July 31, 2026

The Honorable Robert Kennedy
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

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

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Interim Final Rule (IFR) on implementation of work reporting requirements.

Our organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on Medicaid coverage. We have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. Our organizations represent hundreds of millions of patients and consumers facing serious and chronic health conditions across this country.

CMS's IFR on work reporting requirements goes far beyond the framework established by Congress in Public Law 119-21. The restrictive policies in the IFR – most notably provisions narrowing the definition of medical frailty and eliminating the state option to use sworn attestations – will dramatically worsen outcomes for patients with serious and chronic health conditions while at the same time increasing administrative and financial burdens on patients, health care providers, and states. **We request that CMS not finalize the harmful provisions of the IFR, described in more detail below, and instead adopt policies consistent with PL 119-21 and the policy evidence on supporting and improving access to care for individuals living with serious and chronic illnesses.**

Definition of Medically Frail

Current regulations define the term medically frail to include five clinically identified populations (individuals with disabilities, disabling mental health conditions, substance use disorders, functional impairments related to activities of daily living, and "serious or complex" health conditions). PL 119-21 created a broad exclusion to work reporting requirement compliance for individuals who are medically frail and restated the five clinically identified populations in nearly identical terms, recognizing that people who meet these criteria have health conditions that require them to have a regular, consistent source of healthcare coverage to maintain their health. However, in the IFR, CMS transformed the definition of medically frail by adding an entirely new requirement that an individual's identified health condition "significantly impairs the individual's ability to comply with the community engagement requirement." CMS should change the definition of medically frail to make it consistent with PL 119-21 and current policy, and reduce harm and burden to individuals, providers, and states.

CMS's transformation of the definition has no basis in the statute. When Congress uses a term it has previously used, with an established regulatory definition, the best reading of the statute is that Congress meant to apply the term as universally understood. Congress did not *change* the term "medically frail," it *used* the term. The term medically frail has always been tied to an assessment of clinical condition (or daily function)—turning on the existence or absence of at least the five types of health conditions described in the definition. CMS has no reasonable basis to transform the term into a proxy for ability to work.

The IFR's changed definition will create numerous serious problems. First, the definition is much stricter than PL 119-21, meaning many individuals Congress meant to protect from work reporting requirements will be subject to them, and many of these individuals will lose their health coverage. This will include individuals in cancer treatment, with substance use disorders, with mental health conditions, and with many other serious and chronic illnesses.

The narrowed definition in the IFR will also be problematic not only because it conflicts with Congress's definition, but also because it subverts the entire design of Congress's exclusion process by undermining the ability of states to use data-driven identification. PL 119-21 requires states to use data to assess eligibility, including the use of clinical data to assess eligibility for exclusions. Using such data, states

could efficiently identify exclusions based on data sources, without having to resort to burdensome and error-prone processes such as manual verification of documentation sent by mail. By adding a layer of significant impairment assessment onto the clinical eligibility criteria, the IFR makes it much harder or impossible for states to automate their processes. In some cases, providers may be tasked with documenting patients' ability to meet reporting requirements – determinations that are outside the typical scope of diagnosis and treatment. This approach risks placing providers in the untenable position of serving as gatekeepers for Medicaid eligibility and adds significant administrative burdens, diverting resources from patient care. Overall, states, individuals, and providers will have heavy burdens to document medical frailty. In many cases, the system will fail and many individuals will lose their health coverage.

This problem with the medically frail definition in the IFR is gravely compounded by the fact that since at least Fall 2025, CMS had been telling states they would be able to use clinical diagnosis codes to identify exclusions. In reasonable reliance on this guidance, states have built definitions, policies, and infrastructure to implement this policy. Changing the definition only seven months before implementation must begin will result in financial losses and inefficiency for states, and leaves states with an impossible implementation landscape ahead. The IFR itself has ambiguous policies and leaves states with many unanswered questions. Even if the states get answers to their questions, states do not have time to implement the IFR policy by January 2027. Rushed or incomplete implementation will lead to inappropriate coverage losses, with serious and in some cases life threatening implications for the health of the individuals whom our organizations represent.

The significant impairment standard will also create confusion for individuals. Many individuals who do in fact have a qualifying excludable medical frailty condition for work reporting requirements will not understand that they meet the standard, especially if states use language that does not resonate with patients. At the same time other individuals may misapply the significant impairment standard to other exclusions or exceptions where it should not apply. The standard will simply be unintelligible and unworkable for states, providers, and individuals.

Our organizations are also concerned that the significant impairment standard will increase privacy concerns and stigma for patients with sensitive health conditions, such as mental health conditions, substance use disorders, HIV, and others. The increased paperwork and assessments about how health conditions are impacting working hours creates a new layer of state supervision and inquiries about patients that exposes their confidential health and personal conditions.

For all of the above reasons, we recommend that CMS not finalize the "significant impairment" requirement and issue a final regulation that requires only meeting the clinical medical frailty definition–for example, by reference to a diagnosis code, as specified in the statute. CMS should also require states to have processes in places that allow individuals with serious and chronic health conditions that do not have a diagnosis code to be excluded with minimal administrative burden.

Regardless of the standard CMS applies, and including if CMS retains the significant impairment standard, CMS should retract the interpretation on 91 Fed. Reg. 33376 that some conditions (asthma, hypertension, anemia, generalized pain, pre-diabetes, Type I or II diabetes, obesity, psoriasis, headaches, and Attention-Deficit/Hyperactivity Disorder) may <u>not</u> give rise to significant impairment and/or medical frailty. Nothing in PL 119-21 authorizes such a *further* limitation on the significant impairment standard which itself is a limitation inconsistent with PL 119-21. Furthermore, CMS's

interpretive statement is likely to lead states to categorically exclude diagnoses and conditions which in many cases are in fact significantly impairing. CMS's policy ignores multiple realities of living with serious and chronic illnesses –the fact that these conditions often present as comorbidities in combining and multiplying and debilitating ways, and most importantly, how varying and severe these conditions can be. This is given explicit consideration, including for some of these particular conditions, in the 1999 Institute of Medicine (IOM) report CMS uses to identify serious and complex conditions (discussed further below). For example, obesity can be directly associated with severe immobility, Type 1 diabetes can have regular and severe health complications, and anemia can be life-threatening. **CMS should remove the interpretation that some conditions are not significantly impairing because it is overbroad and will lead to clear harms.**

The IFR prohibits states from adding criteria to the medically frail standard. However, the text of PL 119-21 does not specifically prohibit additional state criteria, and Congress, when it selected the medically frail standard, knew it was using a term that is currently interpreted to include state flexibility in definition. The plain meaning of the terms "medically frail" and "special needs" is broad enough to include criteria beyond the five identified in the IFR. In the preamble to the IFR, CMS specifically identifies homelessness as an example of a prohibited criteria. However, homeless populations are both medically frail and have special needs and policy evidence would strongly support promoting continuity of coverage for homeless individuals by excluding them from work reporting requirement compliance.[1] **Our organizations urge CMS to finalize flexibility for states to make reasonable additions to medical frailty criteria.**

Our organizations also have recommendations on specific prongs of the medical frailty definition in the IFR. First, we support the IFR's definition of disability, correctly implementing the PL 119-21 text and based on *having* a section 1614 disability, regardless of whether a 1614 *determination* has been made. In regard to disabling mental health conditions, if CMS needs to give meaning to the term "disabling," CMS should do so subject to two conditions. First, CMS should implement a definition that offers a *clinical* basis for definition–in other words a showing of heightened illness, but not heightened reduction in employability. The former can be operationalized and automated with reference to clinical data and records, while the latter requires a layer of non-clinical evaluation that providers are not prepared to conduct and states cannot easily automate. Second, in all cases, the "disabling" standard for this purpose should be materially less stringent than a section 1614 disability. It would make little sense for Congress to create a broad exclusion based on section 1614 disability and then an entirely redundant exclusion for 1614 disabilities based on mental health.

Regarding substance use disorders, **CMS should also not finalize the limitation of the SUD exclusion for individuals in "stable recovery."** CMS's regulatory limitation has no basis in the statute. More importantly, we do not believe CMS's policy is consistent with broad evidence on addiction[2] (the

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[1] Rachel M Everhart et al., "Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients," *Health Affairs Scholar,* Vol. 4(7), July 2026, https://doi.org/10.1093/haschl/qxag162; Sarah Gillespie and Tracy Johnson, "Medicaid is Essential for Addressing the Homelessness Crisis. The Reconciliation Bill Would Make It Worse." *Urban Institute,* June 24, 2025, https://www.urban.org/urban-wire/medicaid-essential-addressing-homelessness-crisis-reconciliation-bill-would-make-it.

[2] Heather Saunders et al., "Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders," *KFF,* June 23, 2025, https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/; Deborah Steinberg, "CMS Approach to Work Reporting Requirement Won't Work for People with Substance Use Disorders or Mental

evidence cited by CMS in the IFR applies very narrowly), and it will be harmful to patients and arbitrary and problematic to administer (for example, in most cases there is no reliable way to identify when the recovery period begins).

For individuals with functional impairments related to activities of daily living (ADLs), PL 119-21's use of "impairment" in the context of ADLs refers to ability to do the relevant ADLs (bathe, dress, etc.) and does not refer to employability. CMS should not define impairment based on employment nor require "total" impairment. We note that ADL impairment status is difficult to ascertain from medical records, and this is a clear reason that CMS should enable sworn attestation for exclusions (discussed further below).

Finally, while CMS's selection of a 1999 term from the IOM to define serious or complex health conditions is an arbitrary choice, it may help states operationalize the definition. However, it may be unduly narrow for some conditions. **We request that CMS add to the definition to include conditions that meet the 1999 IOM definition *or that are otherwise deemed by the state to be serious or complex*.** Considering that state flexibility to make such determinations is part of the medical frailty definition that was in place when Congress passed PL 119-21, this is the best reading of the statute.

Verification and Use of Sworn Attestations

In PL 119-21, Congress legislated a data-driven approach to work reporting requirement compliance, exclusions and exceptions *and* specifically gave the states the option to use sworn attestation to verify. Numerous policies in the IFR violate the letter and spirit of PL 119-21, and we request that CMS remove these provisions from the final regulation, as described below.

Our organizations support CMS's generalized requirement for states to pursue ex parte information and maximize the use of data sources before requesting information from enrollees. We urge CMS to take a proactive approach in enforcing these requirements, to ensure that states make efforts and investments to use potentially available data sources. However, it is also vitally important that CMS and states do not exclusively rely on data sources such as ICD-10 codes to drive ex-parte reviews. As CMS notes specifically in the IFR, certain conditions are prone to being left off such lists due to their rarity, and it is crucial that those patient populations still have the benefit of ex-parte review.

We do not support, however, CMS's decision to limit the use of claims and encounter data to verify information to the prior 12 months. There are many types of information that would still be entirely relevant and actionable if 18 months old, and in many cases much longer. Twelve months is an arbitrarily selected date that will be extremely underinclusive of health information available for individuals with serious and chronic illnesses and is also inconsistent with many other data lookbacks that are two year lookbacks (such as CMS's Chronic Conditions Warehouse). The policy is even less reasonable when considerable data lag times are considered. For example, CMS policy allows providers

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Health Conditions," *Georgetown University Center for Children and Families,* July 9, 2026, https://ccf.georgetown.edu/2026/07/09/cms-approach-to-work-reporting-requirement-wont-work-for-people-with-substance-use-disorders-or-mental-health-conditions/; Deborah Steinberg, "Protecting People with Substance Use Disorders and Formerly Incarcerated Individuals from Losing Medicaid Coverage: Recommendations on Implementing the H.R. 1 Work Reporting Requirements," *Legal Action Center,* September 3, 2025, https://www.lac.org/resource/protecting-people-with-suds-and-formerly-incarcerated-individuals-from-losing-medicaid-coverage-recs-on-implementing-hr1-work-reporting-requirements.

12 months to submit a bill (42 C.F.R. § 447.45.), and if there is a managed care organization involved, there will be additional time lags before the state sees data about a service provided. **CMS should allow consideration of any data from the past 5 years as a default, and should allow states to always include information that is unlikely to change (such as a permanent health condition or disability).**

Most importantly, the IFR implements an impermissible and harmful standard with respect to sworn attestations. Under PL 119-21, states have the option of using sworn attestations alone to verify various exceptions and exclusions. The IFR, in contrast, allows sworn attestation generally only until the end of 2027, and for medical frailty only adds a one-time attestation allowed starting 2028. In all cases, states lose the option to have on-going sworn attestations. This policy directly contravenes the flexibility explicitly granted in PL 119-21.

In addition to violating the statute, the policy will be very harmful to individuals with serious and chronic health conditions. Congress included the sworn attestation flexibility because many types of exclusions will be impossible to prove through data-driven methods *or* by documentation. For example, only about half of people with mental health conditions receive treatment,[3] and many rely on support groups or other services that might not have documentation. The sworn attestation option is critical to many individuals being able to qualify for the exclusion or exception that they are *fully eligible* for, and without which they will lose their health insurance. **CMS should finalize the regulation without any limitations on sworn attestation, to protect individuals with serious and chronic health conditions as required by PL 119-21.**

Our organizations support and believe CMS should expand upon its rule that individuals with medical frailty can be granted the exclusion for a full year, at state option. **We believe CMS should expand the policy by (1) not making it a state option and (2) allowing states to offer longer durations for exclusions when consistent with the exclusion granted.** For example, permanent conditions should allow for a permanent exclusion (or at a minimum one requiring validation every five years).

Finally, we support some of CMS's provisions that address the duration of exclusions for select populations, including Veterans with a permanent rated disability, American Indian/Alaska Native individuals, and former foster care youth, and recommend CMS should finalize those.

Optional Exception for Short-term Hardship Events

Under PL 119-21, states have the option of selecting four short-term hardship exceptions–for inpatient or related medical treatment, areas with high unemployment, areas with emergency or disaster declarations, and medical travel. These exceptions will be particularly important for individuals with chronic illness, who may apply for Medicaid (for the first time or after losing coverage) during a hospitalization for their condition, or may have to travel to receive treatment for their (or their dependent's) medical treatment.

PL 119-21 and the IFR create a gravely problematic operational paradox for claiming the short-term exception for inpatient or related treatment. An individual who *should* be eligible in a given month because they have been hospitalized in that month and applied for Medicaid in that month, cannot receive the exception because the review process only evaluates whether the exception was applicable in the month *prior* to application (when the individual was not yet hospitalized). This operational flaw,

[3] Statistics - National Institute of Mental Health (NIMH). Available at https://www.nimh.nih.gov/health/statistics.

which CMS has not rationally addressed in the IFR, will render Congress's exception useless in practice, and many individuals with serious and chronic illnesses, in many cases workers with serious and chronic illnesses, will lose or be denied Medicaid coverage precisely when they need inpatient or related care. **We request that CMS implement an exception to the work reporting requirement review process allowing that, for purposes of any short-term hardship event (and at a minimum, the hospital or inpatient care hardship), an individual may qualify if the event occurred in the month prior to application or the current month of application.**

PL 119-21 creates a short-term exception if an individual or their dependent must travel outside of their community for medical services. This exception will be critical to individuals with serious and chronic conditions who frequently need to travel to receive exceptional or regular treatment that is specialized and not locally available. The IFR correctly identifies that in many cases, a dependent may need extended medical travel for specialized services, yet the parent or guardian cannot travel with them because they have other children at home, among other reasons. Even from far away, parents are actively engaged and dedicating countless hours to their dependent's medical care, especially when it comes to serious or complex medical conditions. The IFR acknowledges these complex situations by specifying that an applicable individual can qualify for this hardship event if they show they took leave from work, school, or other qualifying activities for reasons related to the dependent's condition or travel. **We recommend that CMS finalize the IFR policy interpreting the short-term hardship event for extended medical travel (at § 435.555 (d)(4)) to include circumstances where the applicable individual's dependent is traveling for medical care but the parent or guardian does not travel with them.**

Congress intended to protect residents from losing essential health coverage during temporary, unavoidable events, including individuals living in a county "in which there exists an emergency or disaster declared by the President." The IFR narrows this protection for those living through a National Emergencies Act (NEA) declared emergency, adding an extra step requiring that the emergency must "affect[] the ability of applicable individuals to demonstrate community engagement" in that area. Not only does this extra limit have no basis in the statute, it imposes unworkable obligations on state Medicaid agencies – obligations that are ambiguous yet carry high financial risk. The IFR does not explicitly require CMS approval for an emergency hardship exception to take effect, but the rule notes that "CMS will review states' use of and implementation of [this] exception." Under the IFR's vague requirements, it is entirely unclear how states should decide whether and when the residents of a county in an NEA emergency can qualify for the emergency hardship event. Even if a state spends time and resources to implement systems for determining that an emergency "affects the ability" of individuals to meet work reporting requirements, states may still face penalties later if CMS arbitrarily decides their criteria or process for determining the emergency exception is not sufficient. **CMS should not finalize the provision at 435.555(d)(2)(i) that narrows the short-term hardship exception for declared emergencies by requiring that the emergency affect the ability of applicable individuals to demonstrate community engagement.**

Populations Subject to Work Reporting Requirements

Under the IFR, CMS would apply work requirements even to small section 1115(a)(2) demonstrations. While PL 119-21 explicitly applies work requirements to Medicaid expansion and was clearly intended to apply them to large expansion-like demonstrations, like Wisconsin's section 1115 Medicaid expansion demonstration, CMS should not apply work reporting requirements to very small, targeted expansions. It takes a great amount of administrative effort for states to develop and apply work reporting

requirements to a categorical population, and it is extremely inefficient to make a state do extensive administrative work for a tiny population.

In addition, in many cases the eligibility criteria for these small demonstrations make it likely that the overwhelming majority—if not all—of the enrolled individuals are eligible for exceptions and exclusions based on eligibility factors such as serious and chronic health conditions, including HIV, substance use disorders, mental health conditions, or functional impairments, or otherwise by status as parents or other caregivers. Finally, in many cases the demonstrations are targeted to individuals *above* standard income limits, meaning that all (or almost all) the individuals would be compliant with the $580 per month income proxy. CMS's interpretation should not force states (and individuals and CMS) to engage in extensive implementation and administrative work when almost no one will be impacted by the policy. **CMS should retain the exclusion of §§ 1915 and 1115(a)(1) waivers in the final regulation, but narrow the applicability of work reporting requirements s to large § 1115(a)(2) demonstrations that implement coverage for most or all of a Medicaid expansion group.**

Specified Excluded Individuals (other than Medically Frail)

The IFR (at § 435.554) sets out numerous categories of Specified Excluded Individuals whom Congress defined as excluded from demonstrating work reporting requirements, including certain former foster care youth, certain American Indian/Alaska Natives, parents, guardians or family caregivers to a child 13 and younger or disabled individual, veterans with temporary or permanent total disability ratings, those compliant with TANF work requirements, individuals in a household subject to SNAP work requirements, individuals who are medically frail or otherwise have special medical needs, individuals participating in drug or alcohol treatment and rehabilitation, and pregnant or postpartum individuals.

We support the IFR's broad framework requiring that if an individual qualifies as Specified Excluded, they are not subject to work reporting requirements when applying or renewing coverage and states may not evaluate the individual for compliance with work or other qualifying activities at application, renewal, or in between renewal periods (435.553(b)). Individuals with known basis for exclusion, such as a serious or chronic illness, should not be subjected to burden and confusion related to assessment of compliance activities.

PL 119-21 includes a Specified Exclusion for individuals who are participating in a drug addiction or alcohol treatment and rehabilitation program. However, the IFR provision implementing this exclusion (at § 435.554(c)(8)) allows states to narrow the exclusion by requiring a minimum time commitment for participation in the treatment program. There is no basis for this exclusion in PL 119-21 and it will add barriers to health coverage for individuals who are in the earliest stages of some kind of SUD treatment–potentially when they are most at risk. It will also create red tape and barriers, potentially making an individual or their health provider track, verify, and submit their hours, and potentially losing benefits simply because of missing paperwork. It will also be very difficult to practically quantify the current treatment period, because SUD treatment and recovery is often not a regular or linear process, and treatment schedules vary by type of addiction and stage of treatment. **CMS should remove the final sentence of § 435.554(c)(8) allowing states to establish minimum time commitments.**

CMS notes in the preamble that "[c]onsistent with existing requirements under § 435.956(e), the State must accept an attestation of pregnancy or entitlement to postpartum medical assistance unless the State has information that is not reasonably compatible with such attestation" (91 Fed. Reg. 33408). **CMS should explicitly require states to accept attestation for pregnancy and postpartum status in the**

regulatory text itself in § 435.557, relating to verification of exclusions, exceptions, and compliance for work reporting requirements.

Under PL 119-21 and § 435.554(c) of the IFR, Specified Excluded Individuals includes "parents, guardians, caretaker relatives, and family caregivers...of a dependent child 13 years of age and under or a disabled individual." Individuals living with serious and chronic illnesses–including both children and adults–often depend upon caregivers of all kinds to support their health care, function, and health and well-being. Protecting the healthcare of these caregivers is critical to individuals, families, and communities. We generally commend CMS's approach, consistent with the statute, to cover a broad range of caregiving scenarios and arrangements that characterize family life across America. **We specifically support and recommend that CMS retain policies allowing multiple caregivers in a single household to qualify for the caregiver exclusions, clarifying that parents eligible for the exclusion may include those who live or do not live with a child, and adopting the current definition of "caretaker relative" (in §§ 435.110 and 435.4) as states are already familiar with applying it to the Section 1931 Parent/Caretaker Relative Medicaid group.**

Assessment of Compliance

Our organizations specifically support and urge CMS to finalize several sensible interpretations in the IFR of how compliance with work reporting requirements should be assessed. **We recommend that CMS finalize the provision at § 435.556(a)(2) interpreting compliance at renewal to be based on any month (or months) since the prior renewal, whether or not consecutive. We also recommend that CMS finalize the provision at § 435.559(c) requiring states to verify compliance for renewals *initiated* on or after the implementation date.**

Our organizations also recommend that CMS finalize the provision at § 435.557(d)(4) generally prohibiting states from reverifying specified excluded status between regularly rescheduled redeterminations. We do not recommend CMS finalize the language "unless the agency has information indicating the individual's specified excluded individual status has changed," as it is not clear Congress intended this narrowing and it may reduce coverage for individuals during important transition periods.

Noncompliance Procedures

PL 119-21 sets out a detailed process states must follow before ultimately terminating an individual's coverage due to failure to comply with work reporting requirements. A carefully sequenced and sufficiently long process and timeframe is critical for individuals with serious and chronic illnesses who may struggle to navigate the rules or gather documentation to secure exclusions they are eligible for. In some cases, this may be a direct result of health and functional complications directly related to their health condition (hospitalization, vision impairment, immobility, depression, etc.) and in other cases it may be because of delays in obtaining medical records, certifications, or other documents.

First, our organizations specifically support the clarification at § 435.558(a)(3), as described in the preamble (at 91 Fed. Reg. 33411), and required under Medicaid law, that regardless of the timing and response to the noncompliance notice and review period, states must at a minimum continue coverage during the 30-day noncompliance window *as well as* "continue to furnish Medicaid to enrolled beneficiaries until an individual is determined ineligible consistent with long-standing regulations at § 435.930(b)" (91 Fed. Reg 33411). **We request that CMS finalize § 435.558(a)(3).**

However, we have concerns with the noncompliance sequencing options CMS allows for states during renewal. Under normal Medicaid process, when individuals are renewed, individuals may be sent prepopulated forms to provide information needed to confirm eligibility. Under the IFR, states must send individuals noncompliance notices, specific to work reporting requirement compliance, when they have not been determined compliant with the work reporting requirements or eligible for an exception or exclusion. Individuals must then be granted 30 days to demonstrate they are compliant or eligible for exception or exclusion. In the IFR, at § 435.558(b)(2), CMS effectively allows states two options for aligning these processes. First, states can send the prepopulated forms and noncompliance notice *contemporaneously*. Second, states can do these steps *sequentially*; sending the prepopulated form followed by a noncompliance notice (if needed).

Our organizations urge CMS to abandon the first option, and require states to implement these processes sequentially, for numerous reasons. First, of course, in many circumstances the prepopulated form will be necessary to properly evaluating work reporting requirement compliance for the purpose of a noncompliance notice. It is thus inefficient and wasteful to run the processes at the same time. Second, it will be extremely confusing for individuals to receive a form asking for more information–to which a response is necessary to continue their enrollment–*at the same time* as a form telling them they have been found noncompliant. Many individuals will give up, never send in forms necessary to establish their eligibility, and end up disenrolled despite being eligible and compliant. Moreover, in many states the form and notice, each of which requires a response and was received at the same time, will have different deadlines for responding. This will be incredibly confusing to individuals and will result in many missed deadlines due to reasonable and entirely predictable misunderstandings. Finally, doing things sequentially also reduces the burden on individuals, who will have only *one* thing to respond to at a time. This is especially important for work reporting requirement compliance, which may require significant effort to understand and gather documentation to establish compliance. **We recommend that CMS eliminate the option (as allowed at § 435.558(b)(2)(i)) to send prepopulated forms and noncompliance notices contemporaneously, and instead only deem the state unable to verify work reporting requirement compliance *subsequent* to review (or nonsubmission) of a prepopulated form (as per § 435.558(b)(2)(ii)).**

There is a similar concern for new applications. In some instances, states follow up a new application with a request for information (RFI), creating the same sequencing question as with renewals. The IFR regulatory text is silent on the sequencing for applications, however the preamble seems to suggest that states must complete the RFI first; the preamble would not allow a state to deem an individual noncompliant until the individual fails to "provide…additional information or documentation requested by the State." In any case, our organizations recommend that CMS align the policy for new applications with our recommendation for renewals. **We recommend that CMS modify § 435.558(b)(1) to only deem a state unable to verify work reporting requirement compliance pursuant to a new application *subsequent* to review (or nonsubmission) of an RFI or similar request for additional information.**

Outreach Notices

The IFR sets out state requirements for outreach at § 435.561. While the IFR is generally faithful to the statutory requirements, our organizations are concerned that states will send outreach notices to categorical populations who are not subject to work reporting requirements, leading to great confusion and potentially disenrollments or access to care issues for individuals believing (incorrectly) they have lost or are going to lose their coverage. This could put coverage and care at risk for many individuals with serious and chronic illnesses qualifying through disability related pathways, as well as pregnancy or

parental status. The regulatory text at § 435.561(a) sets a floor for who must be provided notice; we recommend that it be both a floor and ceiling. **Our organizations request that CMS clarify (in the final regulation but also through immediate guidance) that states should only send the outreach notices to categorically relevant groups, as described at § 435.561(a).**

Furthermore, we are concerned that individuals who receive work reporting requirement-related notices (both initial outreach and on-going communications) will be confused or need help, and not know who to contact for assistance. **We recommend that CMS add a requirement to § 435.561(c) requiring state notices to include clear information and contact details about how individuals can get further assistance, including from state call centers.**

Data Reporting

Our organizations commend CMS for including provisions for state data reporting requirements in the IFR. State data will be critical for states, CMS, and the public to understand the impact of work reporting requirements, including which individuals with serious and chronic health conditions and other populations, are having trouble complying with or qualifying for exceptions and exclusions. While we commend CMS's intent, we consider two additional improvements essential to the data reporting requirements. **First, CMS should require more disaggregated data fields to improve precise identification of the impacts of the policy. Second, it is absolutely critical that CMS require the data to be made publicly available.** This is foundational to transparency, as well as essential to ensure that a broad community can understand and analyze the function of work reporting requirement systems.

Waiver of Work Reporting Requirement Standards

PL 119-21 prohibits waiver of the work reporting requirement standards set out in PL 119-21. **We support the provision at § 435.563 implementing PL 119-21's prohibition against the waiver of § 1902(xx) standards, in whole or in part.**

Good Faith Effort Exemption

PL 119-21 gives the Secretary authority to approve delays in work reporting requirement implementation for states experiencing delays despite making a good faith effort to implement this policy. Based on our extensive work in and with states, our organizations believe states are making tremendous efforts to implement work reporting requirements, clearly in good faith. Considering the short time frames for implementation, the complexity of reprogramming state eligibility systems, and the significant changes in policy required under the IFR, it is inevitable that many states–likely most states–will be materially unprepared to operate work reporting requirements on January 1, 2027. Most urgently, states will be unprepared to provide the required notice to enrollees in August 2026.

If states are unprepared yet move forward with work reporting requirement notices in August and implementation in January, many individuals with serious and chronic illnesses will be seriously harmed. Many individuals who should be found compliant or eligible for exceptions or exclusions will lose their health coverage, while those who may remain eligible will do so only after struggling to understand unclear policies and navigate dysfunctional systems–struggles which themselves may aggravate their health conditions. In particular, we have two concerns with this section of the IFR on behalf of individuals with serious and chronic illnesses.

First, we are deeply concerned with CMS's estimate in the IFR preamble that only two states will receive good faith effort exemptions and stated policy that approvals "will be limited to States that …

experience extraordinary, severe, or unexpected issues" (91 Fed. Reg. 33418). Given our well-founded belief that most states will be unprepared to properly implement work requirements on January 1, 2027, and that this will cause serious harm to individuals, it is very concerning that CMS anticipates issuing only two approvals. States are implementing a historic policy with incredibly risky consequences for individuals with serious and chronic illnesses. CMS has the authority to protect those individuals and should use that authority as often as needed to protect people.

Second, our organizations recommend that CMS eliminate the provisions in the IFR (at § 435.560(c)) that create artificial time limits for good faith exemptions–particularly the six month increments for approval. CMS should implement the exemption, as suggested in the IFR, on a case-by-case basis based on the actual and reasonable timeframes needed by states, not an arbitrary six month increment. This is important because states implementing complex systems (such as eligibility systems) need certainty about when their system will need to "go live", and some processes need more than six months. For example, a state that does not have certainty that it will get more than six months will be unable to move forward with a process that it reasonably expects to take nine months to be completed; the mere possibility of an extension at month six is not enough certainty for states to undertake complex and expensive systems changes. **Our organizations recommend that CMS grant good faith exemptions to all states that need one, approve them for the time period states need to implement well functioning systems, and retract any policies (such as at § 435.560(c)) setting arbitrary timelines such as six months.**

Harms to Individuals with Serious and Chronic Health Conditions and the Healthcare System They Rely Upon

The policies of the IFR will be extremely harmful to people with serious and chronic health conditions. CMS's policy ignores ample evidence from past work reporting requirements and other relevant data that demonstrates the policies will be harmful.

The IFR seems to ignore that Congress included specific protections for medically frail individuals because it is well established that such individuals lost coverage during prior experiments. When Arkansas tried work reporting requirements, "[p]eople with disabilities were particularly vulnerable to losing coverage … despite remaining eligible."[4] In both Arkansas and New Hampshire, a relatively large percentage of individuals failed the work reporting obligation, yet only a small fraction of them were non-workers who were not eligible for an exception.[5] In 2020, experts concluded that among three states that implemented or were about to implement work reporting requirements, "evidence suggests

[4] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," KFF, June 11, 2019, https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018.

[5] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," KFF, June 11, 2019, https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018; Ian Hill et al., "New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results," Urban Institute, February 10, 2020, https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results.

that people who were working and people with serious health needs who should have been eligible for exemptions lost coverage or were at risk of losing coverage due to red tape."[6]

In addition, Congress created a simple path to obtain exclusions–including a data driven approach *and* the state option to use sworn attestations–because past evidence also shows that many individuals struggled to navigate the process.[7] As described above, the IFR undermines both of these protections. In Georgia's current work reporting requirement waiver, paperwork has been a major reason for coverage loss.[8]

Past evidence from Medicaid work reporting requirements shows that most enrollees won't know about these requirements, much less the detailed processes for compliance.[9] The evidence shows that during past implementations of work reporting requirements, there were major communication failures with individuals, and the PL 119-21 policies on data and sworn affidavits were designed to mitigate that.[10] Even CMS has itself noted, in qualitative research conducted with Medicaid enrollees in April 2026, that many potential enrollees have difficulty determining if they qualify for an exclusion under the new law.[11]

CMS's policy approach, making it harder for people with serious and chronic health conditions to access exclusions and retain their health insurance, is also counterproductive because it ignores the policy evidence that health insurance–specifically Medicaid expansion–*helps* people work and search for work, and this is especially true for people with serious and chronic illnesses.[12]

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[6] Jennifer Wagner and Jessica Schubel, "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements," Center on Budget and Policy Priorities, November 18, 2020, https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements.

[7] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," KFF, June 11, 2019, https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018.

[8] Leah Chan, "Pathways to Coverage: Looking Back Two Years and Into the Future," Georgia Budget and Policy Institute, October 13, 2025, https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future.

[9] Benjamin D. Sommers et al., "Medicaid Work Requirements — Results from the First Year in Arkansas," The New England Journal of Medicine, Vol. 381 (11), June 2019, 10.1056/NEJMsr1901772; Ian Hill et al., "New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results," Urban Institute, February 10, 2020, https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results..

[10] MaryBeth Musumeci, et al., "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees" (Kaiser Family Foundation, December 2018), available at https://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees; Concord Monitor, "New Hampshire Medicaid work requirement faces crucial test," July 6, 2019, https://www.concordmonitor.com/New-Hampshire-Medicaid-work-requirement-faces-crucial-test-26791579; Ian Hill et al., "New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results," Urban Institute, February 10, 2020, https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results..

[11] HHS CMS. (2026). *Medicaid Community Engagement Requirements: Qualitative Research Communication Summary*. https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/resources/Community-Engagement-messaging.pdf.

[12] Tipirneni, R. et al., "Association of Expanded Medicaid Coverage with Health and Job-Related Outcomes Among Enrollees with Behavioral Health Disorders," Psychiatric Services, Vol. 71(1), September 2019, https://doi.org/10.1176/appi.ps.201900179; Ohio Department of Medicaid, "Ohio Medicaid Group VIII

The IFR will also be harmful to state health care systems, triggering large increases in uncompensated care, particularly in rural areas where jobs may be most scarce and healthcare systems may be operating at financial losses and subject to hospital closures.[13] Medicaid expansion coverage supports states and providers.[14]

The IFR's unduly restrictive policies will result in many individuals with serious and chronic illnesses losing Medicaid coverage. The harms associated with this are serious, as Medicaid expansion has been associated with many benefits for enrollees, from health care access to financial security.[15] The harms associated with loss of coverage under past Medicaid work reporting requirements were serious.[16]

Finally, it is important to note that while the Medicaid expansion does not include individuals younger than 19, the harms to adults will hurt children. Evidence consistently shows that children are less likely to have coverage if their parents are uninsured.[17]

Conclusion

While it is impossible to fully shield patients from the impact of the devastating cuts coming to the Medicaid program, our organizations are committed to working with federal and state policymakers throughout the implementation process to set policies that protect access to Medicaid. Our organizations therefore urge CMS not to finalize the harmful provisions of the IFR, described above, and instead adopt policies consistent with PL 119-21 and the policy evidence on supporting and improving access to care for individuals living with serious and chronic health conditions.

Thank you for the opportunity to provide comments. Our comments include numerous citations to supporting research, including direct links to the research, for HHS's benefit in reviewing our comments.

Assessment: A Report to the Ohio General Assembly," August 2018, https://medicaid.ohio.gov/static/Resources/Reports/Annual/Group-VIII-Final-Report.pdf; Tipirneni, R. et al. "Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: A Mixed Methods Study," *Journal of General Internal Medicine*, Vol. (34)(4), December 2018, 10.1007/s11606-018-4736-8 .

[13] https://www.nationaljournal.com/s/677535/medicaid-work-requirements-could-hit-rural-hospitals?; Cecil G. Sheps Center for Health Services Research, "197 Rural Hospital Closures and Conversions since January 2005," available at https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures; Center for Healthcare Quality & Payment Reform, "Rural Hospitals at Risk of Closing" (May 2026), available at https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf; Office of Senator Edward J. Markey, "Letter on Rural Hospitals," June 12, 2025, https://www.markey.senate.gov/imo/media/doc/letter_on_rural_hospitals.pdf.

[14] Madeline Guth and Meghana Ammula, "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021," KFF, May 6, 2021, https://www.kff.org/affordable-care-act/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021.

[15] Madeline Guth and Meghana Ammula, "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021," KFF, May 6, 2021, https://www.kff.org/affordable-care-act/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021; Luojia Hu, et al., "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," Journal of Public Economics, Vol. 163, May 2018, 10.1016/j.jpubeco.2018.04.009.

[16] Benjamin D. Sommers et al., "Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care," *Health Affairs,* Vol. 39(9), September 2020, https://doi.org/10.1377/hlthaff.2020.00538.

[17] Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," Health Affairs, Vol. 36(9), September 2017, https://doi.org/10.1377/hlthaff.2017.0347.

We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you have any questions, please contact Hannah Green with the American Lung Association at hannah.green@lung.org.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autoimmune Association
Blood Cancer United
Cancer Nation
Cancer Support Community
CancerCare
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
EveryLife Foundation for Rare Diseases
Family Voices National
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Hypertrophic Cardiomyopathy Association
Immune Deficiency Foundation
Legal Action Center
Lupus Foundation of America
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Sickle Cell Disease Association of America
Susan G. Komen
The AIDS Institute
The Coalition for Hemophilia B
UsAgainstAlzheimer's
ZERO Prostate Cancer