SUBMITTED ELECTRONICALLY:

July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention:

RE: [CMS-2454-IFC] RIN 0938-AV98 Medicaid Program; Community Engagement Requirement for Certain Individuals

Community Catalyst is pleased to submit these comments in response to the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS") interim final rule CMS-2454-IFC.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and healthcare are made: in communities, state houses, and on Capitol Hill.

We appreciate HHS and CMS' long-standing dedication to improving the lives of individuals through affordable, accessible, high quality, and comprehensive health coverage. That said, we have significant concerns about this interim final rule (IFR), which is expected to result in more than 9 million Americans losing their Medicaid coverage by FY2034, due to needless paperwork requirements, and burden states with more than $725 million in costs to implement. Moreover, the rule exceeds the requirements and statutory text of the Working Families Tax Cut legislation, also known as H.R.1.

Community Catalyst strongly believes that imposing work reporting requirements as a condition of Medicaid enrollment is a harmful policy. Research again and again shows that work reporting requirements result in significant coverage losses – jeopardizing accessing to care and health outcomes for millions of Americans – and does nothing to increase employment or improve economic stability for individuals, communities, or the country. While we urge Congress to repeal this policy, we understand that for the purposes of this rulemaking, CMS is operating under its obligation to execute the statutory requirements of H.R.1. Even so, Community Catalyst believes that this IFR goes well beyond the statute and that this will result in significantly more people losing coverage than necessary under H.R.1. We strongly urge CMS to revisit this rule to ensure compliance with H.R.1 and to minimize harm to both states and Medicaid enrollees. In addition, we urge CMS to grant good faith waivers, given both the statutory language and state readiness, and to grant them for more than six months at a time.

I. Overall Impact of the IFR

Implementation of the IFR as written will cause substantial harm to millions of Americans, causing them to lose their health and dental insurance due to unnecessary paperwork and onerous administrative red tape. While CMS estimates that 3.3 million Americans will be disenrolled from Medicaid as a result of this policy, the nonpartisan Congressional Budget Office (CBO) places that number at 5.3 million Americans by 2034. Both projections, however, are likely a significant underestimate of the number of people who will be harmed; other studies using actual data from state experiences with work reporting requirements indicate that millions more will likely be impacted. Among the people most likely to be disenrolled under the IFR are those with disabilities, chronic conditions, and chronic health needs like diabetes and cancer – people who should keep their healthcare but are likely to fall through the cracks due to this rushed regulation.

> *"I have relied on Medicaid for about ten years or so. When I first was enrolled, I was fresh out of high school and just recently diagnosed as having bipolar disorder. Medicaid has been instrumental in paying for my medicine and doctors' appointments. Without it, my family might've gone bankrupt (again) paying for my treatment. [I am worried that if the] work requirements become more strict...that fact might change." - C.J., Indiana*[1]

HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a policy brief in conjunction with this IFR, attempting to justify the regulation's policy choices by arguing that the work reporting requirements could reduce poverty and increase employment. However, researchers cited in the brief have said that their data and conclusions were mischaracterized or misinterpreted by ASPE. Instead, research overwhelmingly shows that access to healthcare, including Medicaid, is crucial to supporting employment and economic mobility. And previous efforts to implement work reporting requirements show that they are costly, ineffective, and harmful. Undoubtedly, this IFR will result in higher incidences of serious health issues, medical debt, poverty, adverse pregnancy outcomes, and even mortality in communities and states across the country, especially because it impose more burdensome restrictions than permitted under the plain language of the statute.

In addition, the requirements in the IFR will be very costly and burdensome for states to implement. CMS estimates that the total cost burden for states associated with the IFR – including issuing notices, updating applications, verifying plan updates, and reporting data – will be $726 million. Based on estimates from the states themselves, the implementation costs will likely be much higher to adequately update IT systems, hire and train additional eligibility workers, and communicate requirements to enrollees and delivery system partners. At the same time, H.R.1 included only $200 million for state implementation of the work reporting requirements, falling far short of what states will need. In addition, the last-minute changes CMS adopted will leave states scrambling to implement the requirements within the designated timeframe. In particular, CMS has long confirmed that a definition of medical frailty consistent with the plain language of H.R.1 would be used; this 11th hour – and needlessly cruel – change to that definition means that states will be even more behind in developing the processes needed to confirm compliance or

[1] To collect testimonials, Community Catalyst reached out through our organically-built mailing lists and digital media channels and asked people to share the importance of Medicaid to them and their families. All stories/perspectives submitted were shared without compensation.

exemptions, and to ensure that those who should be covered by Medicaid, including those who are medically frail, remain enrolled.

CMS should recognize that states have spent months designing eligibility systems, notices, verification workflows, and implementation plans based on prior guidance and technical assistance. By substantially changing expectations of states in the IFR, CMS has forced states to redesign major portions of their implementation efforts with only months remaining before the January 1, 2027 deadline. This creates avoidable administrative costs, delays readiness, and increases the risk that eligible individuals will lose coverage due to implementation errors. In fact, reports from early-adoption states are already demonstrating widespread confusion among Medicaid enrollees as they work to ensure compliance with rushed and unclear state processes.

States will not be able to develop and test robust, fully operationalized systems by January 1, 2027. Consequently, CMS must re-issue this final rule so that it adheres to the plain language of H.R.1. Absent that, CMS must provide states with sufficient time to implement its new requirements by delaying implementation and granting good faith waivers to states.

II. Defining Medical Frailty, (§ 435.554, § 435.557)

H.R.1 includes an exemption from work reporting requirements for individuals who are medically frail *and* defines "medically frail" as those with a serious or complex medical condition, substance use disorder (SUD), disabling mental health condition, or a disability. The IFR goes beyond this statutory definition, adding a further restriction that limits the exemption to only those people whose disability or condition significantly impairs their ability to comply with the work reporting requirement. The IFR also arbitrarily, and without any evidence, states that individuals who are in "stable recovery" from an SUD (i.e., in recovery for 5 or more years) are excluded from the definition of medical frailty "since their SUDs are unlikely to significantly impair their ability to comply with the community engagement requirement." Additionally, CMS requires that individuals with the exemption must be reverified as medically frail at least once every 12 months. Given the permanent and/or chronic nature of many of the health conditions exempt individuals will have, this requirement is overly burdensome on both enrollees and states.

> *"I have multiple chronic health issues, several that are debilitating. As someone who worked for decades, these conditions made it impossible for me to continue. Medicaid was a lifeline for me. Literally. I would have died years ago without the help of Medicaid." - F.H.B., Maine*

The IFR's medical frailty definition not only exceeds the plain language of, and Congress' intention in, H.R.1, but will also result in millions of Medicaid-eligible people being unnecessarily disenrolled and harmed as a consequence. For example, as the American Cancer Society notes, "cancer patients and survivors who are suffering from debilitating side effects of the disease or treatment would have to officially prove they can't work, in a process that is likely to be difficult and take a long time. Cancer patients who can still work – and many want to, for example, when they are well enough to work in between chemo rounds – will have to choose between losing their Medicaid coverage, working the required 80 hours per month, or giving up working altogether to qualify for an exemption."

"I've been on Medicaid since 2007. Before that, it was a major burden to afford the medications I need just to survive, especially my pain medications. Thanks to...severe health issues, chronic pain, and depression...[I am] unable to work. On many occasions, circumstances beyond my control caused me to run out of my meds, and each time caused me to either seriously contemplate suicide or attempt it. Medicaid...is not [some]thing I can survive without...it is quite literally my lifeline." - M.L., Texas

Aside from the direct harm to people's health, this new, more restrictive definition of medical frailty that goes beyond the statutory provisions will be difficult for states to implement. While the IFR requires states to develop a list of diseases, diagnoses, or other health conditions to identify individuals who will qualify for this exemption, it is impossible for any such list to fully capture all qualifying individuals. Additionally, whether and how states will have sufficient data to make further individualized determinations is unclear, since medical claims and encounter data do not include information that determines one's work capacity or, often, the severity of their illness or disability. Under this IFR, the burden may ultimately fall to healthcare providers, who are already stretched very thin, to assess work capacity and include employment-related language and/or data in their clinical evaluations, despite many lacking the training to conduct such an assessment. Furthermore, even where such evaluations could be arranged, it is simply not appropriate to position providers to make administrative determinations tied directly to their patient's eligibility for coverage.

The IFR's definition of medical frailty reduces efficiency, forces people to navigate complex screeners, and puts coverage at risk for people the statute meant to protect.

CMS must, at minimum, finalize this regulation *without* the additional language limiting the medical frailty exemption to only those people whose conditions impair their ability to comply with the work reporting requirement.

III. Notices, (§ 435.557, § 435.558, § 435.561)

Under the IFR, states must create several new types of notices for enrollees focused on outreach and awareness, verification, and notice of noncompliance. These notices will be the primary mechanism by which enrollees learn about work reporting requirement obligations. As we are already seeing in states that have begun implementing work reporting requirements, many notices are not clear and do not provide adequate information about how enrollees should demonstrate that they are either meeting work reporting requirements or qualify for an exception/exemption. For example, Community Catalyst's state partners in Nebraska have identified numerous instances of individuals receiving such notices from their state, leaving them without clear guidance about available exclusions/exemptions and/or information about how to apply for them. Nebraskans have also reported uncertainty regarding their compliance status, even after connecting with state call center staff. In Montana, the release of complicated qualified activities reporting and exclusion forms has led to confusion among applicants. These forms include information that directly conflicts with definitions outlined in the IFR, including Montana's work reporting requirement exception for caregivers. Further, Montana is requiring individuals to provide documentation and/or self-reporting to prove compliance instead of attempting to use available data to determine compliance verification first, as the IFR requires. These issues serve as early indicators that

states are unprepared to go live with systems that meet regulatory requirements without posing undue burdens and harm to qualified Medicaid enrollees.

CMS should require extensive notice testing, ensure states explain exceptions/exemptions to enrollees, including how long the exception/exemption is effective, and prohibit disenrollments until states demonstrate that notices are easily understandable, accurate, accessible, and available in appropriate languages.

IV. Verifying Compliance with or Exception or Exclusion from the Work Reporting Requirement, (§ 435.557)

The IFR requires states to check data sources to verify compliance with or exemption from work reporting requirements; where such data are not available, the IFR specifies when states may – or must – require documentation from individuals, as well as whether or when self-attestation may be acceptable. More specifically, in 2027, for all exemptions or exclusions *other than medical frailty* (e.g., caregiving, incarceration, etc.), if data is not available, states may either require documentation or accept self-attestation. This structure is consistent with longstanding Medicaid rules. Then, in 2028 and onward states *must* require documentation where reasonably available; only when it is not available may states accept self-attestation. This framework is more restrictive than the statute, and its operational consequences are compounded by the medical frailty definition problem described in Section II. Under prior CMS guidance, states anticipated that claims data confirming a qualifying clinical condition, potentially supplemented by self-attestation, would resolve a significant portion of the medical frailty determinations. The IFR's revised definition has already undermined the sufficiency of claims data for this purpose by layering on an ability-to-work standard those data cannot identify. The 2028 documentation requirement then forecloses the self-attestation pathway that might otherwise have bridged the gap. The procedural barriers, administrative costs, and staff time required for verification starting in 2028 will both overwhelm state agencies and push even more people off Medicaid coverage.

Furthermore, as noted above, the verification scheme required for medical frailty exemptions differs from all other exemptions and exclusions in the IFR. Here, for 2027, when no data are available, the state may require documentation or accept self-attestation. States may rely upon an individual's attestation for 12 months when determining medical frailty in 2027. For 2028 onward, an individual may use self-attestation to establish medical frailty only once during a period of enrollment. In practice, this means that individuals will have to obtain doctor statements or other documentation to prove medical frailty, often at out-of-pocket cost, or otherwise ensure that their medical claims or encounter data demonstrates a condition that impairs their ability to meet the work reporting requirement. States may reverify medical frailty every 6 or 12 months, at the option of the state; however, states can only rely upon data or documentation (not self-attestation) for a 12-month period.

Yet CMS does not offer any credible reason for enacting this different verification process. The proffered goal is to "motivate individuals to access care" but this belies the reality of how healthcare systems operate and how people with the kinds of conditions at issue are most likely to access care. For example, the IFR's verification scheme does not account for scenarios where enrollees with new conditions: do not yet have 12 months of claims; have claims data that lacks sufficient information to determine work

capacity; have conditions like SUD, which have special privacy protections; have mental health conditions, which may not appear in claims; and/or have conditions that are managed without ongoing treatment. As a result, even if a state verifies an individual's exemption at one renewal, that is no guarantee that 12 months later – or sooner, if a state opts for more frequent reverification – claims or encounter data will demonstrate the qualifying condition. If and when this happens, the individual will lose the exclusion and be inappropriately disenrolled due to the limitations placed on self-attestation by the IFR.

We urge CMS to maintain a verification scheme that permits states to verify compliance via self-attestation at application and redetermination for the duration of the work reporting requirements program for all individuals, including under the medical frailty category. To be consistent with the statute, CMS should revise the new 42 C.F.R. § 435.557(b)(2) by removing the medical frailty carve-out, and revise the new 42 C.F.R. § 435.557(b)(2)(i) and (ii) by eliminating the tiered pre-2028 / post-2028 verification hierarchy entirely, replacing both provisions with a single uniform standard that reads: "When there is no reliable information available to the State, or the reliable information available to the State is not reasonably compatible with the information provided by or on behalf of the individual, the agency may require documentation or accept other information as provided in § 435.952(c)."

In addition to allowing for ongoing self-attestation for all individuals at application and renewal, we strongly urge that CMS create multi-year or even permanent exemptions for chronic, lifelong, or progressive health conditions where clinical improvement is not anticipated.

Fundamentally, though, the verification requirements do not resolve an underlying problem with this rule – that the medical frailty definition is too restrictive and impractical to implement.

V. Lookback Period for Eligibility, (§ 435.557(d))

H.R.1 requires applicable individuals to satisfy a "lookback" period at application and renewal to satisfy work reporting requirements, meaning they must demonstrate compliance or an exception for one to three months (as determined by the state) before their application and for at least one month (as determined by the state) since their last eligibility determination or renewal. While this lookback requirement does not apply to "specified excluded individuals" – including those who are medically frail, parents/guardians or caregivers, or pregnant/postpartum people – excluded individuals must first show that they met an exception during the relevant lookback period. This requirement is incoherent. More specifically, requiring someone to demonstrate that a short-term hardship, such as an inpatient hospitalization, occurred during a specific lookback month is completely inconsistent with the purpose of the exemption, which is to protect individuals who are temporarily unable to comply with work reporting requirements due to a significant health event. In practical terms, this requirement will result in significant coverage delays – and a greater risk of denial – for people precisely when they need that coverage the most and will increase the risk of worsened health outcomes and medical debt.

> *"I am permanently disabled. I worked my whole life as a department store manager. It was a physical job. Moving fixtures, processing new receipts, merchandising, were part of my job. When I had 2 cervical spinal surgeries, I became worse with chronic pain so severe I was barely*

able to do my job. Always a single parent, I lived on one income and still do...I live barely paycheck to paycheck. Medicaid is helping me with medical care...I cannot work. I am grateful for this help. I can't lose...my care. It would be detrimental to me physically and financially." - K.B. New York

CMS should realign with the statutory text and allow states to deem individuals experiencing short-term hardship events during months included in review periods, as well as at the time of application and/or redetermination, to be considered in compliance with community engagement requirements for that month.

VI. Compressed Renewal Timelines, (§ 435.556(a)(2)(i) and § 435.912(e)(3))

The IFR creates a new exception to the long-standing 45-day timeliness standard for processing applications when a notice of noncompliance is issued. Through this exception, CMS is explicitly insulating states from enrollee protection/compliance consequences for slow application processing under work reporting requirements. This exception is even more harmful to enrollees when combined with another H.R.1 policy that requires states to reverify eligibility for individuals in the expansion group and comprehensive 1115 waivers every six months (instead of every 12 months per ACA requirements). CMS acknowledges directly that the IFR creates a nearly impossible timing problem, but does not offer any real solution: In the preamble, CMS states that "[m]ost individuals required to demonstrate community engagement are also subject to the new 6-month renewal requirement under section 1902(e)(14)(L) of the Act. Because most States currently take between 60 and 90 days to complete all steps in the renewal process for a cohort, an individual subject to renewals once every 6 months may only have been enrolled in their current eligibility period for approximately 3 months when the State initiates the next renewal and begins checking reliable information available to the State."

As a consequence of this dynamic, enrollees will be subject to a near-continuous renewal status; and state systems will be simultaneously processing renewals while initiating the next ones in sequence. The cumulative impact of 6-month renewals, state processing times, work reporting requirements, and optional more-frequent verifications will be that enrollees are perpetually responding to paperwork demands – and even worse, any single missed notice or unverified data in this never-ending paperwork cycle could result in a loss of coverage. This is to say nothing of the increased burden on state systems and staff, who will be stuck processing paperwork continuously.

VII. Caregiver exemption definition, (§ 435.554(a))

H.R.1 exempts parents of children under age 14, as well as caregivers of disabled individuals, from the work reporting requirement. While the IFR's definitions for parent, guardian, caretaker relative, and family caregiver exemptions are generally reasonable, we are concerned that different state implementation choices may impact whether eligible people actually qualify under these definitions. We encourage CMS to provide guidance to states to help ensure that the caregiver exemption is consistently and appropriately implemented across jurisdictions.

We also note that the caregiver and medical frailty definitions cut against each other in harmful and illogical ways. Under the IFR's definitions, a caregiver would more easily qualify for an exemption and keep their coverage, while the disabled or medically frail person that they care for must pass a much more stringent two-part test to qualify and stay enrolled in Medicaid. Again, this demonstrates the cruelty of the medical frailty definition, and we urge CMS to modify that definition to remove the additional work capacity element.

> *"Medicaid is important to me because without it I could not afford my prescriptions. I also would not receive monthly food that I can just re-heat. I am disabled and cannot really cook for myself. I live alone and cannot stand for more than 2 minutes at a time...[Without Medicaid,] I also would not have a caregiver of my choice come and do the things I cannot do by myself." - C.K., New Jersey*

VIII. Data Reporting, (§ 435.562)

We appreciate that the IFR requires states to submit certain data elements, and we also appreciate that states may be subject to corrective action if reported data are not timely, complete, or of sufficient quality. Robust data collection is essential to understanding how the IFR is being implemented, and how both states and individuals are being impacted. However, there is a significant missing component in the IFR: CMS makes no commitment to making the data publicly available. There are a significant number of stakeholders who should and must have access to the data CMS collects so that it can be used, for example, to facilitate cross-state learning, in research and evaluation efforts, and by advocates and policymakers to inform future policy efforts. Moreover, without public access, the reporting infrastructure may serve CMS's potential oversight of states but provides no means of accountability for CMS itself.

We urge CMS to modify the IFR by requiring states to provide a comprehensive set of data, including:

- Disenrollments attributable to work reporting requirements;
- Number and rates of denials by exemption/exclusion category;
- The number of individuals with an exemption/exclusion by category;
- The number of eligibility reviews, including exemption requests performed on an ex-parte basis for individuals subject to work reporting requirements;
- Average processing times;
- Fair hearing requests and outcomes;
- Call center abandonment rates;
- Reinstatement rates after disenrollment; and
- Demographic breakdowns of disenrollments.

CMS must also make this data publicly available in a comprehensive and timely manner.

IX. Meeting the Work Reporting Requirement, (§ 435.552)

While there are various ways people can meet the work reporting requirement, we anticipate ongoing challenges for enrollees and states in documenting hours in order to prove compliance. We urge CMS to support states as they set up systems, data collection, and documentation standards to ensure that hours are fairly counted, and to hold states accountable when their systems inappropriately undercount hours and subject individuals to wrongful disenrollment.

Additionally, we appreciate that the IFR states that applicants and enrollees can meet the work reporting requirement by engaging in a combination of the specified activities for a total of 80+ hours per month, and that it explicitly says states are *not* permitted to make only a subset of these options available. We will note that many volunteer and community-based organizations lack the staffing, technology, or administrative capacity necessary to track and verify participation hours. CMS should ensure states give enrollees credit for engaging in legitimate community service activities and monitor whether state implementation improperly excludes informal work, unpaid caregiving, seasonal employment, gig work, or other nontraditional forms of labor that are common among Medicaid enrollees.

X. Optional short-term hardship exemptions, (§ 435.555):

H.R.1 included short-term hardship exceptions that states have the option to adopt to exempt people from compliance with the work reporting requirement, including for people:

- Experiencing an inpatient hospitalization;
- Who need to or have a dependent that needs to travel for medical care;
- Are living in areas of the state experiencing declared disasters; or
- Are living in areas of the state with high unemployment.

The IFR clarifies that a state must offer all short-term hardship exceptions if it adopts the option; however, states are not required to implement the unemployment-related hardship exception even when the unemployment rate meets the applicable threshold. This is unduly punitive for enrollees, and **we urge CMS to clarify that unemployment hardship exceptions will be approved based on data, without discretion.**

Additionally, the IFR clarifies definitions for the optional short-term hardship exception included in H.R.1 but goes beyond the statute to limit the exception for a Presidentially declared emergency to apply only when the emergency affects an individual's ability to meet the work reporting requirement. Like the expanded medical frailty definition, **this extra "work capacity" requirement is unnecessary and harmful, and we urge CMS to rescind it.**

> *"Medicaid saved my life—twice...Medicaid helped cover the care that kept me alive during one of the most difficult periods of my life. Without it, I would have faced overwhelming medical bills on top of the physical and emotional challenges of recovery. Today, I am grateful to be working full-time and contributing to my community. However, I still understand firsthand how quickly a health crisis can change a person's life. No one plans to become critically ill. No one expects to need emergency care,*

hospitalization, rehabilitation, or life-saving surgery. Yet when those moments come, access to healthcare can mean the difference between life and death...Medicaid doesn't just provide healthcare. It provides hope, security, and the chance to recover and rebuild after tragedy. It keeps people alive, keeps families together, and helps communities thrive." - M.T., Iowa

This IFR exceeds the plain language of H.R.1, is contrary to statutory intent, will result in a significant number of eligible people losing Medicaid coverage, and will impose substantial burdens on states. We strongly urge CMS to revisit this rule to ensure compliance with H.R.1 and to minimize harm to both states and Medicaid enrollees.

We also implore CMS to approve good faith waivers, given the number and severity of concerns related to the feasibility of the IFR's provisions, the deviations the IFR makes from the statutory language states had been using to build out their systems, and the length of time it is likely to take for states to implement requirements. Specifically, CMS should issue a template waiver as soon as possible, take into account the complexity and last-minute nature of changes in the IFR when evaluating waiver requests, and provide for a lengthier period of time to allow states to focus on implementation rather than renewal of good faith waiver requests.

Thank you for the opportunity to provide comments on the proposed rule. If you have further questions, please contact Shaina Goodman at sgoodman@communitycatalyst.org.

Respectfully submitted,

Community Catalyst