American Network of Oral Health Coalitions

July 29, 2026

Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals, Interim Final Rule

File Code: CMS-2454-IFC

Dear Administrator Oz:

On behalf of the undersigned organizations, the American Network of Oral Health Coalitions (ANOHC) respectfully submits these comments on the Centers for Medicare and Medicaid Services' (CMS) Interim Final Rule implementing the Medicaid community engagement requirement established by H.R. 1, One Big Beautiful Bill Act (OBBBA).[1]

ANOHC is the national membership organization representing state and territorial oral health coalitions across the United States. Our members work collaboratively with public health agencies, health professionals, community organizations, and policymakers to improve oral health outcomes and strengthen prevention efforts. Together, we share a commitment to advancing policies and practices that protect access to affordable dental insurance coverage to ensure lower-income individuals and families can obtain the preventive and restorative care they need to stay productive and healthy.

State oral health coalitions see firsthand how coverage disruptions affect access to dental care, particularly in communities where provider shortages, transportation barriers, limited adult dental benefits, and workforce challenges already make care difficult to obtain. For many Medicaid enrollees, maintaining continuous coverage is essential to receiving preventive services, completing treatment plans, managing ongoing oral health needs, and avoiding more serious disease. Continuous dental coverage also ensures adults are able to obtain and maintain employment.

ANOHC and our members urge CMS to reconsider and revise provisions of this Interim Final Rule that may impose documentation, verification, and procedural requirements beyond what is necessary to implement the statute and that could result in eligible enrollees losing coverage due to administrative barriers rather than actual ineligibility. Coverage losses of this kind could disrupt access to dental care for low-income adults and undermine federal, state, and community investments in prevention, care coordination, workforce capacity, and oral health access.

Coverage losses under this rule are likely to be driven by administrative barriers, not changes in underlying eligibility.

The Congressional Budget Office estimates that OBBBA's work requirement provisions will result in 5.3 million people losing Medicaid coverage by 2034, making it the single largest coverage-loss provision in the law.[2] Independent analyses from the Urban Institute project coverage losses of 3.0 to 7.0 million expansion enrollees from work requirements alone, and a majority of health policy experts surveyed by Cornell University's Health Policy Center agreed that more people will lose Medicaid coverage due to challenges submitting documentation than due to noncompliance with the work requirement.[3] [4]

When Arkansas implemented a Medicaid work requirement in 2018, researchers at the Harvard T.H. Chan School of Public Health found that the policy produced no increase in employment but did produce substantial coverage losses, largely attributable to confusion and administrative burden rather than beneficiaries failing to meet the underlying work standard.[5] Arkansans who lost Medicaid as a result were significantly more likely than those who retained coverage to delay needed care because of cost and to report serious problems paying medical debt.[6] CMS should consider this documented experience directly relevant to how the current rule's verification, documentation, and notice requirements will work in practice.

The Interim Final Rule should minimize administrative burden.

The Interim Final Rule specifies requirements for verification of qualifying activities, outreach to affected populations, steps states must take when they determine individuals are noncompliant, implementation timing, and state reporting requirements.[7] ANOHC is concerned that the rule's phased-in documentation requirements and its approach to the medically frail exemption could push states toward requesting more paperwork from enrollees than is necessary to determine whether an individual meets the requirement or qualifies for an exemption.

Beginning in 2028, the rule permits states to accept self-attestation for the medically frail exemption only once per enrollment period, after which enrollees must produce documentation or reliable third-party data.[8] This approach may be especially challenging for individuals with chronic illness, disability-related needs, behavioral health conditions, or other circumstances that may be difficult to document repeatedly in a format that state eligibility systems can readily process. People with disabilities and older adults in particular are not likely to see their disability or aging-related challenges change.

For eligible enrollees, a single missed notice, inaccessible reporting system, delayed document, or misunderstanding of the process can lead to medical and dental coverage loss.

Coverage losses will worsen oral health outcomes and shift costs downstream.

Oral health is fundamental to overall health. Untreated oral disease is linked to pain, infection, diabetes, cardiovascular disease, missed school and work, difficulty obtaining employment, and avoidable emergency department utilization.[9]

Individuals who lose Medicaid coverage because of a documentation lapse do not stop needing dental care. Instead, they may delay preventive and restorative services until oral health conditions worsen, increasing pain, infection, emergency department use, and avoidable costs. Coverage churn is especially disruptive for oral health because continuity of coverage supports preventive visits, follow-through on treatment plans, and management of chronic dental disease.

Medicaid coverage continuity also supports the broader prevention infrastructure ANOHC members work to strengthen, including early identification of oral disease, referrals to care, care coordination, and connection to community-based prevention programs. State oral health coalitions and public health partners have worked for years to expand preventive dental services, improve care coordination, build workforce capacity, and connect underserved communities to providers. These efforts depend on patients maintaining coverage long enough to receive timely care.

Implementation should protect eligible enrollees from unnecessary coverage loss.

ANOHC urges CMS to require states to use clear, accessible, multilingual notices; provide multiple reporting pathways; conduct targeted outreach; and work with trusted community partners to help enrollees understand requirements and maintain coverage. States should also be required to monitor and publicly report coverage losses, procedural disenrollments, and access impacts, including impacts on preventive and restorative dental care where data are available.

Thank you for the opportunity to comment on this Interim Final Rule. ANOHC and the undersigned organizations urge CMS to ensure that implementation of the Medicaid community engagement requirement protects eligible enrollees from unnecessary coverage loss and does not put access to essential oral health services at risk.

Sincerely,

American Network of Oral Health Coalitions

Alaska Dental Action Coalition

Connecticut Oral Health Advocacy Coalition

Foundation for Health Leadership and Innovation, North Carolina Oral Health Collaborative

HealthPath Foundation of Ohio on behalf of Oral Health Ohio

Idaho Oral Health Alliance

Illinois Oral Health Coalition

Maryland Dental Action Coalition

Michigan Oral Health Coalition

Missouri Coalition for Oral Health

New Jersey Oral Health Coalition

NH Oral Health Coalition

Northeast Ohio Black Health Coalition

NYS Oral Health Coalition

Oral Health Coalition of Alabama

Oral Health Iowa

Oral Health Iowa Steering Committee

Oral Health Kansas

Pennsylvania Coalition for Oral Health

South Carolina Oral Health Action Network

Utah Oral Health Coalition

Virginia Health Catalyst

Endnotes

[1] Centers for Medicare & Medicaid Services, "Medicaid Program; Community Engagement Requirement for Certain Individuals," Interim Final Rule with Comment Period, CMS-2454-IFC, Federal Register, June 3, 2026.

[2] Congressional Budget Office, "Information Concerning Medicaid-Related Provisions in Title IV of H.R. 1," June 24, 2025.

[3] Urban Institute, "Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations," 2026.

[4] Cornell Health Policy Center, "Medicaid and the OBBBA," Cornell Health Policy Insight Panel survey, 2025.

[5] Harvard T.H. Chan School of Public Health, "Coverage losses, substantial confusion in Arkansas following implementation of Medicaid work requirements," June 19, 2019.

[6] Benjamin D. Sommers et al., “Medicaid Work Requirements — Results from the First Year in Arkansas,” New England Journal of Medicine, 2019.

[7] Centers for Medicare & Medicaid Services, “Medicaid Program; Community Engagement Requirement for Certain Individuals,” Interim Final Rule with Comment Period, CMS-2454-IFC, Federal Register, June 3, 2026.

[8] Centers for Medicare & Medicaid Services, “Medicaid Program; Community Engagement Requirement for Certain Individuals,” correction and regulatory text regarding verification of compliance, exceptions, and exclusions, Federal Register, June 29, 2026.

[9] Centers for Disease Control and Prevention, “About Oral Health,” updated May 15, 2024; Centers for Disease Control and Prevention, “Oral Health Facts,” updated May 15, 2024.