July 31, 2026

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Interim Final Rule with Comment Period (IFC) and the Medicaid Community Engagement Requirement for Certain Individuals

To Whom It May Concern:

On behalf of the Medicaid Committee (Committee) of the American Academy of Actuaries,[1] we appreciate the opportunity to offer the following comments regarding the IFC on the Medicaid Community Engagement Requirement for Certain Individuals. Specifically, our comments focus on the interaction of the interim final rule with prospective Medicaid managed care capitation rate development.

Introduction: Volatility and Rate-development Interactions

Actuaries are responsible for ensuring that capitation rates for Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs), (collectively referred to herein as health plans) meet federal requirements for actuarial soundness as defined by 42 CFR § 438.4. Performing this work in times of relative stability is straightforward: The actuary uses historical information and generally accepted actuarial principles and practices to project the historical data patterns forward to estimate future costs, adjusting for any known upcoming changes not reflected in the historical data.

The less information states, health plans, providers, and the actuaries supporting them have about the impact of policy changes on covered populations, the more challenging it becomes to predict future costs. As demonstrated during other recent periods of uncertainty, it is possible to mitigate

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

some of this volatility for some stakeholders. However, given their professional commitment to the public, receiving clear guidance from CMS enables actuaries working within Medicaid to better forecast the populations that will continue to receive Medicaid coverage, while also minimizing administrative complexity and projected cost volatility to the extent possible in the context of government policy priorities.

1. **Requirement to check all reliable information available to the state when verifying eligibility—§ 435.557 (b), § 435.557 (c),**

As proposed within **§** 435.557(b) and (c), the IFC requires state agencies to use information available to them to determine whether applicable individuals meet, are deemed to have met, or are excluded from the requirement to meet community engagement before requesting information from the individual. To the extent that these determinations can be automated, the number of members who need to be reviewed through manual processes is reduced, which reduces administrative burden and complexity. Additionally, to the extent that these automated rules can be applied using historical data, actuaries will be better able to model the impact of the provisions using historical data available to them as part of supporting enrollment and cost forecasts to inform state budgeting and develop actuarially sound capitation rates.

2. **Specified excluded individuals—§ 435.554 (c) (5) (i)**

The IFC defines "medically frail" for community engagement purposes (section § 435.554(c)(5)) separately from the alternative benefit plan (ABP) definition (section § 440.315(f)). The difference between the two is the addition of a primary criterion, "...significantly impairs the individual's ability to comply with the community engagement requirement..." that beneficiaries must meet before states assess that a beneficiary meets conditions that are similar to, but not the same as, the requirements in the ABP definition. While the differences beyond this primary criterion are minimal (for example, the IFC uses "serious or complex" while ABP's definition uses "serious and complex"), the primary criterion adds a notable additional requirement. Currently, states may be able to align the two medical frailty definitions to create a single definition. With this proposed modification, two similar but non-identical medical frailty criteria would apply to the same adult population. In a recent KFF survey, 22 states—roughly half of those subject to community engagement requirements—reported having a medical frailty definition in place today, whether through an ABP, an 1115 waiver demonstration, or other authority.[2]

In the IFC preamble, CMS states that creating a single federal definition was chosen to streamline state processes, rather than allowing each state to maintain its current ability to add

[2] "The Medical Frailty Exemption from Medicaid Work Requirements: Key Issues to Watch for in Upcoming CMS Guidance"; *KFF*; May 27, 2026.

conditions for purposes of the ABP definition. While streamlining processes is an admirable goal, the federal definition appears to lack sufficient specificity to yield a single implementation across states. We believe that this may result in more than 40 new definitions rather than a single one.

Also in the preamble, CMS shared that examples of algorithms to assign acuity scores based on claims data and setting a threshold above which scores would qualify individuals as medically frail have been reviewed.[3] These algorithms could be helpful for implementing these provisions in a way that could streamline and minimize administrative processes that increase costs.

The Committee recommends that CMS share details of the algorithms reviewed, as well as the criteria used to determine compliance with the IFC's requirements.

Additionally, depending on the established criteria for determining medical frailty, there could be an impact on the number of individuals applying for Supplemental Security Income (SSI). With potential uncertainty as to which eligibility group and associated capitation rate cell an individual would fall, as well as the timing of the eligibility determination could further limit the predictability of costs used to develop capitation rates. Consideration should be given to the impact such a shift on SSI program costs, as well as on state and federal Medicaid budgets, given the differential in federal match for adult expansion versus traditional Medicaid populations.

3. **Evolving Data Sources and Verification Process Stability—§§ 435.557(a), (b)(1), (e); 435.945(k)**

The share of beneficiaries who are seen as specified excluded, excepted, or compliant, or deemed compliant with community engagement requirements via an ex parte process is primarily a function of the state's data sources. Any new data source made available through the electronic data service established by the Secretary becomes mandatory for states within 12 months of its first availability per § 435.557(e)(1). In addition, these data source changes affect enrollment outcomes in both directions: verifying beneficiaries who would otherwise face procedural disenrollment or surfacing information that is not reasonably compatible with beneficiaries' attestations. This possibly makes a formerly automated process manual, increasing uncertainty in the population that will continue to be enrolled in coverage as well as commensurate uncertainty in rate setting with every new data source.

The Committee recommends that CMS publish a release schedule for new or updated Federal Data Services Hub data sources with as much advance notice as possible, allowing for prospective consideration in the rate setting process.

---

[3] "Medicaid Program; Community Engagement Requirement for Certain Individuals"; Federal Register; June 3, 2026.

4. Twelve Months of Claims or Encounter Data—§ 435.557(a)

The IFC directs states to verify compliance with the community engagement requirement, exceptions to it, and specifies excluded individual status using reliable information available to the state, which § 435.557(a) defines to include adjudicated claims and encounter data from the preceding twelve months. The reliability of this ex parte step affects the size of the compliant, excepted, and excluded populations, which, in turn, affects enrollment forecasts and acuity assumptions used in capitation rate development, as well as the volume of the caseload that must be verified manually, resulting in additional administrative cost and workload.

Actuaries routinely work with twelve months of encounter or claims data. However, there is often a runout period (generally 6 to 12 months) before querying the data to reflect that care delivered during the 12 months has sufficient time to be submitted, paid, and reported as claims or encounters. A 12-month window of the most recent experience data is likely missing much of its most recent activity; not because nothing happened, but because the claims process has not caught up. Conditions and activities that generate frequent records are reliably captured. Those that generate infrequent or episodic records may not be. A 12-month lookback may therefore fail to identify beneficiaries who may meet an exception or exclusion. Those beneficiaries are routed into documentation requests under section 435.557(b)(2), and some portion of them will not complete the process. They could lose coverage despite qualifying, which could result in an increase in beneficiary churn in and out of the Medicaid population. This likelihood could especially be higher among beneficiaries with less frequent contact with the health care system, such as those facing rural provider shortages, long travel distances to access care, or limited transportation options.

A longer lookback period can reduce the share of excepted months or excluded beneficiaries routed into this manual verification process, as well as reduce the state resources needed to process non-automated applications or renewals.

To reduce the costs of procedural churn and help to mitigate forecasting uncertainty in capitation rate development, the Committee recommends that CMS lengthen the 12-month lookback in section § 435.557(a) to better capture infrequent or episodic qualifying conditions.

CMS may also consider other sources of reliable information available to the state, such as electronic medical records and health information exchange data, in addition to adjudicated claims and encounter data. This information is likely to indicate conditions and utilization at the time of application or renewal that may not show up in claims or encounters until much later.

Managed Care Community Engagement Activities and Value-Added Services—§§ 438.3(e), 438.4, 438.8

The preamble to the IFC states, "...some managed care plans may undertake a variety of enrollee outreach and education processes. For example, managed care plans could provide education on

work program appointment preparation and document collection, establish feedback loops with work programs to enable managed care plans to follow up with enrollees."[4]

In that same section, it also states, "While the costs for these types of activities cannot be included in the development of capitation rates nor counted as *value-added services*, if plans voluntarily elect to provide services that meet the definition of a *value-added service* under § 438.3(e)(1), the services could be included in the medical loss ratio (MLR) numerator as incurred claims." (emphasis added). We request that CMS clarify whether or not these activities can be counted as value-added services, given that the sentence appears to be inconsistent.

If the health plan contract with the state requires the health plan to do something new, then the state actuary would consider the additional value of allowable expenses in terms of the managed care capitation rate.

The Committee therefore requests that CMS clarify which community engagement activities described in the IFC may be considered in capitation rate development for: (1) activities a state requires in its managed care plan contracts, and (2) activities a plan performs voluntarily without a contractual requirement.

The Committee appreciates the opportunity to provide comments on the IFC and the Medicaid Community Engagement Requirement for Certain Individuals. We welcome the opportunity to speak with you to provide more detail and answer any questions regarding these comments. Please feel free to contact Michelle Anaba, Policy Project Manager, Health (anaba@actuary.org).

Sincerely,

Marlene Howard, MAAA, FSA
Chairperson, Medicaid Committee

[4] "Medicaid Program; Community Engagement Requirement for Certain Individuals"; Federal Register; June 3, 2026.