties (NACo)

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