July 31, 2026

VIA MAIL AND EMAIL

The Honorable Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Medicaid Program, Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026) (interim final rule) (CMS-2454-IFC)

Via electronic submission

Dear Secretary Kennedy:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. Our comments are submitted in response to the Centers for Medicare & Medicaid Services' interim final rule (IFR) implementing section 71119 of the 2025 Reconciliation Act.[1]

I. The Effects of Work Requirements

In the IFR, CMS repeatedly indicates that the work requirements will "empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency and independence."[2] CMS claims work requirements lead to employment, which leads to financial stability, which then leads to better health outcomes.[3] CMS further suggests that stable employment intrinsically benefits health.[4] The evidence does not support these claims.

A. Extensive research shows that work requirements do not increase employment.

Between 2017 and 2021, CMS approved a number of section 1115 projects that included work requirements. In 2021, the Assistant Secretary for Planning and Evaluation (ASPE) reviewed the evidence that came from implementation of these projects and found that "[m]ultiple studies indicate that Medicaid work requirements . . . can lead to significant coverage losses and worse access to care, without improvements in employment, job training, or other related activities."[5] For example, a study published in the New England Journal of Medicine found that in Arkansas, implementation of work requirements was associated with "significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment."[6] Additional research published in 2025 confirms these findings.[7]

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[1] CMS, Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026) (promulgated to implement Pub. L. No. 119-21, § 71119, 139 Stat. 172, 306 (2025) [hereinafter "2025 Reconciliation Act"]). Throughout these comments, we refer to the "community engagement" requirements as work requirements.

[2] 91 Fed. Reg. 33349, 33372, 33374, 33450.

[3] *Id*. at 33349-50.

[4] *Id*. at 33350.

[5] HHS, Assistant Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* 1 (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf; *see* Letter from Elizabeth Richter, Acting Adm'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Hum. Servs. 4-10 (March 17, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf (describing results of the studies in detail and noting "CMS is not aware of any reason to expect" the work requirement "would have a different outcome in the future than what was observed during the initial implementation of such a requirement in Arkansas and other states" [*i.e.*, New Hampshire and Michigan]).

[6] Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas,* 381 N. ENG. J. MED. 1073 (2019) (attached) [hereinafter "Sommers, *Results from the First Year in Arkansas*"]; *see* Benjamin D. Sommers et al., *Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFS. 1522 (2020) (attached) (finding "no significant changes in employment, number of hours worked, or community engagement status between 2018 (during work requirements) and 2019 (after work requirements put on hold)") [hereinafter "Sommers, *Consequences of Work Requirements in Arkansas"*].

[7] Anuj Gangopadhyaya & Michael Karpman, *The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data*, HEALTH SERVS. RSCH. E14624 (Apr. 2025) (attached) (finding the work requirement was associated with a 4.4% increase in the uninsurance rate among people ages 30-49 with income below 300% FPL and a 7.4% increase among people ages 30-49 with incomes below 100% FPL, and did not have any effect on hours worked, employment, or employer-sponsored coverage); Anuj Gangopadhyaya & Michael Karpman, Urban Inst., *New Evidence Confirms Arkansas Medicaid Work Requirement Did Not Boost Employment* (2025), https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment (explaining the results of the study); *see also* Hilary Wething, Econ. Pol'y Inst., *Work requirements for safety net programs like SNAP and Medicaid: A punitive solution that solves no real problem* 2 (2025), https://files.epi.org/uploads/294456.pdf (explaining that work requirements do not increase

Further, duplicative and rigorous studies of other public benefits programs demonstrate that work requirements do not increase stable, long-term employment.[8]

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employment because they "do not attack the core problems of weak macroeconomic conditions, the volatile nature of low-wage work, and other barriers to work like caregiving responsibilities").

[8] *See, e.g.*, Lauren Bauer and Chloe N. East, The Hamilton Project, *A primer on SNAP work requirements* (2026), https://www.hamiltonproject.org/wp-content/uploads/2025/04/20260409_THP_SNAPWorkRequirements_Paper.pdf (conducting a comprehensive review of the literature on SNAP work requirements and concluding "the best evidence shows they do not increase employment" and "cause a large decrease in participation in SNAP"); Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage*, THE COMMONWEALTH FUND BLOG (June 21, 2019), https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage ("Several rigorous studies found that SNAP work requirements reduce enrollment and have little to no employment benefits. . . .These studies join a body of research about the damage caused by work requirements in Temporary Assistance for Needy Families and their failure to improve health or employment."); Katherine Richard & Lea Bart, Population Studies Ctr. at the Univ. of Mich., *Penalties in the Safety Net: Effects of Work Requirement Enforcement on Program Participation and Labor Supply* (updated 2026), https://krzrich.github.io/website/Richard_Bart_PenaltiesSafetyNet.pdf (finding that when Michigan imposed harsher TANF work sanctions, individuals who lost eligibility were 13.8% less likely to be formally employed after two years than those subject to the prior, less harsh sanctions and were also 20% less likely to be enrolled in SNAP or TANF); LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Work*, OFF THE CHARTS (Jan. 10, 2018), https://www.cbpp.org/blog/work-requirements-dont-work; LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), https://www.cbpp.org/research/evidence-doesnt-support-claims-of-success-of-tanf-work-requirements; Tazra Mitchell & LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (2018), https://www.cbpp.org/research/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below-half-the-poverty-line (finding that TANF work requirements in Kansas did not result in a measurable uptick in employment among TANF parents; instead, work was common, but unsteady, resulting in inconsistent earnings and periods of unemployment); LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016), https://www.cbpp.org/research/test-work-requirements-dont-cut-poverty-evidence-shows; MaryBeth Musumeci & Julia Zur, Kaiser Fam. Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/ [hereinafter "Musumeci, *Medicaid Enrollees and Work Requirements*"]; Sandra K. Danziger *et al.*, *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MGMT. 231, 234 (2016) (attached); Admin. for Child.& Fams., Dep't of Health & Hum. Servs., *Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2013,* Table 43, https://acf.gov/sites/default/files/documents/ofa/tanf_characteristics_fy2013.pdf (finding that in 2013, only 9.6% of recipients left the TANF program due to finding employment, while almost four times as many individuals (36%) left as a result of sanctions or a failure to comply with the verification and eligibility procedures); Gayle Hamilton *et al.*, Manpower Demonstration Rsch. Corp., *National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs* (2001), https://www.mdrc.org/sites/default/files/full_391.pdf; Ladonna Pavetti et al., Ctr. on Budget & Pol'y Priorities, *Expanding Work Requirements Would Make It Harder for People to Meet Basic Needs* (2023), https://www.cbpp.org/research/poverty-and-inequality/expanding-work-requirements-would-make-it-harder-for-people-to-meet; Heather Hahn et al., Urban Inst., *Work Requirements in Social Safety Net Programs: A Status Report of Work Requirements in TANF, SNAP Housing Assistance, and Medicaid* (2017), https://www.urban.org/research/publication/work-requirements-social-safety-net-programs-status-report-work-requirements-tanf-snap-housing-assistance-and-medicaid.

Nothing in the IFR refutes – or even engages with – this evidence. However, when CMS released the IFR, ASPE released an issue brief finding that "Medicaid work requirements could reduce poverty by between 1.6 and 2.9 million people."[9] Experts have explained that conclusion is highly flawed. Former ASPE directors, Richard Frank and Sherry Glied, found that the conclusion "rest[s] on completely unrealistic assumptions" about the effects of work requirements on employment and, therefore, the issue brief is of "limited use in assessing likely policy outcomes."[10] They detail how the simulation model designed by ASPE is based on faulty design and methodology.[11] They note that to support its conclusions, ASPE primarily cited welfare-to-work initiatives from the 1990s, a few SNAP studies, and a few housing studies.[12] Some of those studies had null findings, and the welfare-to-work programs had substantial work *support* components – which the Medicaid work requirements do not.[13] ASPE entirely ignores studies examining the effects of work requirements in Medicaid, which, as noted above, did not increase employment and caused massive coverage loss.[14] Public health scholars have shared similar concerns about the ASPE brief.[15]

What is more, the IFR wholly ignores how the work requirements will affect applicants and beneficiaries who are unable to comply and, as a result, cannot obtain or maintain Medicaid coverage. Substantial evidence demonstrates that Medicaid coverage itself is a work support – it allows individuals to access the care and services they need to be healthy enough to work.[16]

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[9] Danielle Berman et al., Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Hum. Servs., *Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce Poverty* (2026), https://aspe.hhs.gov/reports/medicaid-work-requirements-should-incentivize-employment-reduce-poverty.

[10] Richard G. Frank & Sherry Glied, *ASPE's Analysis of Medicaid Work Requirements: Argument by Assumption*, HEALTH AFFAIRS FOREFRONT (June 12, 2026) (attached).

[11] *Id.*

[12] *Id.*

[13] *Id.* The authors go on to note that ASPE did not "rely on the results of its own literature review at all" when developing its simulation model.

[14] *Id*.

[15] *See, e.g.*, Chloe East & Adrianna McIntyre, *The Trump Administration's Dubious Case for Work Requirements*, CAN WE STILL GOVERN? (June 9, 2026), https://donmoynihan.substack.com/p/the-trump-administrations-dubious (attached).

[16] *See* Madeline Guth & Meghana Ammula, KFF, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021* (2021), https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/ [hereinafter "Guth, *Building on the Evidence Base*"]; Madeline Guth et al., KFF, *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020* (2020), https://www.kff.org/affordable-care-act/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ [hereinafter "Guth, *The Effects of Medicaid Expansion*"]; Ohio Dep't of Medicaid, *2016 Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* 41 (2017), https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/ohio-medicaid-group-viii-assessment/ohio-medicaid-group-viii-assessment (finding 52% of employed expansion enrollees reported Medicaid makes it easier to continue working and nearly 75% of unemployed enrollees reported Medicaid makes it easier to look for work); Ohio Dep't of Medicaid, *2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid*

B. Research on the relationship between work and health does not support the claim that work requirements improve health outcomes.

Even assuming for the sake of argument that work requirements will lead to an increase in employment (which they will not), it does not follow that the increase in employment will lead to better health outcomes, as CMS now claims.[17]

The body of literature evaluating the correlation between work and health shows the relationship to be complex and suggests that work requirements are detrimental to health.[18] For one, job quality matters.[19] Research CMS cites in the IFR acknowledges as much.[20] Medicaid beneficiaries generally do not have access to high quality jobs – instead, they face low pay, stagnant wage growth, and volatile job prospects.[21] These jobs are often in

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Group VIII Assessment 21-22 (2018), https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/ohio-medicaid-group-viii-assessment/ohio-medicaid-group-viii-assessment [hereinafter "*2018 Ohio Medicaid Group VIII Assessment*"] (finding 85% of employed expansion enrollees reported Medicaid makes it easier to continue working and 60% of unemployed enrollees reported Medicaid makes it easier to look for work); Susan Door Goold & Jeffrey Kullgren, Inst. for Healthcare Pol'y & Innovation at Univ. of Mich., *Report on the 2016 Healthy Michigan Voices Enrollee Survey* 5 (Jan. 17, 2018), https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder34/Folder2/Folder134/Folder1/Folder234/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_11718_final.pdf?rev=bc578064d5be4318acb39796670af8e3 (finding 69% of employed enrollees reported Medicaid helped them do a better job and nearly 55% of unemployed enrollees reported coverage helped them in their job search). Additional research demonstrates that Medicaid coverage does not decrease beneficiaries' work rates. *See*, *e.g.*, Matt Broaddus, Ctr. on Budget & Pol'y Priorities, *Study: Insurance and Access to Care Down, With No Boost in Work Among Tennessee Adults Losing Medicaid* (2018), https://www.cbpp.org/blog/study-insurance-and-access-to-care-down-with-no-boost-in-work-among-tennessee-adults-losing (describing the research); Thomas DeLeire, *NBER Working Paper 24899, The Effect of Disenrollment From Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization* (2018), https://www.nber.org/papers/w24899 (finding that when Tennessee took away Medicaid coverage from approximately 170,000 low-income adults, employment and private coverage rates did not change, but self-reported health and access to care worsened).

[17] 91 Fed. Reg. 33350.

[18] *See, e.g.*, Larisa Antonisse & Rachel Garfield, KFF, *The Relationship Between Work and Health: Findings from a Literature Review* 3-5 (2018) (attached) (explaining the important distinction between evidence on the effect of employment on health and evidence on the effect of unemployment on health and noting the possibility that the work-health association is due to selection bias).

[19] *See, e.g.*, *id.* at 4 (noting that "the quality and stability of work is a key factor in the work-health relationship: research finds that low-quality, unstable, or poorly-paid jobs lead to or are associated with adverse effects on health"); Robert Wood Johnson Found., *Issue Brief: How Does Employment—or Unemployment—Affect Health?* (2013) (attached).

[20] *See* 91 Fed. Reg. 33350, n. 20 (citing Ryan Gerdes et al., *Associations Between Employment and Health Outcomes: A Systematic Review of Reviews*, J. OCCUPATIONAL REHAB. (Jan. 6, 2026), https://doi.org/10.1007/s10926-025-10357-5 ("Insecure or low-quality work demonstrated the potential to override identified health benefits of work.")).

[21] *See, e.g.*, Kristin F. Butcher & Diane Whitmore Schanzenbach, *Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs* (2018), https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf; Hilary Wething, Econ. Pol'y Inst., *Work requirements for safety net programs like SNAP and Medicaid: A punitive solution that solves*

high-risk occupations with health-impairing working conditions[22] and/or are "high strain" jobs that have been demonstrated to increase poor health outcomes.[23] Indeed, studies investigating the experience of lone parents in welfare-to-work programs found that the requirements can "exacerbate[] ill health."[24]

C. Work requirements result in coverage loss, which leads to negative health and financial consequences.

There is no question that work requirements deter and reduce Medicaid coverage.[25] The Congressional Budget Office found as much with respect to the current work requirements.[26] And, a March 2026 study found that the work requirements will reduce

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no real problem (2025), https://files.epi.org/uploads/294456.pdf (finding that jobs available to low-income individuals often have irregular and unpredictable schedules, which make it hard to maintain consistent work).

[22] *See, e.g.*, Andrea L. Steege et al., *Examining Occupational Health & Safety Disparities Using National Data: A Cause for Continuing Concern*, 57 AM. J. INDUS. MED. 527 (2014), https://pmc.ncbi.nlm.nih.gov/articles/PMC4556419/ (finding employment in a high-risk occupation was associated with, among other things, having a high school degree or less and receiving low wages); Sarah A. Burgard & Katherin Y. Lin, *Bad Jobs, Bad Health? How work and working Conditions Contribute to Health Disparities*, 57 AM. BEHAV. SCI. (2013) https://pmc.ncbi.nlm.nih.gov/articles/PMC3813007/ (explaining that insecure or precarious work is an important component of risk, and less advantaged workers have more dangerous work); A.C. Volkers et al., *Health Disparities by Occupation, Modified by Education: A Cross-Sectional Population Study*, BMC PUB. HEALTH 7 196 (2007), https://doi.org/10.1186/1471-2458-7-196 (describing how occupation is a risk factor for poor health outcomes); Andrea L. Steege et al., *Work as a Key Social Determinant of Health: The Case for Including Work in All Health Data Collections*, NIOSH Science Bulletin (Feb. 16, 2023), https://www.cdc.gov/niosh/bulletin/2023/sdoh.html.

[23] Douglas Jacobs, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health*, HEALTH AFFS. FOREFRONT (Aug. 6, 2018) https://www.healthaffairs.org/content/forefront/social-determinants-speak-medicaid-work-requirements-worsen-health; *see* HHS, Off. of Disease Prevention & Health Promotion, *Social Determinants of Health Literature Summaries: Employment*, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment.

[24] Mhairi Campbell et al., *Lone Parents, Health, Wellbeing and Welfare to Work: A Systematic Review of Qualitative Studies*, 16 BMC PUB. HEALTH 188, 195 (2016) (attached).

[25] *See, e.g.*, HHS, Assistant Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* 3 (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf; Letter from Elizabeth Richter, Acting Adm'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Hum. Servs. 4-9 (March 17, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf; Michael Karpman et al., Urban Inst. & Robert Wood Johnson Found., *Assessing Potential Coverage Losses Among Medicaid Expansion Adults under a Federal Medicaid Work Requirement* (2025), https://www.rwjf.org/en/insights/our-research/2025/03/how-many-expansion-adults-could-lose-medicaid-under-federal-work-requirements.html?utm_source=80m.beehiiv.com&utm_medium=referral&utm_campaign=the-reality-of-work-requirements-designed-to-cut-not-to-put-people-to-work.

[26] Congressional Budget Office (CBO), Supplemental Cost Estimate, Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance Subtitle B, Health, Chapter 1, Medicaid (October 28, 2025), https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.

Medicaid enrollment by between 3 and 7 million individuals by 2028, depending on state implementation choices.[27]

While the IFR acknowledges that the work requirements will result in coverage loss,[28] it wholly ignores the negative effects of that coverage loss on low-income individuals. For example, research from Arkansas shows that individuals who lost coverage after work requirements were implemented faced a range of negative health and financial consequences: approximately 56% delayed needed care due to cost; 64% delayed taking medications due to cost; and 50% reported serious problems with medical debt.[29] Indeed, a large body of evidence shows that gaps in Medicaid coverage are associated with worse health outcomes, including premature mortality.[30] In contrast, continuous Medicaid

[27] Matthew Buettgens et al., Urban Inst., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations: National and State Estimates for 2028* at 27 (2026), https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work. Notably, these projections were based on assumptions about states' options for mitigating coverage loss given the text of the statute. *See id*. at vi (describing mitigation scenarios). However, as described in detail below, the IFR has limited those options, which will lead to additional coverage loss.

[28] *See* 91 Fed. Reg. at 33459-61 (estimating that the work requirement will reduce enrollment by 15%). However, as described in section V. below, experts have criticized that as a substantial underestimate. *See, e.g.*, Leighton Ku, George Wash. Univ., Milken Inst. Sch. of Pub. Health, Geiger Gibson Program in Cmty. Health, *Commentary: The Administration's Flawed and Misleading Claims About Medicaid Work Requirements* (2026), https://geigergibson.publichealth.gwu.edu/commentary-administrations-flawed-and-misleading-claims-about-medicaid-work-requirements (attached) [hereinafter "Ku, *The Administration's Flawed and Misleading Claims About Medicaid Work Requirements*"].

[29] Sommers, *Consequences of Work Requirements in Arkansas* (finding the rates were much lower among Arkansans who had maintained their coverage).

[30] *See, e.g.*, Sarah Miller et al., Nat'l Bureau of Econ. Rsch., *Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*, *Working Paper 26081* (2019) (attached) [hereinafter "Miller, *Medicaid and Mortality*"]; Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 N. ENG. J. MED. 586 (2017), (attached) [hereinafter "Sommers, *Health Insurance Coverage and Health*"]; Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. HEALTH ECON. 392 (2017) (attached) [hereinafter "Sommers, *State Medicaid Expansions and Mortality, Revisited*"]; Benjamin D. Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012), https://www.nejm.org/doi/full/10.1056/nejmsa1202099 [hereinafter "Somers, *Mortality and Access to Care*"]; Allyson G. Hall et al., *Lapses in Medicaid Coverage: Impact on Cost and Utilization among Individuals with Diabetes Enrolled in Medicaid*, 48 MED. CARE 1219 (2008) (attached) [hereinafter "Hall, Lapses in Medicaid Coverage"]; Andrew Bindman et al., *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 ANNALS INTERNAL MED. 854 (2008) (attached); Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS INTERNAL MED. 424 (2017) https://pubmed.ncbi.nlm.nih.gov/28655034/; Jacob Goldin et al., *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach*, 136 Q. J. ECON. 1 (2021) (attached); Leighton Ku and Erika Steinmetz, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid,* Association for Community Affiliated Plans (2013) (attached) [hereinafter "Ku, B*ridging the Gap*"].

coverage is associated with positive health outcomes.[31] In addition, research demonstrates that Medicaid coverage has a positive effect on beneficiaries' financial well-being.[32]
In sum, CMS overstated the potential benefits of work requirements while ignoring or discounting the well-documented harms. That flawed reasoning infected choices CMS made throughout the IFR, including its decisions to restrict the definition of medically frail

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[31] *See, e.g.*, Rose C. Chu et al., HHS, Ass't Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid: The Health and Economic Benefits of Expanding Eligibility* (2024), https://aspe.hhs.gov/sites/default/files/documents/effbde36dd9852a49d10e66e4a4ee333/medicaid-health-economic-benefits.pdf (summarizing the research finding that Medicaid expansion led to improved health outcomes) [hereinafter "Chu, *The Health and Economic Benefits of Expanding Eligibility*"]; HHS, Assistant Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* 6-7 (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf (noting the "strong evidence linking health insurance coverage to positive health and economic outcomes" and stating that policies leading to loss of Medicaid coverage will lead to reduced access to care and as a result, adverse health effects).

[32] *See, e.g.*, Chu, *The Health and Economic Benefits of Expanding Eligibility* (gathering research documenting that Medicaid expansion "produced substantial financial benefits to low-income Americans"); Laura Harker & Breanna Sharer, Ctr. on Budget & Pol'y Priorities, *Medicaid Expansion: Frequently Asked Questions* (2024) https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0 (collecting research showing that Medicaid expansion improves enrollees' financial well-being); Guth, *Building on the Evidence Base* (reviewing the literature and finding that expansion has improved financial security); Guth, *The Effects of Medicaid Expansion* (same); Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions Over Time,* 38 HEALTH AFFS. 132-138 (2019) (attached) (finding that Medicaid significantly reduces poverty and that the impact increased over the last decade); Sarah Miller et al., *National Bureau of Economic Research Working Paper No. 25053: The ACA Medicaid Expansion in Michigan and Financial Health* (2018), http://www.nber.org/papers/w25053 (finding Medicaid enrollment is associated with improvements in financial health); Aaron E. Carroll, *Medicaid as a Safeguard for Financial Health*, 321 JAMA 135 (2019), https://jamanetwork.com/journals/jama/fullarticle/2720716; *2018 Ohio Medicaid Group VIII Assessment*, at 26- 28 (finding that in Ohio, "Medicaid promotes economic security"); Jesse Cross-Call, Ctr. on Budget & Pol'y Priorities, *More Evidence Medicaid Expansion Boosts Health, Well-Being*, Off the Charts (Jan. 8, 2018), https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being (highlighting data showing that health coverage reduces poverty and Medicaid expansion improves financial security); Georgetown Univ. Health Pol'y Inst., Ctr. for Child. and Fams., *Medicaid: How Does It Provide Economic Security for Families?* (2017), https://ccf.georgetown.edu/2017/03/09/medicaid-how-does-it-provide-economic-security-for-families/; Dahlia K. Remler et al., *Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFFS. 1828 (2017), https://pubmed.ncbi.nlm.nih.gov/28971930/; Aaron Sojourner & Ezra Golberstein, *Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction*, HEALTH AFFS. BLOG (July 24, 2017), https://aaronsojourner.org/writings/health-affairs-blog-medicaid-expansion-reduced-unpaid-medical-debt-and-increased-financial-satisfaction/; Louija Hu et al., *National Bureau of Economic Research Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being* (2016), http://nber.org/papers/w22170; Nicole Dussault, Maxim Pinkovskiy & Basit Zafar, *Is Health Insurance Good for Your Financial Health?* Federal Reserve Bank of New York – Liberty Street Economics (2016), http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your- financial-health.html; Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 36 NEW ENG. J. MED. 1713 (2013) (attached) (finding Medicaid coverage "led to a reduction in financial strain from medical costs . . . [i]n particular, catastrophic expenditures"); Amy Finkelstein *et al. The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q. J. ECON. 1057, 1057 (2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC3535298/.

and limit the use of self-attestation, as described further below. In fact, a recent Manatt analysis estimates that compared with "a plain-language reading of the statute," the IFR will "increase average annual Medicaid coverage losses by 1.8 million people, from 6.4 million to 8.2 million between FFY 2027-2034 – nearly 1 in 10 Medicaid enrollees nationwide."[33] To promote employment, increase financial stability, and improve health outcomes, CMS should follow the evidence and craft a Final Rule that aligns with the statute and the accumulated, redundant research and that minimizes coverage loss.

II. Criteria for "Medically Frail" Exclusion

A. Restricting the exclusion to individuals whose health condition "significantly impairs" their ability to comply is contrary to statute and without a valid rationale.

The Medicaid Act excludes an individual "who is medically frail or otherwise has special medical needs" from work requirements.[34] While Congress authorized the Secretary to define aspects of the term, it established some clear limits on that authority. It required the definition to include an individual: who is blind or disabled (as defined in section 1614); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or with a serious or complex medical condition.[35] In the IFR, however, individuals who fall within one of these five categories only qualify as "medically frail" if their health condition "significantly impairs [their] ability to comply with the community engagement requirement."[36] To support the grafting on of this additional requirement, CMS asserts that the "best reading of the statutory phrase 'medically frail or who otherwise has special medical needs'" is that it "connotes diminished functional capacity that significantly impairs an individual's ability to meet ordinary demands."[37] The reasoning to support this interpretation does not hold up.

As we said in our prior comment submitted to CMS on November 19, 2025, only one of the categories – "an individual who is . . . disabled (as defined in section 1614) – links medically frail status to ability to work."[38] Similarly, to qualify as "blind" under section 1614, an individual is not required to show an inability to participate in substantial gainful

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[33] Patricia M. Boozang et al., Manatt, *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027-2034* (July 16, 2026) (attached).
[34] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).
[35] *Id.*; *see also* 91 Fed. Reg. 33373.
[36] 42 C.F.R. § 435.554(c)(5)(i). Throughout these comments, citations to the C.F.R. are to the version effective on July 31, 2026.
[37] 91 Fed. Reg. 33373.
[38] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa); *see id*. § 1382c(a)(3) (generally defining disabled as "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months").

activity.[39] If Congress had intended for the exclusion to only apply to individuals who cannot work (or cannot comply with the work requirements) as CMS has done in the IFR, it would have said so explicitly.[40]

Significantly, the phrase "medically frail or otherwise has special medical needs" is not new and, historically, is unrelated to ability to work. In 2006, when Congress amended the Medicaid Act to give states the flexibility to require beneficiaries to enroll in Alternative Benefit Plans, it exempted from mandatory enrollment any individual "who is medically frail or otherwise an individual with special medical needs."[41] Under the implementing regulation, CMS allows states to define the phrase, but their definition must include at least six listed categories of individuals.[42] In creating the six categories, CMS made sure to adhere to the statutory aim of ensuring that individuals with significant health care needs maintain adequate health coverage.[43] In the 2025 Reconciliation Act, Congress adopted five of the categories in the regulation and made slight modifications to expand several of them; Congress dropped only the category that is limited to children under age 19 (who, of course, are not subject to work requirements).[44] In borrowing from this existing language, Congress evidenced the intent to exclude from the work requirements applicants and beneficiaries who need continuous, comprehensive health care coverage. Thus, the statute does not authorize CMS to restrict the "medically frail" exclusion to individuals whose health condition "significantly impairs [their] ability to comply with the community engagement requirement."[45]

CMS's attempts to justify the restriction are illogical. CMS recognizes that "[t]he ABP definition of medically frail at § 440.315(f) is very similar to the community engagement medically frail definition at section 1902(xx)(9)(A)(ii)(V) of the Act" and goes on to highlight slight differences between the two.[46] For example, CMS notes that, unlike the ABP definition, which uses the phrase "serious *and* complex," the "medically frail" definition in section 71119 uses the phrase "serious *or* complex." Similarly, the ABP definition refers to

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[39] *See* 42 U.S.C. § 1382c(a)(2) (individuals who are blind under this provision do not have to show that they cannot participate in substantial gainful activity).
[40] *See, e.g.*, 7 U.S.C. § 2015(o)(3)(B) (exempting from the SNAP work requirements an "individual who is medically certified as physically or mentally unfit for employment").
[41] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044, 120 Stat. 4, 90 (codified at 42 U.S.C. § 1396u-7(a)(2)(B)(vi)).
[42] 42 C.F.R. § 440.315(f).
[43] *See, e.g.*, *Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans*, 78 Fed. Reg. 42160, 42231 (July 15, 2013) ("To ensure appropriate service protection for individuals with disabilities and special medical needs, we have included a basic definition of medically frail that we anticipate will ensure that vulnerable individuals with special medical needs are not mandatorily enrolled in an ABP that may not provide appropriate medical treatment for their individual medical condition. Section 440.315(f) provides states with a minimum standard for defining medically frail populations."); *id*. at 42233 (regarding individuals with a substance use disorder).
[44] *Compare* 42 C.F.R. § 440.315(f) *with* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V) (omitting individuals described in 42 C.F.R. § 438.50(d)(3)).
[45] 42 C.F.R. § 435.554(c)(5)(i).
[46] 91 Fed. Reg. 33372.

individuals with "chronic substance use disorder," while the work requirements definition omits the word "chronic." These differences make the medically frail categories in section 71119 *more expansive* than the categories in the ABP regulation.

Further, CMS attempts to justify its medically frail definition on the basis that the "medically frail exclusion for the ABP only impacts . . . benefit package selection, while the medically frail exclusion under the community engagement requirement determines if an individual needs to demonstrate community engagement to maintain Medicaid eligibility."[47] Again, that reasoning would support adopting a more expansive definition of medically frail in the work requirement context given the more severe consequences associated with failure to qualify as medically frail (*i.e.*, total coverage loss v. loss of coverage for particular services).

Finally, CMS points to the benefits of the work requirements to support its restrictive definition of medically frail.[48] As noted above, CMS has inaccurately stated the potential benefits of work requirements. Even more critically, it has ignored the costs for individuals who should be excluded as medically frail under the statute, are not excluded under the IFR, and will lose Medicaid coverage for failure to comply with the work requirements as discussed in more detail below.

We ask CMS to amend 42 C.F.R. § 435.554(c)(5)(i) in the Final Rule to remove the following language: "whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement in this subpart and is an individual."

B. Restricting the exclusion to individuals with an SUD who are not in "stable recovery" is contrary to statute and without a valid rationale.

As noted above, Congress excluded from the work requirement an individual "with a substance use disorder."[49] However, under the IFR, an individual is not an individual "with a substance use disorder" if they are "in stable recovery (which means, an individual who is in recovery for 5 or more years)."[50]

An individual with a substance use disorder includes an individual whose condition is in remission. Substance use disorders are chronic, relapsing medical conditions that are treatable and manageable, but not curable in the traditional sense. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) is the authoritative guide for diagnosing mental health conditions in the U.S.[51] Under the DSM-V-TR, an individual continues to have a SUD if their condition is in remission. A SUD is in remission if the individual previously met the diagnostic criteria for the condition but has not met any of the criteria

[47] *Id*.
[48] *Id*. at 33372, 33376.
[49] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb).
[50] 42 C.F.R. § 435.554(c)(5)(i)(B).
[51] 91 Fed. Reg. 33374.

(other than craving or a strong desire to use the substance) for at least three months.[52] Relatedly, it indicates that an individual who is receiving maintenance therapy for opioid use disorder (OUD) or tobacco use disorder continues to have a SUD.[53] The DSM-V-TR characterizes remission as "early" (3 to twelve months) or "sustained" (12 months or longer). There is no suggestion that, after a certain period of years in remission, an individual no longer has a SUD diagnosis.[54]

CMS acknowledged the authority of the DSM-V-TR but disregarded it. CMS stated that it was appropriate to subject an individual "in stable recovery" to the work requirements because they are "better able to participate in community engagement activities than an individual who is in active treatment or early or sustained recovery."[55] However, the single article that CMS cited in support of this claim explicitly states there is no uniform definition or understanding of "recovery" or "being in recovery."[56]

And again, CMS justified its position on the basis that the work requirements could help individuals in stable recovery "maintain their recovery by helping them escape isolation and dependency, build confidence, achieve self-sufficiency and prosperity, and improve health."[57] As described in detail above, the evidence does not support that claim. Further, the same article that CMS cited indicates that some workplace conditions and/or norms can be harmful to individuals with a SUD which, in turn, undermines recovery.[58]

CMS also again ignored how its restrictive definition of an individual with a SUD would harm individuals who do not meet the definition and lose Medicaid coverage as a result. Individuals with a SUD in remission face serious harm if their Medicaid coverage is terminated. Research shows that continuing care is beneficial for many individuals in recovery.[59] For example, some individuals taking methadone to treat OUD need to remain on the medication long-term.[60] Medicaid coverage makes it possible for individuals to

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[52] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 547, 553-54, 575-76, 587-88, 601-02, 608-10, 620-21, 632-34, 645-46, 652-53 (5th ed., text rev.) (2022) [hereinafter "DSM-V-TR"] (distinguishing between early remission (3 months to 12 months) and sustained remission (12 months or longer) for SUDs).
[53] *Id*. at 608-10, 645-46.
[54] *See id*. at 547, 553-54, 575-76, 587-88, 601-02, 608-10, 620-21, 632-34, 645-46, 652-53.
[55] 91 Fed. Reg. 33374.
[56] *See* 91 Fed. Reg. 33374 (citing M.R. Frone et al., *Workplace Supported Recovery from Substance Use Disorders: Defining the Construct, Developing a Model, and Proposing an Agenda for Future Research*, 6 OCCUP. HEALTH SCI. 475 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC10193449/) [hereinafter "Frone, *Workplace Supported Recovery*"].
[57] 91 Fed. Reg. 33374.
[58] *See* Frone, *Workplace Supported Recovery*.
[59] *See, e.g.*, James R. McKay, *Impact of Continuing Care on Recovery from Substance Use Disorder* 41 ALCOHOL RSCH. 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7813220/pdf/arcr-40-1-1.pdf ("Regardless of the intervention selected for use, it is clear that the status of most patients with SUD will change and evolve over time, and interventions need to include provisions to assess patients on a regular basis and to change or adapt treatment when warranted.").
[60] *Methadone*, SAMHSA, https://www.samhsa.gov/substance-use/treatment/options/methadone (March 29, 2024); *see also Buprenorphine*, SAMHSA, https://www.samhsa.gov/substance-

access these ongoing services.[61] Losing coverage and, as a result, access to SUD treatment services, could result in dire health consequences.[62] As detailed above, rather than acknowledge these consequences, CMS acted on the unsupported and inaccurate conclusion that work requirements promote health.

We ask CMS to amend 42 C.F.R. § 435.554(c)(5)(i)(B) in the Final Rule to remove the following language: "excluding an individual in stable recovery (which means, an individual who is in recovery for 5 or more years)."

C. CMS's interpretations of other "medically frail" categories are too narrow, unsupported by the relevant authorities, or improperly shaped by the "significantly impairs" analysis.

Individual with a Disabling Mental Disorder: In the IFR, CMS declines to define an individual "with a disabling mental disorder," instead directing states "to consider whether the…disorder significantly impairs an individual's ability to comply" with the work requirement.[63] That logic collapses two inquiries into one. In effect, this appears to mean that a mental disorder is only disabling if it "significantly impairs an individual's ability to comply" with the work requirement.

Under the DSM-V-TR, a mental disorder is "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects" a problem in mental functioning and "is usually associated with significant distress or disability in social, occupational, or other important activities."[64] Many mental disorders are chronic conditions, many with episodic onsets, that are treatable but not curable.[65]

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use/treatment/options/buprenorphine (March 28, 2024) (noting that treatment with buprenorphine can be indefinite).

[61] *See, e.g.*, Guth, *The Effects of Medicaid Expansion* (collecting research showing that Medicaid expansion is associated with increased access to SUD treatment, including medications to treat OUD); Guth, *Building on the Evidence Base*; Mark Olfson et al., *Healthcare Coverage and Service Access for Low-Income Adults with Substance Use Disorders*, 137 J. SUBSTANCE ABUSE TREATMENT 108710 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9086121/ (finding that among low-income adults with a SUD, those with no insurance coverage had lower likelihood of receiving SUD treatment, compared to those with discontinuous or continuous coverage); Joanne Constantin et al., *Medicaid Unwinding and Changes in Buprenorphine Dispensing*, 8 JAMA NETWORK OPEN e258469 (2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833436 (finding that Medicaid unwinding was associated with disruptions in buprenorphine use).

[62] *See, e.g.*, Thomas Santo, Jr. et al., *Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People with Opioid Dependence*, 78 JAMA PSYCHIATRY 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8173472/#H1-4-YOI210027 (finding opioid agonist treatment is associated with a 50% lower risk of all-cause mortality).

[63] 91 Fed. Reg. 33375.

[64] DSM-V-TR at 14.

[65] *See, e.g.*, *Bipolar Disorder*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/diagnosis-treatment/drc-20355961 (Aug. 14, 2024) (noting bipolar disorder is a lifelong condition); *Schizophrenia*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443 (Oct. 16, 2024) (noting people with schizophrenia need lifelong treatment); *Depression*, Mayo Clinic,

CMS directs states to use guidance from the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), thereby treating "serious mental illness" as equivalent to "disabling mental disorder."[66] But the ISMICC definition does not support limiting the medically frail exclusion to individuals whose condition "significantly impairs [their] ability to comply with the work requirement.""[67]

ISMICC defines an adult with serious mental illness as a person "who currently or at any time in the past year has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the [DSM] and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities."[68] CMS's other cited authority defines the term substantially the same way.[69] Neither definition ties impairment only to work capacity; instead both measure it against major life activities generally, which include eating, sleeping, standing, concentrating, learning, communicating, as well as limits on major bodily functions like circulation and reproduction, all in addition to work.[70]

If states use the ISMICC definition of "serious mental illness" to identify those who have a "disabling mental disorder," then the exclusion should include all persons who: (1) have a mental disorder listed in the DSM; and (2) because of that disorder, also meet the definition of "disability" under the Americans with Disabilities Act. Indeed, this approach would align with how CMS defines "disabled individual" in the parent/caretaker exclusion to work requirements.[71] CMS declined to adopt such alignment arguing it would be unable to reconcile the definition of "disabling" in § 435.554(c)(5)(i)(C) with similar terms used at § 435.554(c)(4) ("…veteran with a temporary or permanent *disability*…"); § 435.554(c)(5)(i)(A) ("…*disabled* (as defined in section 1614 of the Social Security Act"), and

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https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007 (noting depression can require life-long treatment; most people have multiple episodes); *Personality Disorders*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/personality-disorders/diagnosis-treatment/drc-20354468 (July 14, 2023) (noting treatment can last for months or years); Tyler J. Torrica et al., *Posttraumatic Stress Disorder*, STATPEARLS (last updated Feb. 2024), https://www.ncbi.nlm.nih.gov/books/NBK559129/ ("Chronic PTSD is common, with estimates that one-third of patients still have symptoms 1 year after diagnosis, and another third of patients still have symptoms 10 years after diagnosis.").

[66] 91 Fed. Reg. 33375.

[67] 91 Fed. Reg. 33373; 42 C.F.R. § 435.554(c)(5)(i).

[68] ISMICC, *2024 Report to Congress, Building on Progress: Federal Action for a System That Works for All People Living with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and Their Families and Caregivers* 11 (2024), https://www.samhsa.gov/sites/default/files/ismicc-rtc-2024.pdf.

[69] *See* 91 Fed. Reg. 33374 (citing *What Is Mental Illness?*, American Psychiatric Association (last modified July 2025), https://www.psychiatry.org/patients-families/what-is-mental-illness).

[70] *See* 28 C.F.R. § 35.108(c) (this is the same regulatory definition CMS refers to in the IFR to define "disabled" at 42 C.F.R. § 435.554(a)).

[71] *See* 91 Fed. Reg. 33369; *see also* 42 C.F.R. § 435.554(a)(iv) (defining "disabled individual" as "an individual who meets the Americans with Disabilities Act definition of disability at 28 CFR 35.108.").

in § 435.554(c)(5)(i)(D) ("…physical, intellectual or developmental *disability*…").[72] This concern is misplaced.

The veteran and Social Security provisions incorporate terms that Congress has already defined; those statutory definitions control and are unaffected by how CMS construes an undefined term elsewhere. Where no statutory definition governs, CMS must supply a definition that is non-arbitrary, in a consistent manner across similar terms. The remaining terms are readily reconciled, because each turns on the same inquiry: whether an impairment substantially limits one or more major life activities—or, for physical, intellectual, and developmental disabilities, one or more activities of daily living. Aligning "disabling mental disorder" under § 435.554(c)(5)(i)(C) with the ADA standard is therefore not merely permissible; it is the only construction consistent with the authorities CMS itself invokes.

Further, with respect to individuals with a disabling mental disorder, CMS was once again silent as to what impact loss of health coverage would have on this group. Like people whose SUD is in remission, individuals receiving treatment for a disabling mental disorder face serious harm if their Medicaid coverage is terminated. Continuing treatment is critical for this population, and Medicaid coverage enables individuals to access that care.[73] Losing access to ongoing care will exacerbate their conditions and lead to higher utilization of more costly, intensive psychiatric services.[74]

We therefore ask CMS to align "disabling" at § 1396a(xx)(9)(A)(ii)(V)(cc) with "disabled" at § 1396a(xx)(9)(A)(ii)(III), as defined at 42 C.F.R. § 435.554(a).

Individual with a Serious or Complex Medical Condition: Since at least 2013, CMS has recognized that individuals with HIV/AIDS, hepatitis, sickle cell disease, dementia, cancer, and end-stage renal disease all have a serious medical condition that renders them medically frail.[75] CMS has now taken precisely the opposite position, stating it will not

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[72] *See* 91 Fed. Reg. 33373.

[73] *See, e.g.*, Guth, *The Effects of Medicaid Expansion* (collecting research showing that Medicaid expansion is associated with increased access to behavioral health care); Xu Ji et al., *Effect of Medicaid Disenrollment on Health Care Utilization Among Adults with Mental Health Disorders*, 57 MED. CARE 574 (2019), https://pubmed.ncbi.nlm.nih.gov/31295187/.

[74] *See*, *e.g*, Xu Ji et al., *Discontinuity of Medicaid Coverage: Impact on Cost an Utilization among Adult Medicaid Beneficiaries with Major Depression*, 55 MED. CARE 735 (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC6684341/ (finding that among adults with depression, those whose coverage was disrupted had higher use of ED and inpatient services, suggesting that maintenance of continuous coverage helps prevent acute episodes); Bentson H. McFarland & Jon C. Collins, *Medicaid Cutbacks and State Psychiatric Hospitalization of Patients with Schizophrenia*, 62 PSYCHIATRIC SERVS. 871 (2011), https://pubmed.ncbi.nlm.nih.gov/21807824/ (finding a "strong connection between Medicaid termination and increased state psychiatric hospitalization"); Jeffrey S. Harman et al., *Association Between Interruptions in Medicaid Coverage and Use of Inpatient Psychiatric Services*, 54 PSYCHIATRIC SERVS. 999 (2003), https://pubmed.ncbi.nlm.nih.gov/12851437/ (finding interruptions in Medicaid coverage are associated with increased psychiatric hospitalization among individuals with schizophrenia).

[75] *See e.g.*, CMCS, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160, 42233 (July 15,

consider an individual with a serious or complex condition medically frail unless the condition significantly impairs their ability to comply with the work requirement.[76] CMS justifies this about-face with a single Institute of Medicine report from 1999.[77] Yet, it offers no explanation as to why it is relying on a 25-year-old report that predates its own longstanding conclusion that these conditions categorically qualify individuals as medically frail.

Furthermore, the impact of the loss of Medicaid coverage for individuals who have one or more of these conditions but do not meet the significantly impairs requirement would be devastating.[78] For those with HIV, the Medicaid expansion group "is the most common pathway for Medicaid coverage."[79] As KFF aptly notes, "[a]ccess to antiretroviral medication, including through Medicaid, is necessary to manage HIV and prevent immune system dysfunction, illness, and ultimately death."[80] These health consequences will most certainly drive individuals out of employment, not – as CMS suggests – to it.[81] Additionally,

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2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions."); CMS, *Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program*, 88 Fed. Reg. 78818, 78938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/ AIDS, severe mental illness, and substance use disorder (SUD)."); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 *Medicare Claims Processing*, Transmittal 12461 (Jan. 18, 2024) https://www.cms.gov/files/document/r12461cp.pdf ("[I]f the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., sickle cell disease, HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

[76] 91 Fed. Reg. 33375.

[77] *Id.* at 33375-76.

[78] Abundant research demonstrates that gaps in Medicaid coverage lead to negative health outcomes, including premature mortality. *See, e.g.*, Miller, *Medicaid and Mortality*; Sommers, *State Medicaid Expansions and Mortality, Revisited*; Sommers, *Health Insurance Coverage and Health*; Sommers, *Mortality and Access to Care*; Hall*, Lapses in Medicaid Coverage*; Andrew Bindman et al., *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 ANNALS INTERNAL MED. 854 (2008), https://pubmed.ncbi.nlm.nih.gov/19075204/; Ku, *Bridging the Gap*.

[79] Lindsey Dawson & Jennifer Tolbert, KFF, *Medical Frailty and Medicaid Work Requirements: Challenges for People with HIV* (July 1, 2026), https://www.kff.org/medicaid/medical-frailty-and-medicaid-work-requirements-challenges-for-people-with-hiv/ [hereinafter "Dawson, *Medical Frailty and Medicaid Work Requirements*"].

[80] Dawson, *Medical Frailty and Medicaid Work Requirements*; *see also* Elizabeth Hamlyn et al., *Plasma HIV Viral Rebound Following Protocol-Indicated Cessation of ART Commenced in Primary and Chronic HIV Infection*, PLOSONE (2012), https://pubmed.ncbi.nlm.nih.gov/22952756/; Gerald Friedland & Ann Williams, *Attaining Higher Goals in HIV Treatment: The Central Importance of Adherence*, 13 AIDS S61 (1999) ("Therefore, potent and continuous suppressive therapy for the duration of viral replicative capability is necessary for therapy to be effective."), https://pubmed.ncbi.nlm.nih.gov/10546786/.

[81] *See, e.g.*, Dana P. Goldman & Yuhui Bao, *Effective HIV Treatment and the Employment of HIV+ Adults*, 39 HEALTH SERVS. RSCH. 1691 (2004), https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00313.x.

inability to access antiretroviral medications necessary to suppress transmission will curtail prevention efforts and have a negative effect on public health generally.[82]

For those with cancer, cutting off access to health coverage would be similarly catastrophic. In addition to the obvious deleterious health consequences,[83] a loss of insurance would increase financial instability.[84]

CMS asserts that individuals with other serious or complex conditions, including Type I or Type II diabetes, should not be classified as medically frail because they would not "typically expect" the conditions to "significantly impair an individual's ability to meet the community engagement requirement."[85] Again, this assertion entirely ignores that conditions like Type I (and often Type II) diabetes require consistent insurance coverage to ensure an individual can access necessary care and in turn, participate in daily life, including work, volunteering, or participating in educational programs.[86] Without access to prescription drugs like insulin, individuals will end up sick and in the hospital.[87] In fact, one

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[82] *Viral Suppression and an Undetectable Viral Load*¸ hiv.gov (July 23, 2026), https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression.

[83] K. Robin Yabroff et al., *Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research*, 112 J. NAT'L CANCER INST. 671 (2020), https://pubmed.ncbi.nlm.nih.gov/32337585/; Jingxuan Zhao et al., *Health Insurance Status and Cancer Stage at Diagnosis and Survival in the United States*, 72 CA CANCER J. CLIN. 542 (2022), https://acsjournals.onlinelibrary.wiley.com/doi/10.3322/caac.21732 (finding that coverage disruption increases chances of mortality and "that individuals living in states that expanded Medicaid…had greater improvement in cancer-related outcomes compared with those living in states that did not expand"); Min Rex Cheung, *Lack of Health Insurance Increases All Cause and All Cancer Mortality in Adults: An Analysis of National Health and Nutrition Examination Survey (NHANES III) Data*, 14 ASIAN PAC. J. CANCER PREVENTION 2259 (2013) (finding that "there was an almost 300% increase in all cancer mortality associated with no health insurance coverage…."), https://pubmed.ncbi.nlm.nih.gov/23725123/.

[84] Stephanie B. Wheeler et al., *Multidimensional Financial Hardship Among Uninsured and Insured Young Adult Patients with Metastatic Breast Cancer*, 12 CANCER MED. 11930 (2023), https://pubmed.ncbi.nlm.nih.gov/37148550/ (in evaluating financial insecurity in young women with advanced breast cancer, concluding that policy changes, including Medicaid expansion, "is urgently needed to prevent and mitigate the financial devastation associated with cancer.").

[85] 91 Fed. Reg. 33376.

[86] *See, e.g.*, Derek S. Brown & Timothy D. McBride, *Impact of the Affordable Care Act on Access to Care for US Adults with Diabetes, 2011–2012*, 12 PREVENTING CHRONIC DISEASE 140431 (2015), https://www.cdc.gov/pcd/issues/2015/14_0431.htm (finding that "the uninsured were much less likely to obtain prescriptions, make office visits to physicians, and to have a usual source of care"); Catherine Pihoker et al., *Diabetes Care Barriers, Use, and Health Outcomes in Younger Adults with Type 1 and Type 2 Diabetes*, 6 JAMA NETWORK OPEN e2312147 (2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804551; Sarah S. Casagrande et al., *Health Insurance and Diabetes*, Diabetes in America (Dec. 20, 2023), https://www.ncbi.nlm.nih.gov/books/NBK597725/; Jusung Lee et al., *The Impact of Medicaid Expansion on Diabetes Management*, 43 DIABETES CARE 1094 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7171935/; KFF, *The Role of Medicaid for People with Diabetes* (2013), https://www.kff.org/wp-content/uploads/2013/01/8383_d.pdf.

[87] *See, e.g.,* Hall, *Lapses in Medicaid Coverage* (concluding that the overall study results "suggest that interruptions in Medicaid coverage may lead to greater program expenditures and higher inpatient and emergency room utilization among beneficiaries with diabetes, at least for the 3 months immediately after the lapse"); Ashish Jha et al., *Greater Adherence to Diabetes Drugs is*

study found that insulin rationing – which occurs when individuals are unable to afford prescribed amounts of insulin – was the primary cause of hospital admission for diabetic ketoacidosis, an acute and life-threatening condition triggered by the lack of insulin in those with diabetes.[88] Perversely, under the IFR, a diabetic will become medically frail for Medicaid purposes only when their condition becomes uncontrolled due to a loss of treatment.[89]

We therefore ask CMS to revert back to earlier, evidence-based guidance finding certain conditions, including HIV/AIDS and cancer, render someone "medically frail" without qualification.

III. Limitations on Verification, Including Self-Attestation

A. The general limits on verification of compliance or exclusion are unnecessary and will cause eligible individuals to lose coverage.

As a general rule, the IFR provides that "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 State must seek additional information from the individual to verify compliance or deemed compliance with the community engagement requirement or the individual's status as a specified excluded individual."[90] Prior to January 1, 2028, CMS affords states the flexibility to allow individuals to self-attest to compliance or to an exclusion.[91] After that date, however, CMS significantly curtails the use of self-attestation.[92]

Linked to Less Hospital Use and Could Save Nearly $5 Billion Annually, 31 HEALTH AFFS. 1836 (2012), https://pubmed.ncbi.nlm.nih.gov/22869663/; Mary A.M. Rogers et al., *Interruptions in Private Health Insurance and Outcomes in Adults with Type 1 Diabetes: A Longitudinal Study*, 37 HEALTH AFFS. 1024 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6590517/pdf/nihms-1027240.pdf (finding an interruption in private coverage was associated with a roughly fivefold increase in acute-care use, including hospitalization, among working-age adults with Type 1 diabetes, and noting that Medicaid coverage interruptions have been shown to produce similarly poor outcomes); *see also* Sarah Sugar et al., Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Hum. Servs., No. HP-2021-10, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (2021), https://aspe.hhs.gov/sites/default/files/documents/5f6e4d78d867b6691df12d1512787470/medicaid-churning-ib.pdf.

[88] *See* V.C. Musey et al., *Diabetes in Urban African Americans: Cessation of Insulin Therapy is the Major Precipitating Cause of Diabetic Ketoacidosis*, 18 DIABETES CARE 483, 485-486 (1995), https://pubmed.ncbi.nlm.nih.gov/7497857/; *see also* Dyanne P. Westerberg, *Diabetic Ketoacidosis: Evaluation and Treatment*, 87 AM. FAM. PHYSICIAN 337 (2013), https://pubmed.ncbi.nlm.nih.gov/23547550/.

[89] *See* 91 Fed. Reg. 33376 (recognizing that "acuity may change over time" but only citing to examples of acuity improving, not declining and failing to connect loss of coverage to potential for increased acute medical need).

[90] *Id*. at 33395.

[91] 42 C.F.R. § 435.557(b)(2)(i); 91 Fed. Reg. 33395.

[92] 42 C.F.R. § 435.557(b)(2)(ii)-(iii); 91 Fed. Reg. 33395 (stating that on and after January 1, 2028, if states are unable to verify compliance or exceptions/exclusions via reliable information or the reliable information is not reasonably compatible with other information provided by an individual or

It is important to note at the outset that *ex parte* verifications will be critical to reducing the administrative burdens placed on applicants and enrollees and thus, to ensuring that eligible individuals obtain and maintain coverage.[93] It is equally important to recognize, however, that *ex parte* verifications will not be possible for all applicants and beneficiaries. The systems states rely on to verify applicant and enrollee data have limited utility and can be unreliable.[94] Wage data systems, for example, are costly to states and often fail to capture seasonal, intermittent, or gig work; and even when they do capture employment information, that information can be out of date.[95] State databases will likewise be unable, in certain instances, to capture all possible exclusions—they will likely be unable to identify those who are caring for a dependent with a disability, those enrolled half-time in an educational program, or those engaged in unpaid work or community service.[96] And, as the unwinding of the public health emergency demonstrated, states may fail to implement *ex parte* verifications in full.[97] As a result, many individuals will need to provide additional information to verify their compliance or exclusion.

The IFR presumes most people have easy access to documentation such as working in a traditional job with regular access to pay stubs. It ignores the difficulties associated with getting documentation to verify unpaid work (including unpaid caregiving), volunteering, and as mentioned above, seasonal, intermittent, or gig work.

These hardships can also apply to those who should be excluded. For example, to document one's status as aged out of foster care, a young adult must obtain paperwork from child welfare agencies or even the dependency court itself. That paperwork is governed by an inconsistent patchwork of federal and state confidentiality laws.[98]

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their representative, then states must require documentation except in limited circumstances where the documentation is not reasonably available).

[93] *See generally* Pamela Herd et al., *Interventions to Automate Medicaid Renewals Reduce Procedural Denials and Increase Coverage*, 44 HEALTH AFFS. 1336 (2025), https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00316?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed [hereinafter "Herd, *Interventions to Automate Medicaid Renewals*"].

[94] Adrianna McIntyre et al., *New Medicaid Enrollment Barriers and Lessons from Unwinding*, 6 JAMA HEALTH F. e254849 (2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2838677 [hereinafter "McIntyre, *New Medicaid Enrollment Barriers*"].

[95] *Id.*; *see also* U.S. Gov't Accountability Off. (GAO), *GAO-17-111*, *Supplemental Nutrition Assistance Program: More Information on Promising Practices Could Enhance States' Use of Data Matching for Eligibility* 19 (2016), https://www.gao.gov/products/gao-17-111; GAO, *GAO-21-183*, *Federal Low-Income Programs, Use of Data to Verify Eligibility Varies Among Selected Programs and Opportunities Exist to Promote Additional Use* 37 (2021), https://www.gao.gov/products/gao-21-183.

[96] McIntyre, *New Medicaid Enrollment Barriers*.

[97] Herd, *Interventions to Automate Medicaid Renewals* at 1342 ("In the case under study, it was not enough to require states to automate renewal processes for beneficiaries.… [S]tates needed both the capacity and the policy and technical expertise to effectively implement automation and ensure that those eligible for critical benefits such as Medicaid can actually access them.").

[98] *See, e.g.* Tex. Dep't of Fam. & Protective Servs., *Child Protective Services Handbook* § 1450 (Confidentiality of Information), https://www.dfps.texas.gov/handbooks/cps/files/CPS_pg_1450.asp

Depending on the state and often the county, obtaining it may require a specialized release, an agency-specific request form, or a petition to the juvenile court for permission to inspect a confidential case file.[99] Even where a former foster youth holds a statutory right of access to their own file, that right is not always honored at the point of request. For example, advocacy organizations advise youth to bring a printed copy of the governing statute and court rule to the clerk's window and to escalate to a supervisor if access is refused.[100]

To be sure, in the above examples, it is not that the documentation is unavailable. We agree that scenario triggers the state's ability to accept self-attestation under 42 C.F.R. § 435.557(b)(2)(ii) even after January 2028. Instead, the problem here is that CMS does not acknowledge the significant time and effort it will take to obtain the documentation. This is an established reality.[101]

There is no valid reason for severely curtailing states' ability to accept self-attestation after January 2028. Ample evidence demonstrates that self-attestation reduces both administrative burden and churn. Specifically, it is less burdensome for the state[102] and is

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(last visited July 21, 2026) (describing the layered federal and state confidentiality framework and noting that authorized recipients are bound by the same restrictions as the disclosing agency).

[99] *See, e.g.*, Cal. Welf. & Inst. Code § 827 (limiting inspection of juvenile case files to enumerated persons and requiring all others to petition the juvenile court); Tex. Dep't of Fam. & Protective Servs., Form 4884, *Request From Former Foster Youth For Case Records*; Jud. Council of Cal., Ctr. for Fams., Child. & the Cts., *Sharing Information From Juvenile Agency Files Regarding Children in Foster Care* (2024), https://courts.ca.gov/sites/default/files/courts/default/2024-08/cfcc_jcfinfobrief.pdf.

[100] Advokids, *Accessing Your Juvenile Case File*, https://advokids.org/accessing-your-juvenile-case-file-2/ (last visited July 21, 2026) (advising current and former foster youth to print Cal. Welf. & Inst. Code § 827(a)(1)(C) and Cal. R. Ct. 5.552 to present to the court clerk if access is denied, and to request a supervisor); *see also* Juvenile Law Ctr., *Know Your Rights Guide ch. 8: Health Care, Child Welfare and Adoption Records: Confidentiality and Accessibility*, https://jlc.org/resources/know-your-rights-guide-chapter-8-health-care-child-welfare-and-adoption-records (last visited July 21, 2026) (noting that a Pennsylvania agency receiving a youth's request may decline to share all information in the case record).

[101] Amy Mulzer, *The Doorkeeper and the Grand Inquisitor: The Central Role of Verification Procedures in Means-Tested Welfare Programs*, 36 COLUM. HUM. RTS. L. REV. 663, 698 (2005) (noting that documentary verification requires claimants to devote substantial time to assembling and presenting documentation); *see also id.* at 696–97 & n.150–51 (cataloging the transportation, childcare, telephone, photocopying, postage, and forgone-wage costs of document collection); *id.* at 702 n.176 (observing that documentation demands presume record-keeping capacity that low-income applicants rarely have).

[102] MACPAC, Public Meeting Transcript 88-90 (Sept. 18-19, 2025), https://www.macpac.gov/wp-content/uploads/2025/09/09-18-25-and-09-19-25-MACPAC-Public-Transcript.pdf (former CMS official testifying that self-attestation is less expensive and easier to implement from a systems perspective); *see also* Ctr. on Budget & Pol'y Priorities, *A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement* (2025), https://www.cbpp.org/research/health/a-guide-to-reducing-coverage-losses-through-effective-implementation-of-medicaids (recommending – prior to the release of this IFR – that states accept self-attestation wherever possible because "requiring documentation of all exemptions would delay processing, burden individuals who may have to acquire medical documentation, create more work for eligibility workers, and increase churn").

the best method for ensuring that eligible individuals do not lose health coverage because of administrative barriers.[103] Indeed, substantial research demonstrates that additional administrative barriers deter and reduce coverage.[104] Further, CMS's concerns about "program integrity" are unavailing. Self-attestation is a highly reliable form of verification.[105]

Acceptance of self-attestation as the standard form of verification also aligns with existing Medicaid regulations. Those regulations give states the option to accept self-attestation for information necessary to establish eligibility unless the law requires other procedures (as is the case for citizenship and immigration status, for example).[106] Nothing in the 2025 Reconciliation Act requires other procedures here. CMS has not explained why it has deviated from the existing regulations with respect to information necessary to establish compliance with or exclusion from the work requirement. It should also be noted that allowing states to use self-attestation is similarly the general rule under SNAP, where states are not required to verify ABAWD exceptions unless the attestation is questionable.[107]

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[103] *See, e.g.*, Herd, *Interventions to Automate Medicaid Renewals* at 1340 ("People frequently lose coverage because they did not receive the renewal form, were confused about how to complete it, or *struggled to find the information and documentation they needed to complete it*.") (emphasis added).

[104] *See, e.g.*, Farah Erzouki, Ctr. on Budget & Pol'y Priorities, *States Need More Time to Prepare for Medicaid Work Requirement* (2026), https://www.cbpp.org/research/health/states-need-more-time-to-prepare-for-medicaid-work-requirement; Jennifer Wagner & Judy Solomon, *States' Complex Medicaid Waivers will Create Costly Bureaucracy and Harm Eligible Beneficiaries* 3-4 (2018), https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible; KFF, *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (2018), https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/ (explaining that adding enrollment barriers leads to significant declines in enrollment, while streamlining enrollment and renewal processes contributes to an increase in enrollment and retention); Ashley M. Fox et al., *Administrative Easing: Rule Reduction and Medicaid Enrollment*, 80 PUB. ADMIN. REV. 104 (2020), https://onlinelibrary.wiley.com/doi/epdf/10.1111/puar.13131; Michael Perry et al., KFF, *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* (2000), https://www.kff.org/medicaid/medicaid-and-children-overcoming-barriers-to-enrollment/; Leighton Ku et al., Ass'n for Cmty. Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care* 12-16 (2009) (attached).

[105] *See, e.g.*, MaryBeth Musumeci et al., KFF, *Medicaid Public Health Emergency Unwinding Policies Affecting Seniors & People with Disabilities: Findings from a 50-State Survey* (2022), https://www.kff.org/report-section/medicaid-public-health-emergency-unwinding-policies-affecting-seniors-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/ (noting that when New Jersey compared self-attestation with actual electronic asset verification in a representative sample of applicants from 2015-2016, it found a 0% error rate).

[106] *See* 42 C.F.R. § 435.945(a); *see also id*. § 435.956(e) (requiring states to accept self-attestation for pregnancy unless not reasonably compatible with other information already in the state's possession).

[107] Food & Nutrition Servs., *Letter to Supplemental Nutrition Assistance Program All Regions*, *Supplemental Nutrition Assistance Program (SNAP) – Question and Answer #1 for the Program Purpose and Work Requirement Provisions of the Fiscal Responsibility Act of 2023 Final Rule* (Dec. 20, 2024), https://www.fna.usda.gov/snap/work-requirements/policies/qa1-fra-final-rule ("State agencies are not required to verify exception status, unless questionable. State agencies must accept an individual's attestation that they or another household member meets an exception from the time limit, unless it is questionable."); *see also* 7 C.F.R. §§ 273.24(l), 273.2(f)(8)(i)(D).

B. The additional limits on verification for the "medically frail" exclusion are unnecessary and will cause eligible individuals to lose coverage.

CMS further limits self-attestation for those who qualify for an exclusion because they are medically frail. For that group, prior to January 1, 2028, individuals may self-attest to the medically frail exclusion where reliable information is not available to the state or reliable information is not reasonably compatible with information the individual provided.[108] After that date, however, CMS limits self-attestation to only once during an individual's entire period of enrollment.[109] Once a state has accepted self-attestation a single time, it must verify medically frail status again within six months using reliable information available to the agency or documentation submitted by the beneficiary.[110]

CMS's justification for this differential treatment holds no water. First, CMS claims that unlike other categories of specified excluded individuals, medically frail status is subject to change.[111] But for a substantial number of medically frail individuals, that is not true – many conditions will never change or improve over the course of an individual's lifetime. This includes conditions like diabetes, cystic fibrosis, sickle cell disease, muscular dystrophy, multiple sclerosis, spinal cord or brain injuries, and HIV/AIDS – none of which are curable and all of which require ongoing medical care to manage.

Second, CMS asserts that requiring documentation without exception will "motivate individuals to access care" and ultimately lower Medicaid costs.[112] CMS cites no research to support this theory. Indeed, it is access to coverage and subsequent preventive care that achieves that end.[113] What is more, CMS ignores the evidence about the difficulties that

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[108] 42 C.F.R. § 435.557(f)(1)(i).
[109] *Id*. § 435.557(f)(1)(ii); *see also id.* § 435.557(a) (a "period of enrollment" is defined as "a continuous period of enrollment in coverage under the State plan or waiver without the individual being disenrolled, regardless of the number of consecutive eligibility periods, of redeterminations or renewals, or of transitions between eligibility groups").
[110] *See id*. § 435.557(f)(1)(ii)(A)-(B).
[111] *Compare* 91 Fed Reg. 33366 ("Notably, unlike other exclusions which may change from month to month or be time-limited, States will not be required to (and may not) reverify someone's status as an American Indian for exclusion from the community engagement requirement.").
[112] *See id*. at 33406.
[113] *See* Guth, *Building on the Evidence Base* ("Analyses find effects of expansion on numerous economic outcomes, including state budget savings, revenue gains, and overall economic growth. Multiple studies suggest that expansion can result in state savings by offsetting state costs in other areas."); *see also* Milbank Memorial Fund, *Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease* (2026), https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/ (finding adults with chronic disease who had a usual source of primary care were 20% less likely to be hospitalized and 11% less likely to have an emergency room visit); Favel L. Mondesir et al., *Medicaid Expansion and Hospitalization for Ambulatory Care-Sensitive Conditions Among Nonelderly Adults With Diabetes*, 43 J. AMBUL. CARE MGMT 312 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6710100/ (noting that diabetes is expensive in part, due to hospital utilization rates, but that Medicaid expansion, and the resulting increase in access to care, was associated with a decrease in the proportion of those hospitalizations).

obtaining such documentation poses. When states implemented work requirements through section 1115 projects, for example, many individuals who were required to submit evidence from a provider to verify a disability-related exemption struggled to find a provider who was willing, or one who could sign off in time.[114] CMS has recognized as much.[115] Because Medicaid beneficiaries are limited to the smaller pool of providers that accept Medicaid—and, if subject to a managed care model, to in-network providers as well—finding a willing provider becomes even more difficult.[116]

Third and relatedly, it is wrong for CMS to assume that "once a beneficiary has enrolled in coverage," the individual will immediately begin receiving covered services. Finding available providers quickly is a challenge for Medicaid beneficiaries.[117] Ultimately, these

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[114] Ian Hill et al., Urban Inst., *New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results* 24 (2020), https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results.

[115] Letter from Elizabeth Richter, Acting Adm'r, CMS, to Lori Shibinette, Comm'r, Dep't of Health & Hum. Servs. 6 (March 17, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-ca2.pdf (noting that in New Hampshire "providers were resistant to signing forms needed to establish that the beneficiary was unable to work" and concluding that this "may have contributed to the low compliance rate").

[116] Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 1 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6452575/; MACPAC, *Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services* (2025), https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf ("In general, physicians are less likely to serve patients covered by Medicaid than those with Medicare or private insurance. In a MACPAC analysis of the 2017 National Electronic Health Records Survey (NEHRS), fewer physicians reported accepting new Medicaid patients (74%) compared to those accepting new Medicare patients (88%) or new privately insured patients (96%)."); Off. of Inspector Gen., HHS, *Rep. No. OEI-02-22-00050, A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.

[117] *See* Off. of Inspector Gen., HHS, OEI-05-24-00090, *Inaccurate Medicaid Managed Care Provider Directories May Limit Enrollees' Access to Maternal Health Care* 9 (2026), https://oig.hhs.gov/reports/all/2026/inaccurate-medicaid-managed-care-provider-directories-may-limit-enrollees-access-to-maternal-health-care/ (finding multiple deficiencies in plan directories that "can create significant delays and challenges for Medicaid managed care plan enrollees seeking covered services"); Off. of Inspector Gen., HHS, OEI-09-21-00410, 1 (2025), https://oig.hhs.gov/reports/all/2025/availability-of-surveyed-behavioral-health-providers-to-treat-new-patients-enrolled-in-medicare-and-medicaid/ (finding roughly 50% of Medicaid and Medicare behavioral health providers unable to accept any new patient and of those accepting new patients, 24% reported wait times of more than 30 days); Off. of Inspector Gen., HHS, OEI-02-13-00670, *Access to Care: Provider Availability in Medicaid Managed Care* 8, 10 (2014), https://oig.hhs.gov/reports/all/2014/access-to-care-provider-availability-in-medicaid-managed-care/ (finding "slightly more than half of providers could not offer appointments to enrollees."); Diksha Brahmbhatt & William L. Schpero, *Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities*, 332 JAMA 668 (2024), https://jamanetwork.com/journals/jama/fullarticle/2821639 (finding that "only 17.8% of clinicians listed as in-network for Medicaid were reachable, accepted Medicaid, and could provide a new patient appointment"); Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 1 (2019), https://pubmed.ncbi.nlm.nih.gov/30947608/ (synthesizing 34 audit studies and concluding that "Medicaid patients have greater difficulty obtaining appointments compared with privately insured patients…").

restrictions on self-attestation mean that people who otherwise meet the criteria but cannot find a willing provider or cannot obtain the necessary medical records cannot qualify as medically frail. The result is a system in which some people will simply be unable to participate, no matter what they do.

Concerningly, the limits on self-attestation will disproportionately harm Black and Latino beneficiaries. Black and Latino patients are more likely than White patients to report delayed care because of factors like long wait times and lack of transportation, and this disparity has only grown over the past decades.[118] Racial segregation also plays a large role in distance to and access to providers.[119] Studies have shown that zip codes with larger Black populations are more likely to have primary care provider shortages or be further from medical services in general—and this holds true across both rural and urban areas.[120] These entrenched issues can be traced to factors such as hospital closures and physician flight, which are more likely to occur in predominantly Black neighborhoods.[121]

In addition, individuals with disabilities will be disproportionately impacted by these additional administrative burdens. Data show that people with disabilities, more than any other group, are erroneously swept up into determinations, like work requirements, from which they should be exempt.[122] Thus, while Congress clearly intended that individuals with

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[118] César Caraballo et al., *Trends in Racial and Ethnic Disparities in Barriers to Timely Medical Care Among Adults in the US, 1999 to 2018*, 3 JAMA HEALTH F. e223856 (2022), https://doi.org/10.1001/jamahealthforum.2022.3856.

[119] Ruqaiijah Yearby et al., *Structural Racism in Historical and Modern US Health Care Policy*, 41 HEALTH AFFS. 187 (2022), https://doi.org/10.1377/hlthaff.2021.01466 [hereinafter "Yearby, *Structural Racism*"]; Darrell J. Gaskin et al., *Residential Segregation and the Availability of Primary Care Physicians*, 47 HEALTH SERVS. RSCH. 2353 (2012), https://doi.org/10.1111/j.1475-6773.2012.01417.x [hereinafter "Gaskin, *Residential Segregation*"].

[120] Gaskin, *Residential Segregation*; see also Jan M. Eberth et al., *The Problem of the Color Line: Spatial Access to Hospital Services for Minoritized Racial and Ethnic Groups*, 41 HEALTH AFFS. 237 (2022), https://doi.org/10.1377/hlthaff.2021.01409; Elizabeth J. Brown et al., *Racial Disparities in Geographic Access to Primary Care in Philadelphia*, 35 HEALTH AFFS. 1374 (2016), https://doi.org/10.1377/hlthaff.2015.1612.

[121] Yearby, *Structural Racism*.

[122] MaryBeth Musumeci, KFF, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018* (2019), https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/ (study finding that a significant number of Arkansans with a disability lost cost coverage despite the purported exemptions and other safeguards in place); *see also* L. Chen & B.D. Sommers, *Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018*, 110 AM. J. PUB. HEALTH 1208 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7349442/ (finding that adults with chronic conditions were more likely (than adults without) to lose coverage for failure to comply with the work requirements); *see, e.g.*, Anna Baily & Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Medicaid Work Requirements Don't Protect People with Disabilities* (2018), https://www.cbpp.org/sites/default/files/atoms/files/11-14-18health.pdf (evidence from other public benefit programs with similar exemptions confirms that, in practice, individuals with disabilities are often not exempted as they should be); Musumeci, *Medicaid Enrollees and Work Requirements*; Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities* 4, 14 (2014),

disabilities not be impacted by work requirements,[123] as the data show, CMS's decision to narrowly define verification for this exclusion will have the opposite effect.

C. CMS's 12-month limit on the claims lookback period does not account for known lags in claims submission and processing and will cause eligible individuals to lose coverage.

Under the IFR, states must attempt to verify that an individual is medically frail using reliable and available information, "including claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended, or denied, and encounter data, as relevant to the individual."[124] At the same time, the IFR prohibits states from using claims or encounter data older than twelve months, on the theory that earlier data may not "reflect the individual's current condition."[125]

This restriction will significantly reduce the number of medically frail individuals who will be excluded on an *ex parte* basis and thus, increase the number of medically frail individuals who will lose Medicaid coverage for failure to comply with the work requirement. Harvard scholars have conducted research examining the relationship between the length of the claims and encounter data lookback period and the percentage of beneficiaries a state would automatically identify as medically frail.[126] A twelve-month lookback period led to 24.13% of beneficiaries being identified automatically, compared to 31.28% with a twenty-four-month lookback period.[127] The research shows that, at a minimum, approximately 1.5 million people would *not* be identified as medically frail under a twelve-month lookback, but *would be* identified under a 24-month lookback period.[128] All of these individuals have

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https://www.researchgate.net/publication/274006096_Impact_of_the_Work_Requirement_in_Supplemental_Nutrition_Assistance_SNAP_on_Low-Income_Working-Age_People_with_Disabilities; Andrew J. Cherlin et al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 SOC. SERV. REV. 387, 398 (2002) (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health") (attached); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REV. 199 (2008) (attached).

[123] U.S. Rep. Brett Guthrie, *Don't Buy the Lies About the GOP's Plan for Medicaid — We're Actually Strengthening It*, N.Y. Post (June 22, 2025), https://nypost.com/2025/06/22/opinion/dont-buy-the-lies-about-the-gops-plan-for-medicaid-were-actually-strengthening-it/ ("You're exempt if you're medically frail, which includes anyone who's blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer…Plainly, the policy is targeting just a subset of fully able adults who are voluntarily choosing not to work or give back to their communities"); *see also* Off. of the Senate Republican Leader, *Republicans' Reconciliation Bill Strengthens Medicaid* (July 15, 2025), https://www.republicanleader.senate.gov/newsroom/research/republicans-reconciliation-bill-strengthens-medicaid ("The work requirement doesn't apply to anyone who is disabled, pregnant or caring for a child younger than age 14. Volunteering 20 hours a week or enrolled in school? You can get Medicaid.").

[124] 42 C.F.R. § 435.557(f)(1).

[125] 91 Fed. Reg. 33405.

[126] *See* Letter from Ari Ne'eman, et al., Asst. Professors of Health Policy & Mgmt., Harvard T.H. Chan Sch. of Pub. Health, to Mehmet Oz, Adm'r, CMS (July 31, 2026) (re: CMS-2454-IFC).

[127] *Id.*

[128] *Id.*

serious, long-term medical conditions.[129] Indeed, in a separate conclusion, the authors warn that those inaccurately excluded under a twelve-month lookback period "are significantly sicker than other Medicaid beneficiaries, with a more than 2.5 fold increase in mortality risk as compared to non-exempt individuals."[130] Part of the need for a longer lookback period is attributable to a lag in the claims data states will use to help evaluate eligibility for the exclusion.[131]

Clinicians serving in state Medicaid agencies have emphasized the importance of using claims data to identify individuals who are medically frail.[132] We ask CMS to follow the evidence and allow at least a 24-month lookback period.

D. The procedures for verification of pregnancy need to be clarified.

There is an apparent inconsistency in the Federal Register regarding self-attestation for the pregnancy exclusion. In the preamble, CMS states that 42 C.F.R. § 435.956(e) applies to the pregnancy exclusion.[133] This subsection requires states to accept self-attestation of pregnancy unless they have information that is not reasonably compatible. The operative regulatory text, however, does not clearly reflect this: 42 C.F.R. § 435.557(b)(2)(ii) contains no cross-reference to § 435.956(e). It is therefore unclear whether states must accept self-attestation of pregnancy to establish an exclusion from the Medicaid work requirement, or whether, on or after January 1, 2028, a pregnant individual must instead provide documentation to establish the pregnancy whenever reliable information is not available to the state (or the information provided is not reasonably compatible), unless such documentation is not reasonably available. To be sure, the value of verifying pregnancy through self-attestation is well understood. As the Office of Disease Prevention and Health Promotion notes, "[p]renatal care is most effective when it starts early and continues

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[129] *Id.*
[130] *Id.*
[131] *Id. See* 42 C.F.R. §§ 447.45(d)(1) (allowing states to give providers up to 12 months from the date of service to submit claims), 447.45(d)(2)-(4) (setting deadlines for states to pay claims and generally setting an outer limit of 12 months from the date of receipt by the state); *see also id.* § 447.46.
[132] Christopher Chen et al., *Implementing Medical Frailty Exemptions Under HR 1: Clinical Considerations from Medicaid Medical Directors*, 7 JAMA HEALTH F. e261808 (2026), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2849107 (finding that "[a]ttestations and screeners will allow programs to identify individuals with medical frailty who are not yet formally captured in other data sources").
[133] 91 Fed. Reg. 33408 (stating only 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.").

through pregnancy."[134] Medicaid expansion has without doubt had significant positive effects of maternal and child health.[135]

We ask CMS to clarify that states must continue to comply with 42 C.F.R. § 435.956(e) and accept self-attestation to establish an individual is a specified excluded individual based on pregnancy status.

IV. Due Process Protections

A. The application of 42 C.F.R. § 431.210 to all adverse actions needs clarification.

We ask CMS to make clear that the entirety of 42 C.F.R. § 431.210 applies to eligibility determination notices, a category that encompasses not only notices of eligibility approval, but also notices of denial and termination.[136] The IFR states that subparts (a) and (b) of § 431.210 apply to all such notices.[137] Elsewhere, however, CMS explains that when individuals are determined ineligible for failing to comply (or to demonstrate that they meet an exception or exclusion), the State must provide "written notice and fair hearing rights consistent with . . . [all of] part 431, subpart E."[138] Because eligibility determination notices include denials and terminations, CMS should clarify that, in those instances, § 435.558(d)(2)(ii)—and therefore all of part 431, subpart E—applies. As currently drafted, the rule is internally inconsistent: § 435.556(d) requires only that subparts (a) and (b) govern the content of denial and termination notices, while § 435.558(d)(2)(ii) provides that all of part 431, subpart E applies to ineligibility determinations (*i.e.*, denials and terminations).

We ask CMS to amend § 435.556(d) as follows:

> (d) A State must inform applicants and beneficiaries of the State's eligibility determination consistent with §§ 435.917 and 435.918 and part 431, subpart E of this subchapter, which includes a clear statement of the basis of eligibility consistent with § 435.917(b)(1)(i), or a statement of the State's intended

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[134] Off. of Disease Prevention & Health Promotion, U.S. Dep't of Health & Hum. Servs., *Increase the Proportion of Pregnant Women Who Receive Early and Adequate Prenatal Care — MICH-08*, Healthy People 2030, https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08 (last visited July 24, 2026); *see also* Rebecca A. Krukowski et al., *Correlates of Early Prenatal Care Access Among U.S. Women: Data from the Pregnancy Risk Assessment Monitoring System (PRAMS)*, 26 Maternal & Child Health J. 328, 329 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC8488070/pdf/10995_2021_Article_3232.pdf (citing multiple studies to support conclusion that "[e]arly prenatal care presents a critical window for changes to personal and systemic factors that may compromise the health of women and infants.").

[135] Madeline Guth & Karen Diep, *What Does the Recent Literature Say About Medicaid Expansion?: Impacts on Sexual and Reproductive Health*, Kaiser Fam. Found. (June 29, 2023), https://www.kff.org/affordable-care-act/what-does-the-recent-literature-say-about-medicaid-expansion-impacts-on-sexual-and-reproductive-health/.

[136] *See* 42 C.F.R. § 435.556(d); *see also* 91 Fed. Reg. 33392.

[137] *Id.*

[138] 42 C.F.R. § 435.558(d)(2)(ii); *see also* 91 Fed. Reg. 33414.

action and the specific reasons for the action consistent with § 431.210(a) and (b) of this subchapter, as applicable, which must specify whether the individual:

(1) Meets the criteria as a specified excluded individual as defined in § 435.554; or

(2) Is determined to be an applicable individual as defined at § 435.551, and whether the individual demonstrates community engagement under § 435.552 or is deemed to have demonstrated community engagement under § 435.553 or, if applicable, § 435.555, for the month(s) specified in accordance with paragraph (a) of this section.

(3) For individuals determined ineligible under the State plan (or waiver of such plan), the State's notice of eligibility must be consistent with § 435.558(d)(2) of this subchapter.

B. Elimination of 45-day timeliness standard for processing Medicaid applications will unduly delay access to critical healthcare coverage.

We further recommend CMS establish a defined outer limit on any delay authorized under new 42 C.F.R. § 435.912(e)(3). As drafted, the exception tolls the 45-day timeliness standard of § 435.912(c)(3) to accommodate the 30-calendar-day noncompliance period, but it sets no outside limit on the total time a state may take to reach a final determination.[139] This exception – which leaves an open-ended deadline for states to process applications – fails to align with reasonable promptness and the corresponding fair-hearing rights that attach whenever a state fails to act in a reasonably prompt manner.[140] Each day an applicant remains in processing limbo is a day an eligible individual goes without coverage; this delay harms beneficiaries and providers alike.[141] A firm time limit is the only thing that will hold states accountable to their obligations under the Medicaid Act.[142]

Instead of an open-ended deadline, CMS should set a 90-day standard when a state cannot meet the existing standard for applicants who are provided a notice of noncompliance with the work requirement. This would more than account for the concern

[139] *See* 42 C.F.R. § 435.912(e)(3); *see also* 91 Fed. Reg. 33414.
[140]42 U.S.C. § 1396a(a)(8); *see also id.* § 1396a(a)(3) (fair hearing required where a claim "is not acted upon with reasonable promptness").
[141] *See e.g., Koss v. Norwood*, 305 F.Supp.3d 897, 922-23 (N.D. Ill. 2018) (in finding irreparable harm to plaintiffs experiencing Medicaid application delays, noting that one plaintiff lost her eyesight while awaiting coverage for needed eye injections and crediting the testimony of two nursing facilities "describing the financial and administrative pressure the delays put on them"); *see also Ability Center of Greater Toledo v. Lumpkin*, 808 F.Supp.2d 1003, 1018 (N.D. Oh. 2011) (crediting the organizational plaintiff's claim that they have "expended substantial organizational resources providing advocacy assistance to individuals seeking a timely determination of their disability status.").
[142] *See* 91 Fed. Reg. 33466 (acknowledging the importance of a time limit by noting that "the 45-day timeliness standard under § 435.912 for MAGI beneficiaries is necessary to prevent delays in applicants' eligibility determinations").

that states must provide individuals a full 30 days from the date of the notice of non-compliance (plus 5 days for mailing) before it can reach a final eligibility determination based on work requirement criteria.[143] As CMS is aware, it has long required states to determine eligibility within a maximum of 45 days for most applicants and 90 days for individuals who apply on the basis of disability.[144] The longer, 90-day window is not arbitrary. Instead, it is reserved for the eligibility pathway that demands the most individualized development of evidence; namely, disability determinations.[145] Verifying compliance with the work requirement is comparably, if not less, fact-intensive, entailing review of an applicant's compliance (*e.g.*, employment, educational, or volunteer status) and of the existence of the applicable exceptions and exclusions (*e.g.*, medically frail or caregiver status). If CMS considers 90 days sufficient to complete its most complex, evidence-driven determinations (which also already incorporates a case-by-case exception standard to timeliness),[146] that same period is more than adequate here and offers a ceiling the agency has already tested and validated.

Including a firm timeliness standard in the new 42 C.F.R. § 435.912(e)(3) is also warranted based on previous CMS guidance. For example, during unwinding, CMS permitted states to delay timely processing of certain eligibility actions only through a fixed end date of December 31, 2025, and cautioned that unresolved backlogs could trigger formal compliance action.[147]

Accordingly, we recommend CMS amend § 435.912(e)(3) to cap any authorized delay at 90 days from the date of application—mirroring the maximum the agency already applies to disability-based determinations—and to require the state to document the case-specific basis for any delay extending beyond the standard 45-day period.

We ask CMS to amend § 435.912(e)(3) to include the bolded language below:

> (e) The agency must determine eligibility within the standards except in unusual circumstances, for example—
>
> (1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action; or

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[143] *Id.*
[144] 42 C.F.R. § 435.912(c)(3)(i)-(ii) (reflecting the version of the CFR in effect as of June 2, 2024, as restored in relevant part by the IFR).
[145] *See id.* § 435.541 (governing the state's reliance on, or independent making of, disability determinations, and contemplating the additional development required where no SSA determination has been made).
[146] *See id*. § 435.912(e) (allowing the state to exceed the timeliness standards, in part, where the applicant "fails to take a required action, or [w]hen there is an administrative or other emergency beyond the agency's control").
[147] *See* CMS, CMCS Informational Bulletin, *Guidelines for Achieving Compliance with Medicaid and CHIP Eligibility Renewal Timeliness Requirements Following the Medicaid and CHIP Unwinding Period* 2-3 (Aug. 29, 2024), https://www.medicaid.gov/federal-policy-guidance/downloads/cib08292024.pdf.

(2) When there is an administrative or other emergency beyond the agency's control.

(3) When the agency is unable to meet the standards for applicants who are provided a notice of noncompliance to demonstrate community engagement due to the 30-calendar day period that States must provide for the individual to respond to such notice at § 435.558. **In this instance, unless the unusual circumstances in paragraphs (1) or (2) of this section exist, the determination of eligibility may not exceed 90 days.**

V. The Regulatory Impact Statement is Fatally Flawed.

We end by noting that public health experts have raised serious concerns about CMS's regulatory impact statement. One researcher, Leighton Ku, a professor of health policy and director of the Center for Health Policy Research at George Washington University, noted that "[i]n many years of reading regulations and regulatory impact statements, I have never seen assessments so untethered from the evidence and misleading to the public."[148] Professor Ku notes that the analysis "wildly exaggerates the benefits of Medicaid work requirements, underestimates the harm (or "costs") and simply ignores how the loss of Medicaid coverage will reduce access to health care and medications, imperil health for needy Americans, harm the nation's health care providers and damage state economies."[149]

We urge CMS to revise the regulatory impact statement so that it accurately reflects the effects of the IFR on beneficiaries, providers, and states.

VI. Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record on this rule for purposes of the Administrative Procedure Act.

We appreciate your consideration of our comments. If you have questions about these comments, please do not hesitate to contact Katy DeBriere, Senior Attorney, debriere@healthlaw.org or Catherine McKee, Senior Attorney, mckee@healthlaw.org.

Sincerely,

/s/ Jennifer Cannistra
Executive Director
cannistra@healthlaw.org

[148] Ku, *The Administration's Flawed and Misleading Claims About Medicaid Work Requirements*.
[149] *Id.*