Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC SUBMISSION

July 30, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2452-IFC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments to CMS-2452-IFC
Medicaid Program; Community Engagement Requirement for Certain Individuals; Interim Final Rule with Comment Period

Dear Administrator Oz,

Thank you for the opportunity to comment on "Medicaid Program; Community Engagement Requirement for Certain Individuals; Interim Final Rule with Comment Period (CMS–2454–IFC)," hereinafter referred to as the "WRR IFR." The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. We have deep experience and understanding of how health care policies impact access to health care, health, and household security for children and families, as well as the impacts on states and health care systems broadly.

In particular, CCF has extensive experience analyzing Section 1115 demonstrations related to Medicaid work requirements over the past decade and has authored numerous issue briefs, blogs, and public comments on pending Section 1115 demonstration requests on work reporting requirements – all of which are available on our website.[1]

The Center for Medicare and Medicaid's (CMS) Interim Final Rule (IFR) on work reporting requirements (WRR) goes far beyond the framework established by Congress in H.R. 1 for implementing WRR in Medicaid. The restrictive policies in the

[1] https://ccf.georgetown.edu/

WRR IFR – most notably provisions narrowing the definition of medical frailty and eliminating the state option to use sworn attestations – will lead to loss of health coverage, reduced access to care, and worsened outcomes for families while at the same time increasing administrative and financial burdens on individuals, health care providers, and states. Furthermore, the provisions of the IFR are not workable for states; numerous parts of the WRR IFR are unclear, difficult to implement, and in any case impossible for states to implement by January 1, 2027, given how inconsistent the WRR IFR is with H.R. 1 and the implementation guidance states have received from CMS thus far. Finally, the IFR lacks meaningful data and transparency requirements to track the implementation of this policy which puts at risk access to health care for as many as 20 million Americans – many of whom have serious and chronic health conditions.[2]

Overview: Evidence from past WRR makes clear that these policies are harmful, create unnecessary barriers to accessing coverage, and will result in coverage losses, without actually supporting work. The IFR does little to address or mitigate known harm caused by WRR.

A recurring failure point of past WRR experiments is that most enrollees don't know about the WRR and whether they are impacted by them, much less the detailed processes for compliance. When Arkansas implemented WRR in 2018, large percentages of the affected population had not heard about the policy, and of those who had heard about it, even larger percentages were unsure of whether it applied to them.[3] Within two months of implementation, New Hampshire suspended its 2019 WRR, in part due to a failure to reach affected enrollees.[4] In Nebraska, the first state to implement H.R.1-mandated WRR, extreme confusion is already rampant among Medicaid enrollees.[5] Even CMS has itself noted, in qualitative research conducted with Medicaid enrollees in April 2026, that many potential enrollees are

[2] Centers for Medicare & Medicaid Services, "Medicaid Program; Community Engagement Requirement for Certain Individuals," Department of Health and Human Services, June 30, 2026, https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals.
[3] 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.; 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.
[4] 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.
[5] Elizabeth Chuck, "New Medicaid work requirements prompt 'extreme mass confusion' in Nebraska," NBC News, July 12, 2026, https://www.nbcnews.com/news/us-news/medicaid-work-requirements-nebraska-extreme-confusion-rcna353644.

unaware of work requirements and may have difficulty determining if they are affected under the new law.[6] These findings are included as Appendix A.

For those enrollees who are aware of WRR, many struggle to obtain or retain coverage due to difficult enrollment and renewal processes. In Georgia, despite a $21 million outreach campaign, fewer than 18,000 individuals are enrolled in the Pathways to Coverage program, a small fraction of the individuals potentially eligible for the program.[7] Of denied Pathways to Coverage applications, significantly more were due to procedural reasons, such as missing paperwork, rather than failure to meet qualifying hours and activities for the program.[8] Georgia's experience is exactly why we are so concerned that rushed and flawed implementation of WRR will lead to millions of people losing life-saving coverage because of bureaucratic barriers.

H.R. 1 established an impossible and unworkable timeline for states to implement WRR. The IFR further exacerbated this timeline and created new challenges for states by narrowing definitions, adding requirements not specified in H.R. 1, and undermining the policies established by H.R. 1 that could mitigate harms and challenges created by lack of awareness and complicated administrative processes. For example, Congress created a simple path to obtain exclusions–including a data driven approach *and* the state option to use sworn attestations–because of this past evidence that shows many individuals struggle to navigate the process. As described above, the WRR IFR undermines both of these protections, and makes clear that states are unlikely to be able to count on a good faith exemption to delay implementation.

These challenges will undoubtedly lead to inappropriate coverage losses, made clear by past Medicaid WRR.[9] The resulting churn threatens access to needed health care, undermines continuity of care, and increases state administrative burden. Evidence shows that even temporary losses of coverage result in people forgoing necessary preventative services, medications, and continuous care for chronic illnesses, and

[6] Centers for Medicare & Medicaid Services, "Medicaid Community Engagement Requirements: Qualitative Research Communication Summary," Department of Health and Human Services, 2026, https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/resources/Community-Engagement-messaging.pdf.
[7] 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/.
[8] Ibid.
[9] 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

can lead to more hospitalizations and ER visits.[10] Although Medicaid expansion does not include individuals younger than 19, when parents and caregivers lose coverage, their children will be hurt too. Evidence consistently shows that children are less likely to have coverage if their parents are uninsured.[11] For low-income families, one member being uninsured exposes the entire family to grave economic risk due to medical debt and even bankruptcy.[12] Twenty-six percent of child-care workers are also covered by Medicaid expansion.[13] If a state does not establish proper procedures to identify and verify pregnant and postpartum individuals, these individuals face the same risks of churn and gaps in coverage, increasing risks of adverse outcomes for both mothers and babies.[14] Nearly 140,000 pregnant women, 16 percent of all pregnant women enrolled in Medicaid, were enrolled in the Medicaid expansion category in 2022 during the month of birth, making the question of how to identify pregnant and postpartum women in this category quickly of consequence for many births as well as critical pre- and postpartum care.[15]

Medicaid WRR will create significant harm without meaningful gains in employment. Research has consistently shown that WRR fail to promote employment.[16] In fact, access to Medicaid coverage is supportive of finding and maintaining employment.[17] Medicaid expansion has been associated with many

[10] MaryBeth Musumeci et al., "Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care," The Commonwealth Fund, June 11, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.
[11] 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.
[12] Lunna Lopes et al., "Health Care Dept in the U.S.: The Broad Consequences of Medical and Dental Bills," KFF, June 16, 2022, https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[13] Georgetown University Center for Children and Families, "Medicaid is a Critical Support for the Early Childhood Education Workforce," Updated July 22, 2026, https://ccf.georgetown.edu/2025/04/21/medicaid-is-a-critical-support-for-the-early-childhood-education-workforce/
[14] Lindsay K. Admon et al., "Insurance Coverage and Perinatal Health Care Use Among Low-Income Women in the US, 2015-2017," JAMA Network Open, Vol. 4(1), January 2021, available at https://doi.org/10.1001/jamanetworkopen.2020.34549.
[15] Laura Barrie Smith et al., "Ensuring Continuous Coverage for Pregnant and Postpartum Medicaid Enrollees Under OBBBA," Urban Institute, March 31, 2026, https://www.urban.org/research/publication/ensuring-continuous-coverage-pregnant-and-postpartum-medicaid-enrollees-under.
[16] LaDonna Pavetti, "TANF Studies Show Work Requirements Proposals for Other Programs Would Harm Millions, Do Little to Increase Work," Center on Budget and Policy Priorities, November 2018, https://www.cbpp.org/sites/default/files/atoms/files/11- 13-18tanf.pdf; Benjamin Sommers, et al., "Medicaid Work Requirements In Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care"; Leighton Ku et al., "How National Medicaid Work Requirements Would Lead to Large-Scale Job Losses, Harm State Economies, and Strain Budgets," The Commonwealth Fund, May 1, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/may/medicaid-work-requirements-job-losses-harm-states; Robert Wood Johnson Foundation, "Work Requirements Threaten Health and Increase Costs," April 24, 2025, https://www.rwjf.org/en/insights/our-research/2025/04/work-requirements-threaten-health-and-increase-costs.html.
[17] 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

benefits, including improved health care access, health outcomes, and financial security.[18] Medicaid expansion also supports states, hospitals, and providers. Undermining expansion through this policy will be harmful to health care providers, state health care systems, triggering large increases in uncompensated care, particularly in rural areas where jobs may be most scarce and health care systems may be operating at financial losses and subject to hospital closures.[19]

The policies of the IFR will be extremely harmful to people with chronic illness. It is well established that medically frail individuals lost coverage during prior WRR experiments. When Arkansas tried work requirements, "[p]eople with disabilities were particularly vulnerable to losing coverage … despite remaining eligible."[20] 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.[21] In 2020, experts concluded that among three states that implemented or were about to implement WRR, "evidence suggests 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."[22] CMS's policies making it harder for people with SUDs to get exclusions based on treatment or medical frailty does not adequately consider the fact that current and past SUDs can impact the ability of individuals to find and maintain employment.[23] Without sworn attestation, for example, many people with

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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 .

[18] 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.

[19] "Medicaid Work Requirements Could Hit Rural Hospitals," National Journal, 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," 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.

[20] 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.

[21] MaryBeth Musumeci, "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.

[22] MaryBeth Musumeci, ibid.

[23] Dayton Daily News, "New challenge for recovering addicts: finding a job," August 12, 2018, https://www.daytondailynews.com/news/local/new-challenge-for-recovering-addicts-finding-job; Heather

SUDs will be unable to prove their condition, since the vast majority of people with substance use disorders do not receive treatment.[24]

We request that CMS <u>not</u> finalize the harmful provisions of the IFR, described in more detail below, and instead adopt policies consistent with H.R. 1 and the policy evidence on supporting and improving access to care for children and families in Medicaid.

Comments on Specific Provisions of the IFR

A. Populations subject to work reporting requirements (§§ 435.550 and 435.551)

The WRR IFR applies the WRR to individuals in Medicaid expansion and those "eligible to enroll or…enrolled in a demonstration project under section 1115(a)(2)." CMS subsequently identified 13 waivers in 8 states where the WRRs would apply. While we support CMS's intent to narrow the applicability of WRRs to a subset of waivers, the IFR's definition is still overinclusive of demonstrations. We believe Congress's intent in H.R. 1 can reasonably be understood to apply the WRR to large demonstrations effectively implementing Medicaid expansion through waiver—namely the "partial" Medicaid expansions in Wisconsin and Georgia. However, WRRs should not be applied broadly to all of the § 1115(a)(2) waivers identified by CMS for a number of reasons.

First, CMS should not apply the WRRs to very small demonstrations. It takes a great amount of administrative effort for states to develop and apply WRRs to a categorical population, and it is extremely inefficient to make a state do extensive administrative work for a tiny population. Second, at the same time, 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 factors such as substance use disorders, mental health conditions, functional impairments, or status as parents or other caregivers. Finally, in many cases the demonstrations are limited to (or largely include) individuals above applicable default income limits, meaning that all or almost all the individuals would be compliant with the $580 per month income proxy. CMS's

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/.

[24] Substance Abuse and Mental Health Services Administration, "Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60)," Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2025, https://www.samhsa.gov/data/data-we-collect/nsduh-national-surveydrug-use-and-health/national-releases.

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 WRRs to large § 1115(a)(2) demonstrations that implement coverage for most or all of a Medicaid expansion group.*

We commend CMS for confirming, as mandated by the text of H.R. 1 (which applies the WRRs to "the 50 States or the District of Columbia"), that the WRRs do not apply to the U.S. territories. CMS should retain this policy in the final regulation.

B. Specified Excluded Individuals generally (§ 435.554)

1. Specified Exclusion and Compliance

The WRR IFR at § 435.554 sets out numerous categories of Specified Excluded Individuals whom Congress defined as excluded from demonstrating WRR, 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 WRR IFR's broad framework requiring that if an individual qualifies as Specified Excluded, they are not subject to WRR 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)). This approach is consistent with the statute, which treats specified excluded individuals as distinct from populations that must comply with WRR. Individuals with a known basis for exclusion, such as a chronic illness, should not be subjected to burden and confusion related to assessment of compliance activities.

At the same time, states have built eligibility systems that collect information from multiple data sources at one time – such as income data from quarterly wage data sources and information about household size or pregnancy from other available sources. We appreciate CMS' acknowledgement in the preamble that a state may collect *all reliable information* available to the state *at once* (rather than sequentially, or checking data sources in a certain order) (91 Fed. Reg. 33393). Therefore, it's possible a state may collect information saying an enrollee meets the

$580 monthly income proxy *and* qualifies as Specified Excluded as a parent of a child age 13 and under. Allowing states to collect all reliable information available to the state at once, coupled with the explicit protection for Specified Excluded individuals, streamlines operations and reduces administrative burden for both states and individuals while also protecting Specified Excluded individuals from being denied coverage.

2. Pregnancy (§ 435.554(c)(10))

The WRR IFR includes a Specified Exclusion for pregnancy, as required by H.R. 1. 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). This is an important clarification, and we recommend CMS make these requirements clear in the regulatory text itself in § 435.557, relating to verification of exclusions, exceptions, and compliance.

We recommend that CMS also require states to require Medicaid managed care organizations (MCOs) to report to states when pregnancy is identified for Medicaid expansion members so that the state eligibility system can be updated with data from a reliable source and newly pregnant individuals can receive the exclusion they are eligible for. This is an efficient and effective way to identify pregnancy, and states should be expected to utilize all tools available.

3. Parents, Guardians, Caretaker Relatives, and Family Caregivers (§ 435.554(c)(3))

Under H.R. 1 and § 435.554(c) of the IFR, Specified Excluded individuals who are not subject to WRRs include "parents, guardians, caretaker relatives, and family caregivers...of a dependent child 13 years of age and under or a disabled individual." Caregivers for young children and people with disabilities are essential to the health, economic stability, and well-being of families and communities across the country. As acknowledged both in the statute and the IFR, the time- and labor-intensive nature of caregiving – whether it be caring for an infant or caring for an elderly or sick relative – may interfere with such individuals' ability to fulfill WRR, necessitating a specific exclusion in the law. We support the IFR's intent, consistent with the statute, to cover a broad range of caregiving scenarios and arrangements that characterize family life across America.

The IFR defines various terms used in this exclusion, some of which already exist in Medicaid law and others that have not been defined previously for Medicaid policy. We offer the following recommendations and statements of support:

- **We support the IFR's clarification that multiple caregivers in a single household may qualify for the exclusion** (e.g., two adults caring for an elderly grandparent who lives with them).
- **We support the IFR's recognition that parents may include those who live or do not live with a child**, recognizing that non-residing parent's availability to care for their child remains paramount.
- **We support the IFR's adoption of 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**. Some states have expanded the caretaker relative group beyond the federal definition for purposes of 1931 Parent/Caretaker Relative Medicaid eligibility, such as adding half-blood relatives or a domestic partner of the parent or other caretaker relative. We support the IFR's requirement that, if a state has added adults as caretaker relatives for their Section 1931 Medicaid group, the state must use that definition for this WRR exclusion. This alignment will simplify state implementation of this exclusion. Caretaker relative enrollees may have fluctuating income and switch back and forth between their state's Section 1931 Medicaid group and Medicaid expansion group; a uniform definition of caretaker relative in the state will simplify state administration and enable smoother transitions between coverage groups.
- **We recommend that CMS allow a more flexible definition for unrelated, non-residing family caregivers.** The WRR IFR requires unrelated, non-residing family caregivers to provide at least 80 hours of care to qualify for the family caregiver exclusion. We recommend that CMS eliminate or modify the 80-hour threshold. Even when the hours are well over 80 hours, it may be nearly impossible for family caregivers to prove a specific number of hours – which themselves likely vary from week to week and month to month, depending on the availability of parents, caregivers, etc. Furthermore, even a family caregiver providing, for example, 40 hours of care, is providing an essential function. Therefore, we recommend that CMS eliminate any special standard for unrelated, non-residing caregivers and use the same "regular basis (not incidental)" standard as with other types of family caregivers. This standard would better protect their important role, and eliminate terminations related to being unable to prove an exact number of hours.
- **We urge CMS to provide guidance to states on family caregiving involving children to illustrate the full range of caregivers in the regulatory definition.** The application of the term "family caregiver" is new in the Medicaid context. We appreciate that the definition of family caregiver in the IFR includes those who care for children aged 13 and under, regardless of the child's disability status. Notably, this definition includes both paid and

unpaid caregivers, does not require the child to be a dependent of the family caregiver, and includes relatives, individuals who live with the care recipient, and others who provide regular care.[25] However, the examples in the IFR focus largely on family caregivers of adults with disabilities, which may cause confusion. CMS has itself noted, in qualitative research conducted in April 2026 with Medicaid enrollees, that many enrollees have difficulty determining if they qualify for an exclusion under the new law, with *uncertainty being highest among people with caregiving responsibilities*.[26] These findings are included as Appendix A. Given the low awareness of the new law and the caregiving exclusion, and since the term "family caregiver" is often used to refer to caregivers of adults, we urge CMS to provide clear guidance and examples to states to ensure family caregivers who care for children, including home-based child care providers, are not inadvertently left out of the exclusion.

Elsewhere in our comments we recommend that CMS revise its policy narrowing the use of sworn attestations. This recommendation is particularly important for family caregiving. Adding unnecessary paperwork on such caregivers runs the risk of them erroneously losing health coverage, jeopardizing not only their own health but that of the people and families that benefit from their support. As CMS acknowledges, family caregiving can be paid or unpaid, and there are many circumstances in which *no documentation exists*, or documentation is not reasonably available (e.g. pay stubs, contracts, time sheets, or tax documents). This may include an individual who gives regular assistance to their disabled parents, or an aunt who regularly cares for her niece while parents are working. This also includes home-based child care providers who are the backbone of many communities and care for over 7 million children from birth to 5 years old, including 30 percent of infants.[27] *While the IFR's allows self-attestation until December 31, 2027, the fact that documentation does not exist in many family caregiving scenarios will not end on that date.* Starting in January 2028, if documentation is not reasonably available, the IFR expects states to set criteria and processes for determining what information is "sufficient" to verify an exclusion. However, the IFR does not provide guidance on the "reasonably available" standard or what information might be considered "sufficient" in its absence, potentially creating substantial confusion and variability

[25] As noted in the IFR: "[W]e are not requiring that a family caregiver reside with or assume primary responsibility for the care of the dependent child or disabled individual".
[26] Centers for Medicare & Medicaid Services, "Medicaid Community Engagement Requirements: Qualitative Research Communication Summary," Department of Health and Human Services, 2026, https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/resources/Community-Engagement-messaging.pdf.
[27] Katrina Coburn, "Places for All Babies: Home-Based Child Care is an Essential Part of the Solution," ZERO to THREE, 2021, https://www.zerotothree.org/wp-content/uploads/2022/06/Places-for-All-Babies_-Home-Based-Child-Care-is-an-Essential-Part-of-the-Solution.pdf

across states. Sworn attestation, which occurs under penalty of perjury, remains the best way to verify eligibility for the family caregiver exclusion. **CMS should allow sworn attestations for family caregivers, and at a minimum give states clear guidance on a user-friendly, efficient process for family caregivers when documentation is not reasonably available.**

4. Drug Treatment (§ 435.554(c)(8))

H.R. 1 includes a Specified Exclusion for individuals who are participating in a drug addiction or alcohol treatment and rehabilitation program. However, the WRR 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 limitation in H.R. 1 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 addition and stage of treatment. **CMS should remove the final sentence of § 435.554(c)(8) allowing states to establish minimum time commitments.**

C. Medically Frail Specified Excluded Individuals (§ 435.554(c)(5))

1. Significant Impairment Requirement

Current law and regulations define the term "medically frail" to include five clinically identified populations (individuals with disability, disabling mental health conditions, substance use disorders, functional impairments related to activities of daily living, and "serious or complex" health conditions). H.R. 1 created a broad exclusion to WRR compliance for individuals who are medically frail, and restated the five clinically identified populations in nearly identical terms. 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 H.R. 1 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 only reasonable interpretation 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 the five types of health conditions described in the definition. CMS has no reasonable basis to transform the term into a proxy for work status.

The IFR's changed definition will create numerous serious problems. First, the definition is much stricter than H.R. 1, meaning many individuals Congress meant to protect from WRRs will be subject to WRRs, 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, etc. There will be incredible harm to individuals and their families and children as a result of this policy.

The narrowed definition in the IFR will also be problematic because it conflicts not only 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. H.R. 1 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 "work ability" assessment onto the clinical eligibility criteria, the IFR makes it much harder or impossible for states to automate their processes. As a result, states, individuals, and providers will have heavy burdens to document medical frailty and in many cases the system will fail and many individuals will lose their health insurance.

This problem with the medically frail definition in the IFR is gravely compounded by the fact that since at least Fall 2025 – for approximately the past 9 months – 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.

We 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 may

double or triple the exposure of their confidential health and personal conditions. In addition, the significant impairment standard will create confusion for individuals. Consider for example, an individual that is evaluated for "medical frailty," based on the same underlying condition, *twice* – once for ABP purposes and once for WRR purposes – each time using a *different definition* that would yield a different outcome. Whether because of this duality or the ambiguity of "significant impairment, many individuals who do in fact have a qualifying excludable medical frailty condition for WRRs will not understand that they meet the standard. 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*.

The policies of this IFR also threaten to undermine physician-patient relationships and the ability of physicians to provide care. New paperwork burdens will interfere with patient care and treatment, as patients will schedule appointments solely to obtain documentation thus reducing appointment availability, and completing paperwork will consume physician time that could otherwise be devoted to care.[28] These policies will also place physicians in an untenable position. As a consequence of the WRR IFR's medical frailty definition, physicians will be asked to make judgments about their patient's health that have the consequence of cutting their patients off from health insurance. Placing these conditions on eligibility for Medicaid on compliance with WRR is likely to place physicians in the position of violating their ethical obligations to their patients.[29] Physicians are not trained to assess compliance with a completely new standard.

Regardless of the standard CMS applies, and even 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 H.R. 1 authorizes such a *further* limitation on the significant impairment standard which itself is a limitation inconsistent with H.R. 1.

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 chronic illness – the fact that these conditions often present as comorbidities in combining and

[28] Commonwealth of Massachusetts et al. v Oz et al. Brief of amicus curiae of American Medical Association and Massachusetts Medical Society, July 21, 2026. https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/07/Massachusetts_2026.07.21_AMICUS-BREIF-AMERICAN-MEDICAL-ASSOCIATION-ET-AL.pdf

[29] Joan Alker, "Large cuts to Medicaid and other new policies may create untenable choices for clinicians in the US," *BMJ*, 389:r563 doi: 10.1136/bmj.r563.

multiplying and debilitating ways, and 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 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, anemia can be life-threatening, etc. **CMS should remove the interpretation that some conditions are not significantly impairing because it is overbroad and will lead to clear harms.**

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, as specified in the statute.

2. Other Problems with IFR Medically Frail Standards

The IFR prohibits states from adding criteria to the medically frail standard. However, the text of H.R. 1 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 criterion. 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 WRR compliance.[30] **CMS should finalize flexibility for states to make reasonable additions to medical frailty criteria, including adding homelessness as a criterion.**

The first prong of H.R. 1's medical frailty exclusion is for individuals who are "blind or disabled" as defined in § 1614. **We support the IFR's use of that same definition, based on *having* a § 1614 disability, regardless of whether a § 1614 *determination* has been made**.

The second prong of H.R. 1's medical frailty exclusion is for individuals with a substance use disorder (SUD), without further limitations. The WRR IFR, however, prohibits the exclusion for individuals in "stable recovery," which is defined as "an individual who is in recovery for 5 or more years." CMS's regulatory limitation has

[30] 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.

no basis in the statute. More importantly, we do not believe CMS's policy is consistent with broad evidence on addiction. The limited evidence cited by CMS in the IFR applies very narrowly, as it "only focused on alcohol use disorder and defined recovery as abstinence-only."[31] CMS provided no evidence that 5-year recovery is comparably stable across SUD populations generally, including under different recovery standards. In addition, this standard is unworkable for states and CMS has provided no clear guidance on when 5-year recovery begins. In many cases there will be no reliable way to identify when the recovery period begins, as recovery is often not a linear process. CMS's standard is vague and states will have no clear way to define and operationalize it.

The third prong of H.R. 1's medical frailty exclusion is for individuals with a disabling mental health condition. We have above urged CMS to abandon the generalized "significant impairment" standard. We recommend that, if CMS needs to give meaning to the term "disabling" for the purposes of this prong of medical frailty, 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 a 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.

The fourth prong of H.R. 1's medical frailty exclusion is for individuals with a function impairment impairing their capacity to do activities of daily living (ADLs). H.R. 1's use of "impairment" in the context of ADLs refers to the ability to do the relevant ADLs (bathe, dress, etc.) and does <u>not</u> 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).

The fifth prong of H.R. 1's medical frailty exclusion is for individuals with a serious or complex condition. The WRR IFR defines "serious or complex" using a 1999 definition by the Institute of Medicine. While the definition may help states

[31] Deborah Steinberg, "CMS Approach to Work Reporting Requirement Won't Work for People with Substance Use Disorders or Mental 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/.

operationalize the term, it may be unduly narrow for some conditions, so 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 H.R. 1, this is the best interpretation and more likely to identify all of the individuals Congress intended to protect.

D. Mandatory Exceptions generally (§ 435.553)

We recommend that for § 435.553(a)(3) CMS revert to the language of the statute ("described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i)"), to avoid ambiguities created by the wording of the WRR IFR text.

We further recommend that CMS should clarify in the preamble to the final rule (and through guidance) that states must grant exceptions to all individuals *described* in subclauses (I) through (VII) of § 1902(a)(10)(A)(i), which includes individuals categorically *eligible* for such coverage but who are actually enrolled in Medicaid expansion, for whatever reason. CMS should ensure that states have processes to implement this requirement before they are being implemented.

E. Optional Exception for Short-term Hardship Events (§ 435.555)

In SSA Section 1902(xx)(3)(B), H.R. 1 gives states the option to adopt an exception that covers four specific short-term hardship events: for inpatient or related medical treatment, areas with high unemployment, areas with emergency or disaster declarations, and medical travel. These exceptions offer individuals a temporary reprieve from demonstrating WRR compliance until their next redetermination. These exceptions will be critical for individuals applying or enrolled in Medicaid, 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 condition, or who may be unable to work due to local or regional conditions beyond their control, such as a plant closure.

Under the WRR IFR, if a state adopts the optional exception for short-term hardship events, the state must adopt all four short-term hardship events. Congress specifically designed these exceptions to protect eligible residents during temporary, unavoidable crises. CMS' approach maximizes the protection of health coverage, promotes consistency across states, and reduces confusion among enrollees and new applicants. **We recommend that CMS finalize the IFR requirement (at § 435.555(a) and discussed at 91 Fed. Reg. 33380) that states**

choosing optional short-term exceptions must choose all four. We recommend that CMS clarify the requirement in the regulatory text.

The IFR also sets criteria and definitions for individuals to qualify for each of the four exceptions. Below, we make recommendations about the WRR IFR policies for three of the exceptions.

1. Inpatient or related services

First, we believe the WRR IFR impermissibly narrows the exception for inpatient or related care. H.R. 1 applies this exception for "inpatient hospital services … or such other services of similar acuity (including outpatient care *relating to* other services specified in [the] subclause)." The WRR IFR, however, does not allow outpatient services to qualify for exception, other than through an exception at § 435.555(d)(1)(ii)(E), which appears to be intended to create an exception for home-care services that prevent long term care institutionalization. **CMS should modify § 435.555(d)(1)(ii) to specifically include an exception for outpatient services related to treatment at any of the inpatient settings.**

Furthermore, H.R. 1 and the WRR 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 qualifying as hospitalized). This operational problem, which CMS has not rationally addressed in the WRR IFR, will render Congress's exception useless in practice, and many individuals with chronic illness, (in many cases workers with 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 WRR 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.***

2. Emergency/Disaster Declarations

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 WRRs, 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.**

3. Medical Travel

H.R. 1 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 who frequently need to travel to receive exceptional or regular treatment that is specialized and not locally available. This is especially true for families and people that live in rural areas where specialized treatment is often not 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.**

F. Compliance with Work Reporting Requirements (§ 435.552)

H.R. 1 includes seven different options for complying with WRR, including 80 hours per month of work, community service, or participation in a work program; at least half-time education; 80 hours of any combination of the above; or $580 per month

of income (minimum wage for 80 hours per month) or the equivalent average income for a seasonal worker. The WRR IFR is largely faithful to the statutory design for evaluating WRR compliance and we broadly support CMS's provisions and urge CMS to finalize them, subject to some specific comments below.

In particular, we support CMS's adoption of a MAGI income standard for evaluation of income. Using the relevant eligibility standard will dramatically simplify the process for states and individuals, who will be able to use one methodology for all purposes. States will have fewer rules to administer and fewer systems to program, saving significant resources. It is also the fairest standard for households, as individuals will not be punished based on the division of household roles. We also support the definition of work (at § 435.552(b)) being inclusive of in-kind and unpaid work, which will be important to some caregivers, and the proxy for calculating hours based on income less than $580 per month. **We urge CMS to retain the MAGI income standard for assessing income as well as the definition of work at § 435.552(b) and the proxy for calculating hours based on income less than $580 per month (at (e)(2)(i)).**

We also specifically support the policies related to education which continue enrollment status through normal break periods and create a proxy for counting the hours of education for individuals enrolled less than half-time. However, while we support the determination of half-time status via school designations which may have the advantage of being matchable through data sources, **we recommend CMS should in the regulatory text (and through clarification in the preamble) create a second *additional* option for individuals to demonstrate half-time status when the school designation may be flawed, unavailable, or inapposite.** States should automate, as possible, based on the school designations, but if automation does not identify half-time, individuals should have an explicit option to provide information to demonstrate half-time education.

The WRR IFR provision for compliance based on community service includes stringent requirements for the service to be in a "structured program … under the auspices of public or nonprofit organizations," that "[m]ust provide oversight of the activity … and have a process in place to track the community service completed by individuals, including the type of community service activity, dates and hours the community service is completed, and a point of contact who can confirm the hours completed." The language of H.R. 1 does not include such narrow criteria, and this narrowed interpretation will undercut Congress's intent in encouraging community involvement and will result in many individuals losing access to health care despite being actively involved in their communities. This requirement will be burdensome to non-profits undertaking charitable activities which often operate with very tight budgets, especially in rural areas and small towns where organizations operate with

very small staffs. **We recommend that CMS finalize a broad definition of community service, and at a minimum, eliminate the language in § 435.552(b) that we have identified above.**

G. Assessment of Compliance (§§ 435.557, 435.559(c), § 435.556(a)(2))

We specifically support and urge CMS to finalize several sensible interpretations in the WRR IFR of how compliance with WRR should be assessed, and also make one recommendation below.

- States initiate their renewals several months before they are due. The WRR IFR requires states to begin assessing compliance for files *initiated* in January 2027. This is a sensible policy because otherwise states would be forced to start implementing the policy before January 2027. **We recommend that CMS finalize the provision at § 435.559(c) requiring states to verify compliance for renewals *initiated* on or after the implementation date.**
- The WRR IFR allows states to verify WRR compliance as often as monthly, but prohibits states from reverifying specified excluded status between regularly scheduled redeterminations. This prohibition is necessary to properly implement the statutory framework entirely excluding specified excluded individuals from WRR compliance. **We 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.
- Under the WRR IFR, individuals who must demonstrate WRR compliance at renewal can do so by showing compliance in any month or months (depending on state election) since their prior renewal; there is no requirement that it be the most recent month or consecutive months (if multiple months are required). **We recommend that CMS finalize this 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 recommend that CMS extend the regulatory period for compliance review, to give full meaning to the intent of H.R. 1. In H.R. 1, Congress changed Medicaid expansion eligibility to be reviewed every six months. As discussed further below, Congress also requires states to use *ex parte* sources to review for potential compliance since an individual's most recent redetermination. However, almost all

states begin *ex parte* review at least two months before renewal dates, and many begin three months early.[32] This means that, for example, under the WRR IFR individuals in numerous states will only effectively have *half* of their renewal period reviewed for compliance. This will significantly reduce the *ex parte* success rate intended by Congress. **We recommend that CMS should amend § 435.556 to require that *ex parte* reviews assessing WRR compliance review the full six-month period prior to the date of the ex parte review.** For example, a review in a state which starts *ex parte* review two months early would cover the first four months since the last renewal, plus two additional prior months, for a total of six months reviewed on an *ex parte* basis.

H. Verification of Compliance, Exception, and Exclusion (§ 435.557)

In H.R. 1, Congress legislated a data-driven approach to work reporting requirement compliance, exceptions, and exclusions, *and* specifically gave the states the option to use sworn attestation to verify their status. Numerous policies in the WRR IFR violate the letter and spirit of H.R. 1, and we request that CMS remove these provisions from the final regulation, as described below.

As mentioned above, we support CMS's generalized requirement for states to pursue *ex parte* information and maximize 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.

We do not support, however, CMS's decision to limit claims and encounter data 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 various health conditions and is also inconsistent with many other data lookbacks that use longer periods of consideration (such as CMS's Chronic Conditions Warehouse). The policy is even less reasonable when considerable claims and other data lag times are considered. **We recommend that CMS should allow consideration of any data from the past 5 years as a default, and should allow states to rely on information of any age if that information is very unlikely to change (such as a permanent health condition or disability).**

[32] Tricia Brooks, et. al., "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond" (Table 17), KFF, June 20, 2024, https://www.kff.org/medicaid/a-look-at-medicaid-and-chip-eligibility-enrollment-and-renewal-policies-during-theunwinding-of-continuous-enrollment-and-beyond/#Table17.

Most importantly, CMS's WRR IFR implements an impermissible and harmful standard with respect to *sworn attestations*. Under H.R. 1, 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 an extra one-time attestation allowed starting in 2028. In all cases, states lose the option to have on-going sworn attestations. This policy directly contravenes the flexibility explicitly granted in H.R. 1.

In addition to violating the statute, the policy will be very harmful to individuals eligible for exceptions and exclusions who are by definition facing hardships. As described above, it creates special challenges for family caregivers. 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, a majority of individuals with substance use disorder have not received treatment for their condition. Such individuals will not be identified by data and will have no documentation to submit. As another example, an aunt caring for her niece will be unable to prove through data or documentation that she is providing that care. 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 eligible for exceptions and exclusions, as required by H.R.1.**

We 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 recommend that CMS should expand the policy by (1) not making it a state option; (2) setting the default duration minimum as 2 years; and (3) 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, exclusions that only need to be reverified every five years).

We support CMS's provisions that extend the duration of exclusions for select populations, including Veterans with a disability rated permanent, American Indian/Alaska Native individuals, and former foster care youth, and recommend CMS should finalize those as proposed. We recommend that CMS require states to monitor implementation of these exclusions, including through data collection. If data suggests problems with individuals accessing these exclusions, CMS should take action to ensure proper implementation and administration.

I. Noncompliance Procedures

H.R. 1 sets out a detailed process states must follow before ultimately terminating an individual's coverage due to failure to comply with WRR. A carefully sequenced and sufficiently long process and timeframe is critical for individuals to respond as they may struggle to navigate the rules and process or gather documentation to secure exclusions they are eligible for. In some cases, this may be a direct result of health, functional, and life complications directly related to their qualifying exception or exclusion (hospitalization, illness, child care, disaster relocation, SUD treatment, etc.) and in other cases it may be because of delays in obtaining medical records, certifications, etc. We have two critical comments to the noncompliance procedures established in the WRR IFR.

First, we 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). In all cases, the U.S. Constitution and Medicaid law broadly require due process for Medicaid benefits. **We request that CMS finalize § 435.558(a)(3).**

Second, we have concerns with the noncompliance sequencing options CMS allows for states during renewal. Under normal Medicaid process, when individuals are renewed, individuals are sent prepopulated forms to provide information needed to confirm eligibility. Under the IFR, states must send individuals WRR noncompliance notices when they have not been determined compliant with the WRR 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 WRR IFR, at § 435.558(b)(2), CMS effectively allows states two options for arranging 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).

We 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 evaluate WRR compliance for the purpose of an accurate noncompliance determination. 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 that they have been found noncompliant. Many individuals will misunderstand or give up, never send in forms necessary to establish their eligibility, and end up disenrolled despite being eligible and compliant or eligible for exclusion or exception. 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* notice to respond to at a time. This is especially important for the WRR compliance, exception, or exclusion, which may require significant effort to understand and require gathering documentation. **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 WRR 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 WRR 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, we 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 WRR compliance pursuant to a new application *subsequent* to review (or nonsubmission) of an RFI or similar request for additional information.**

J. Outreach

The IFR sets out state requirements for outreach at § 435.561. While the IFR is generally faithful to the statutory requirements, we are concerned that states will send WRR outreach notices to categorical populations who are not subject to WRR, leading to great confusion and potentially disenrollments. In Montana, where Medicaid WRR were implemented on July 1, 2026, the state sent a universal communication to all individuals enrolled in Medicaid, not just those enrolled in expansion.[33] Already, there are reports of confusion and concerns from providers in Montana that enrollees don't know whether WRR apply to them, or if they are

[33] Montana Department of Public Health and Human Services, "Universal Medicaid Client Communication," https://dphhs.mt.gov/assets/medicaidchanges/Universal-Medicaid-Client-Communication.pdf.

excluded or excepted.[34] Universal communications sent to Medicaid enrollees who are not subject to WRR threatens coverage for individuals who are categorically eligible for Medicaid, including many parents, pregnant individuals, disabled or chronically ill individuals eligible through disability related pathways, or individuals who are dually eligible for Medicaid and Medicare, as they may incorrectly believe they are losing Medicaid eligibility, or may deter these individuals from applying for coverage in the first place. 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. **We 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 WRR-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.**

K. Data Reporting

The IFR requires states to report timely and complete data that is of sufficient quality to monitor enrollment, retention, and eligibility processes for WRR. We commend CMS for including provisions for state data reporting requirements in the IFR but believe that they are inadequate because they will be insufficient to monitor the implementation of WRR and understand where challenges to enrollment, retention, and state administration are occurring.

The IFR sets out five categories of data states must report, but most of these required data elements are already required in the Medicaid performance indicators that states report to CMS. Moreover, the IFR does not require this data to be disaggregated for the expansion adult population. *Without disaggregation, states, CMS, and the public will be unable to effectively use state data to monitor WRR and assess challenges.* Existing data, including performance indicator and enrollment data, are published by CMS with considerable lag (ranging from 3-6 months), further limiting its usefulness for timely monitoring and rapid response. In addition, *there is no requirement that this data be made available to the public in a timely*

[34] Aaron Bolton, "Medicaid work requirements are in effect in Montana. Health providers are worried." Montana Public Radio, July 2, 2026, https://www.mtpr.org/montana-news/2026-07-02/medicaid-work-requirements-are-in-effect-in-montana-health-providers-are-worried.

manner despite Secretary Kennedy's repeated assertions of commitment to "radical transparency."[35]

To ensure states, CMS, and the public have the data essential to understand the impact of WRR, we recommend that CMS modify §435.562(c) to include the following:

- **Require states to disaggregate the performance indicator data by major Medicaid groups: 1931 parent/caretaker relatives, expansion adult, child, and pregnant or postpartum.**
- **Require more detail on the reasons for denials or disenrollment to help identify issues and areas in need of improvement. Specifically, states should report the percent of expansion adults losing coverage for procedural reasons as opposed to noncompliance with WRR requirements.**
- **Require states to report the number of expansion adults up for renewal.**
- **Require states to disaggregate the number of expansion adults who demonstrated compliance or were deemed compliant based on ex parte data or via submission of information.**
- **Require further disaggregation of data, particularly regarding medical frailty, to identify barriers to enrollment and retention for these vulnerable individuals.**
- **Require states to collect and disaggregate data on specified exclusions, particularly Veterans with a disability rated permanent, American Indian/Alaska Native individuals, and former foster care youth.**
- **Require states to disaggregate the number of expansion adults who requested fair hearings for disenrollment, including fair hearing requests pending for more than 90 days.**
- **Require that this data be made publicly available in a timely fashion.**

These recommendations are foundational to ensure that a broad community can understand and analyze the function of the WRR systems as well as the overall success of this signature policy of H.R. 1.

[35] Department of Health and Human Services, "Radical Transparency," https://www.hhs.gov/radical-transparency/index.html; Secretary Robert F. Kennedy Jr., "RFK Jr. Confirmation Hearing Day One," [Hearing transcript],https://www.rev.com/transcripts/rfk-jr-confiramation-hearing-day-one; Secretary Robert F. Kennedy Jr., "RFK Jr. Delivers Welcoming Remarks to HHS Staff" [Speech transcript], February 19, 2026, https://www.rev.com/transcripts/rfk-jr-delivers-welcoming-remarks-to-hhs-staff; Mike Stobb, "RFK Jr. pledged more transparency. Here's what the public doesn't know anymore," AP News, February 12, 2026, https://apnews.com/article/rfk-jr-transparency-data-997a11fa0e3b15ea2c71bc26e50a27f3; Isabella Cueto, "RFK Jr. moves to eliminate public comment on HHS decisions," Stat News, February 28, 2025, https://www.statnews.com/2025/02/28/rfk-jr-eliminating-public-comment-hhs-decisions-richardson-waiver/.

L. Waiver of WRR

H.R. 1 prohibits waiver of the WRR standards set out in H.R. 1. **We support the provision at § 435.563 implementing H.R. 1's prohibition against the waiver of § 1902(xx) standards, in whole or in part.**

M. Conflict of Interest and Use of Managed Care

H.R. 1 prohibits states only from using a managed care organization (MCO) or similar entity from "determin[ing] beneficiary compliance" with WRR. Thus, the law bars an MCO making official determinations on compliance, but allows MCOs to help people be compliant. The WRR IFR correctly implements this distinction in theory and in the regulatory text, however, the preamble to the regulation may narrow the statutory framework. The WRR IFR interprets that "[s]tates cannot delegate activities to conduct tracking or information gathering that are not related to the provision of Medicaid covered services, such as the collection of information on work, community service, or education activities." There is no basis in H.R. 1 for such a limitation; CMS instead bases this limitation on the regulatory limits as to what states can include in managed care capitation.

Regardless of whether a state could or could not *require* a managed care plan, as part of its *contractual obligations*, to (for example) track community service hours, we believe Medicaid law clearly allows MCOs to *voluntarily* choose to engage in such an activity. Furthermore, we believe that MCOs, as part of their care management functions (and case management if applicable) can provide an assortment of related support, such as referrals to other social services supports. **We recommend that CMS clarify in the preamble that MCOs retain authority to voluntarily provide support for WRR compliance, and that MCOs retain all of their normal care management authority to broadly support enrollees.**

N. Good Faith Effort Exemption

H.R. 1 gives the Secretary authority to approve delays in the required start date for operating WRRs in states experiencing delays despite making a good faith effort to implement WRRs. As a threshold matter, based on our extensive work in and with states, we believe all or almost all states are making tremendous efforts to implement WRRs, and doing so 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 WRRs on January 1, 2027. Most urgently, states will be unprepared to provide the required notice to enrollees in August 2026.

If states that are unprepared move forward with WRR notice in August and implementation in January, many individuals will be seriously harmed. Many individuals who should be found compliant or eligible for exceptions or exclusions will lose or be denied health coverage, while those who may remain enrolled will do so only after struggling to understand unclear policies and/or navigate dysfunctional systems–struggles which themselves may aggravate their health problems. In particular, we have two concerns with the WRR IFR on the good faith exemption.

First, we are deeply concerned with CMS's estimate in the WRR IFR preamble that only *two* states will receive good faith effort exemptions and the related 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 initiate work requirements on January 1, 2027, it is very concerning and arbitrary that CMS anticipates issuing only two approvals. We believe that given all of the timeline challenges we described above, it will in fact be quite *ordinary* for states to be unprepared on January 1, 2027. States are implementing a historic policy with incredibly risky consequences for individuals that depend on Medicaid for their health coverage and access to life-saving health care services, and CMS has the authority to protect those individuals and should use that authority as often as needed to protect people.

Second, we recommend that CMS eliminate the provisions in the WRR IFR (at § 435.560(c)) that create artificial time limits for good faith exemptions–particularly the 6-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 arbitrary 6-month increments. 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 building processes need more than 6 months. For example, a state that does not have certainty that it will get more than 6 months will be unable to move forward with a process that it reasonably expects to take 9 months to be completed; the mere *possibility* of an extension at month 6 is not enough certainty for states to undertake complex and expensive implementation process changes needed to fully implement the complexity of the law.

We recommend that CMS grant good faith exemptions to all states that need one, and that CMS approve those for the time period states need to implement well-functioning systems, and that CMS retract any policies, such as at § 435.560(c), setting arbitrary timelines such as six months.

Conclusion

The unduly restrictive policies set out in this IFR are unworkable for states and will result in many individuals, including parents, pregnant and postpartum individuals, and individuals with chronic illness, losing Medicaid coverage. This will have impacts beyond the Medicaid expansion population, as it will harm children whose parents and caregivers rely on Medicaid coverage, and threaten the financial stability and health care access of families, communities, and states. The consequences of a hasty implementation of WRR will make a harmful policy even worse; as such we recommend that CMS slow down the process and make the needed changes to the IFR to conform with H.R. 1 and support state implementation. Recent research suggests that from 3 to 7 million people could lose access to health insurance as a consequence of implementation primarily of WRR depending on state implementation.[36]

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

Thank you for your consideration of our comments. For additional information on any of these points, please contact Joan Alker at joan.alker@georgetown.edu

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[36] Matthew Buettgens et al., "Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations," Urban Institute, March 25, 2026, https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work.

Appendix A

Medicaid Community Engagement Requirements

Qualitative Research Communication Summary

This summary of findings comes from a focus group study conducted with current Medicaid beneficiaries in four expansion states in early April 2026.

- Almost all participants had not heard about the new Medicaid work requirements.
- After reading a high-level description about the changes, participants understood the basics but had many questions.

Participants Lacked Awareness and Desire Specifics

After reading a high-level description, almost all participants said they hadn't heard of work requirements yet and desired more practical guidance. A list of common questions is provided in an appendix, but some of those questions are:

- What activities count?
- What documentation is required?
- Who verifies information?
- How often do you have to report?

Many participants could not determine if they qualify for exemptions

- Many weren't sure who determines if someone is exempt.
- Many weren't sure if they had to report that they were exempt.
- Uncertainty was highest among people with:
  - Chronic illness but no disability designation with the Social Security Administration (SSA)
  - Caregiving responsibilities

Message Guidance

We avoid describing the actual requirements because there are a variety of options to meet work requirements and to be exempt. These messages drive people to look for more information.

Short messages that motivate information seeking:

- "Medicaid rules are changing"
- "Find out how the new rules affect you"
- "Don't lose your coverage"
- "Keep your coverage"
- "Medicaid changes are coming"

Longer suggestions that combine these concepts:

- Don't lose your [state program name] coverage. Medicaid rules are changing for certain adults. Find out what you need to do.
- Do you have [state program name]? Rules are changing for certain adults under 65. Find out how they affect you, so you don't lose coverage.
- New requirements are here for certain adults on [state program name]. Find out what steps you need to take now so you don't lose your coverage.

Language to Avoid (If possible)

These terms are vague and can make it seem like requirements are optional.

- "May affect"
- "Stay engaged"
- "May help you keep your Medicaid"

Preferred Terminology

- **Use:** "Work Requirements" and then list options (i.e. volunteering or training) in sub-bullets. Work requirements are what people call these organically. "Work/Volunteer/Study & Report" is another possibility that is viewed as a comprehensive name.
- **Avoid:** "Community Participation" or "Community Engagement." These terms are unknown and aren't relatable by the Medicaid recipients.

Trusted Communication Channels (Ranked)

1. Member services phone line
2. State/county offices
3. Clinics
4. Community organizations
5. Mail/Text (Text would be deemed credible if paired with mail, otherwise viewed with suspicion).

What Beneficiaries Need Most

- Clear, plain language communications that explicitly reference Medicaid or their state program name
- The availability of accurate personalized information (preferably from a person)
- Personalized exclusion checklists
- Support from trusted community organizations
- Step by step reporting instructions

Appendix of Common Questions

- **Applicability**
  - Am I one of the adults who has to meet the 80-hour requirement, or am I exempt?
  - Is my state one of the ones these changes apply to?
  - Who will tell me if I am required to meet work requirements? How do I find that out?
  - What about people who are too sick to work reliably but not on SSA disability?
  - How will this impact homeless adults?
- **Qualifying Activities**
  - What are "qualifying activities" in real life?
  - How will they verify my work or activity counts?
  - Does gig/cash work (Uber, babysitting, seasonal or commission work) count, and how do I prove it?
  - What kinds of volunteering and school/training programs count, and what does "half-time" actually mean?
  - If I work enough to meet 80 hours, will I earn too much and lose Medicaid?
- **Tracking/Reporting**
  - What do they want us to track — just total hours, or detailed logs/timecards?
  - How do I submit — portal, app, mail, phone, through employers/volunteer sites?
  - How often — monthly, quarterly? What are the deadlines?
  - Who must verify hours (employer, pastor, volunteer supervisor, program director, self-attestation)?
- **Consequences**
  - What if I don't reach 80 hours in a month (health flare, job loss, family emergency)?
  - What if I can't find another job or service opportunity?
  - Can hours roll over from one month to another?
  - What if I miss a reporting deadline or the system loses my paperwork, how fast do I lose coverage? What does "temporarily lose your coverage" actually mean (days, weeks, months)? How hard is it to get back? Will it impact other federal benefits?