July 31, 2026

Submitted electronically via regulations.gov

The Honorable Robert F. Kennedy, Jr.
Secretary of the U.S. Department of Health and Human Services
Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20201

RE: American Public Health Association, Grantmakers in Health, Jacobs Institute of Women's Health, National Center for Medical-Legal Partnership, and Public Health Deans and Scholars' Comments on Department of Health and Human Services "Medicaid Program; Community Engagement Requirement for Certain Individuals" (CMS-2454-IFC; RIN 0938-AV98)

Dear Secretary Kennedy:

The American Public Health Association (APHA), Grantmakers in Health, the Jacobs Institute of Women's Health, and the National Center for Medical-Legal Partnership, along with public health and health policy deans, chairs, and scholars (in their individual capacities), file this comment on the Department of Health and Human Services (HHS) June 1, 2026 interim final rule with comment (the Rule),[1] which purports to implement and interpret the Medicaid community engagement requirement under section 1902(xx) of the Social Security Act (the Act) (herein referred to as "community engagement" or "work requirements").

The Rule is inconsistent with the statutory language of section 1902(xx) of the Act, as added by H.R. 1, and with other cornerstone provisions of Title XIX. Specifically, the Rule restricts eligibility for exclusion from the community engagement requirements that Congress explicitly mandated in the text of H.R. 1. Most egregiously, the Rule unlawfully narrows the exclusion for individuals who are medically frail or otherwise have special medical needs, limiting it to only those individuals whose condition "significantly impairs" their ability to comply with the extra-statutory ability to work test that appears nowhere in the statute Congress enacted. The Rule also imposes administrative burdens on states, providers, and beneficiaries that contravene section 1902(xx)'s express terms directing states to rely, wherever possible, on data to make *ex parte* determinations. Finally, the Rule will force states to violate other Medicaid statutory requirements, including the express command to " . . . assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."[2]

The Rule is arbitrary and capricious in violation of the Administrative Procedure Act because it exceeds the authority of Title XIX of the Act. It is also arbitrary and capricious because, in promulgating it, CMS failed to engage in the reasoned decision-making the APA requires: it did not adequately explain or justify its most consequential policy choices, disregarded substantial evidence of the Rule's likely effects, and reversed its own prior guidance without acknowledging

[1] 91 Fed. Reg. at 33348
[2] 42 U.S.C. § 1396a(a)(19)

the change or accounting for the reliance it invited. As just one important example, the Rule fails to consider a longstanding, fundamental policy goal of the Medicaid program, namely, the Rule's impact on the millions of beneficiaries who seek coverage annually because of significant health needs, its effects on access to health care, the stability of the health care system on which Medicaid beneficiaries depend, and ultimately, individual and population health.

The Rule will also cause serious and substantial harms that CMS unreasonably underestimates. States' prior work requirement experiments—each significantly less harsh than the requirements in the Rule—have yielded robust evidence that CMS ignores of the significant harms that will result as states implement this Rule. Contrary to the Rule's suggestions that it will help beneficiaries become more self-sufficient, it will instead cause people who should otherwise remain eligible to lose coverage, reducing access to care and leading to poorer health outcomes and preventable deaths, particularly for individuals with chronic conditions. In turn, this will cause individuals to be unable to work and lead to decreases in labor force participation—the exact opposite of the stated purpose of the Rule. Additionally, CMS significantly underestimates the Rule's impact. It will dramatically increase burdens on providers, including causing increased levels of uncompensated care as patients lose or are denied insurance coverage, an inability to maintain continuous health care for sick or higher need patients, and impossible demands on health care providers. Safety net health care providers are especially threatened, particularly hospitals that furnish a disproportionate percentage of uncompensated care, as well as community health centers, state and local public health clinics, and clinics providing specialized care for people with mental illnesses, substance use disorders, or HIV.

For these reasons, we urge HHS to rescind the Rule and issue a subsequent Rule that is consistent with the law and appropriately accounts for the significant health, public health, and economic harms the Rule will cause.

APHA is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and health-related businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness.

The Jacobs Institute of Women's Health is based at the Milken Institute School of Public Health at George Washington University and publishes the peer-reviewed journal Women's Health

Issues. Its mission is to identify and study aspects of healthcare and public health, including legal and policy issues, that affect women's health at different life stages; to foster awareness of and facilitate dialogue around issues that affect women's health; and to promote interdisciplinary research, coordination, and information dissemination. The Institute supports policies that promote women's access to comprehensive health care and other conditions that enable them to live healthy lives.

The National Center for Medical-Legal Partnership (NCMLP), based at the Milken Institute School of Public Health at the George Washington University, leads education, research, and technical assistance efforts to help health organizations throughout the United States incorporate legal aid services as a standard component of their response to health-related social needs. Medical-legal partnerships integrate the unique expertise of lawyers into health care settings to help health care teams, providers, and systems address the root causes of poor health outcomes and costs. NCMLP aims to shift healthcare practices and policies to proactively consider legal needs and solutions as part of a comprehensive approach to patient care. We achieve this by leading efforts to transform policy and practice, convene stakeholders, build evidence, and attract investment to support medical-legal partnerships.

The individual signatories are distinguished deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals known for their expertise in access to healthcare, including Medicaid as the leading insurer for low-income people and other populations that face systemic barriers to essential healthcare services. The individual signatories join this comment in their individual capacities and not as representatives of their respective institutions. The complete list of individual signatories is included at the end of this letter.

I. The Medicaid Community Engagement Requirement Rule Violates the Law

A. The Rule's Restrictive Definition of Medical Frailty Impermissibly Narrows the Statutory Exclusion and Exceeds the Secretary's Delegated Authority.

1. The "Significantly Impairs" Test Conflicts with the Statute's Own Terms for "Specified Excluded Individual."

The "significantly impairs" standard in the Rule contradicts the statute. The statutory exclusion for individuals who are medically frail or who have special medical needs unambiguously specifies five categories of individuals who must be excluded from the community engagement requirements. Section 1902(xx)(9)(A)(ii)(V) of the Act includes in the definition of "specified excluded individual" an individual who is medically frail or otherwise has special medical needs, "*including* an individual—(aa) who is blind or disabled (as defined in section 1614); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of

daily living; or (ee) with a serious or complex medical condition"[3] (emphasis added). Congress clearly defined these categories by the existence of a medical condition, not by any individual's ability to work, with the sole exception of the Social Security definition of disability in (aa). The Rule, however, redefines the entire medically frail exclusion to reach only those individuals whose "physical, mental, or other behavioral health condition *significantly impairs* the individual's ability to comply with the community engagement requirement"[4] (emphasis added). That extra-statutory test of ability to work exceeds the authority Congress conferred and is contrary to law.

The Secretary's authority to define individuals who are medically frail or who otherwise have special medical needs does not extend as far as CMS contends. Congress delegated authority to define who is medically frail or otherwise has special medical needs,[5] but the statute simultaneously requires that the definition "*includ[e]*" the five enumerated categories of individuals. The word "including" is widely understood as a word of enlargement, expansion, and illustration that is best read to mean "to contain as part of something."[6] The term "including" in 1902(xx)(9)(A)(ii)(V) establishes a floor, not a list of illustrative examples that the Secretary may narrow through added qualifications.[7] The five categories in (aa) through (ee) are mandatory components of the statutory definition, and CMS concedes as much: it acknowledges that its definition must "include[] the five categories specified at section 1902(xx)(9)(A)(ii)(V)."[8] Where CMS is incorrect, however, is that the Secretary's discretion only applies to the umbrella phrase "medically frail or otherwise has special medical needs (as defined by the Secretary)." The parenthetical delegating the Secretary the authority to define "medically frail" or "otherwise hav[ing] special medical needs" does not give him authority to add a work-capacity requirement into each of the categories of individuals Congress mandated be excluded in the subparagraphs that follow. By restricting each enumerated category to require a separate showing that the condition significantly impairs the ability to work, the Rule impermissibly narrows the statutory floor.

Section 1902(xx) of the Act's statutory structure confirms this reading and further demonstrates that it is the only permissible reading of the statute. Congress cross-referenced the Social

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[3] Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act.
[4] 42 C.F.R. § 435.554(c)(5)(i); 91 Fed. Reg. at 33472.
[5] Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act ("who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual— . . . "). The parenthetical "(as defined by the Secretary)" immediately follows and modifies the umbrella phrase "medically frail or otherwise has special medical needs." It precedes the word "including," which introduces the five mandatory subcategories. As a matter of statutory syntax, the delegation attaches to the term being defined, not to the enumerated categories that Congress itself defined by specifying them in the statute.
[6] *Include*, Black's Law Dictionary (11th ed. 2019) ("To contain as part of something. The participle *including* typically indicates a partial list . . . some drafters use phrases such as *including without limitation* and *including but not limited to*—which mean the same thing.").
[7] *See Federal Land Bank of St. Paul v. Bismarck Lumber Co*., 314 U.S. 95, 100 (1941) ("the term 'including' is not one of all-embracing definition but connotes simply an illustrative application of the general principle").
[8] 91 Fed. Reg. at 33373.

Security disability standard, which turns on inability to engage in substantial gainful activity, in only subparagraph (aa). The remaining categories (i.e., substance use disorder, disabling mental disorder, physical, intellectual or developmental disabilities that impact an ADL, and serious or complex medical condition) are stated as conditions alone, joined by "or," with no ability to work qualifier. In fact, the functional limitation test for individuals with disabilities expressly provided for in the statute in (dd) (requiring a "disability that significantly impairs their ability to perform 1 or more activities of daily living") allows individuals to qualify for the exclusion without meeting such a punishing ability to work standard, and in fact, many individuals with ADL limitations are able to work. Congress explicitly excluded this population in (dd) from the work requirement without requiring that their limitations impact their ability to work, recognizing the important services Medicaid provides to people with disabilities and showing how the Rule directly conflicts with the scope of this exclusion.

Under ordinary canons of construction, where Congress includes limiting language in one subsection but omits it from others, the omission is presumed deliberate.[9] The Rule inverts that canon: it extracts the inability to engage in substantial gainful employment construct Congress placed only in subparagraph (aa) and imposes a similar work-impairment test onto every category. Congress knew how to condition an exclusion on impaired ability to work and did so selectively in only subparagraph (aa); CMS may not supply the limitation Congress deliberately withheld for each of the other categories of individuals who are medically frail or have a serious or complex medical condition. Indeed, if every category required a Social Security disability-type showing, the separately enumerated categories, especially the ADL limitation for disabled individuals, would be surplusage.

CMS' unlawful addition of the "significantly impairs" standard is particularly egregious with respect to the category of individuals with "a serious or complex" medical condition. The statutory text leaves no question that such individuals must be excluded from the work requirement without limitation, including showing that their condition makes them unable to work. Congress added language about severity or acuity in other exclusions and intentionally did not do so for this population. Consider that, for example, the statute says that for individuals with mental disorders, the condition must be *disabling*. Similarly, for individuals with physical, intellectual, or developmental disabilities, the disability must impact *at least 1 ADL*. The statute includes no such qualifier before "serious or complex medical condition," demonstrating that the significant impairment test conflicts with the statute.

Moreover, the "significantly impairs" requirement will disproportionately burden and lead to unlawful coverage loss for a key population of individuals with serious or complex medical conditions that the statute explicitly sought to protect: older, poor working-age adults who are health-burdened and nearing the end of their work life (i.e., individuals with serious or complex medical conditions). Among the most vulnerable Medicaid adult group enrollees are individuals living with chronic health conditions such as cancer, HIV, serious heart or pulmonary conditions,

[9] *Russello v. United States*, 464 U.S. 16, 23 (1983).

and other conditions that can be managed with proper care. Paradoxically, Medicaid coverage enables this population to work when they can.[10] The truth—and one that CMS is fully aware of given states' past Medicaid community engagement experiments—is that health-burdened poor working age adults depend on access to stable and continuous health care to be able to work.[11] Yet the Rule not only adds an unlawful condition of eligibility but also demands evidence (proof of inability to work) that state Medicaid programs are not prepared to develop and that health care providers lack the competence and financial support to measure.

Relatedly, the Rule's significant narrowing of the medical frailty exemption is also in tension with other categories excluded from the community engagement requirements, adding to the arbitrariness and capriciousness of the rule discussed in section II of this comment. Specifically, the Rule allows for exemptions from the community engagement for family caregivers who provide care to people with disabilities, as defined under the Americans with Disabilities Act.[12] Yet in many cases, because the disabled person would have to meet the Rule's incredibly high bar of showing that their condition substantially impairs their ability to work, the family caregiver will be exempted but the disabled person to whom they are providing care would not be.

Finally, although courts need to look no further than the plain text of the statute to determine its meaning, the legislative history is instructive here too. In particular, Congressional statements made contemporaneously with the statute's consideration and passage make clear that the Rule's ability to work restrictions are inconsistent with Congressional intent. Members of Congress repeatedly described the medically frail exclusion in purely condition-based terms, with no suggestion that beneficiaries would also need to prove their condition impairs their ability to work. For example, Chairman Guthrie assured the public that individuals are "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," and that "our bill couldn't be clearer" that it "includes a long list of exempted individuals."[13] Senator Grassley likewise explained that Congress provided "reasonable exemptions" for "[i]ndividuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition," tracking the statute's plain terms without reference to

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[10] Compared to other working-age adults, those who work and are low-income are significantly more likely to work at physically demanding jobs; more than half do so; The SCEPA Team. (2017, January 6). Over Half of Low-Wage Older Workers Have Physically Demanding Jobs. Schwartz Center for Economic Policy Analysis The New School. https://www.economicpolicyresearch.org/research/over-half-of-low-wage-older-workers-have-physically-demanding-jobs

[11] Sommers Benjamin D., Goldman Anna L., Blendon Robert J., Orav E. John, & Epstein Arnold M. (2019). Medicaid Work Requirements - Results from the First Year in Arkansas. New England Journal of Medicine, 381(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772

[12] 91 Fed. Reg at 33369–33370.

[13] Center for Health Law and Policy Innovation. (2026, June 17). A Shift Between Congressional Intent and Implementation: Work Requirements. Harvard Law School. https://chlpi.org/wp-content/uploads/2026/06/HCIM_Congressional-Quotes_FINAL_6.17.26-1.pdf

any independent work-capacity threshold.[14] Senator Crapo assured colleagues that the legislation "does not take Medicaid away from . . . the medically frail,"[15] and Senator Sullivan touted exemptions for "individuals who are medically frail or are dealing with a substance use disorder" as unqualified protections.[16] None of these contemporaneous statements suggested that Congress intended medically frail individuals to bear the additional burden of proving that their condition "significantly impairs" their ability to work, confirming that CMS's added requirement is inconsistent with Congress's own understanding of the exclusion it enacted.

In summary, the Rule directly conflicts with the best and only permissible reading of the statute.[17] CMS reasons that the phrase "medically frail or otherwise has special medical needs" in the statute "connotes diminished functional capacity" and therefore requires that a condition impair the ability to meet the community engagement requirement, warning that otherwise individuals capable of 80 hours of monthly activity would qualify.[18] But it is the enumerated categories, not the umbrella phrase, that determine who must be excluded, and Congress defined those categories by condition. CMS's own explanation exposes the overreach: the Rule states that "if a person is able to demonstrate community engagement by performing 80 hours per month of qualifying community engagement activities, notwithstanding their physical, mental, or other behavioral health condition, they would not qualify as medically frail."[19] The Rule additionally states that "it is [not] reasonable to categorically consider conditions as serious or complex without factoring in criteria such as the severity of the condition."[20] That transforms a condition-based, categorical exclusion into an ability-to-work test that appears nowhere in the enumerated categories. The five-year "stable recovery" carve-out CMS engrafts onto the substance use disorder category[21] is a further instance of the same defect: Congress excluded individuals "with a substance use disorder" without qualification, and CMS cannot add a temporal limitation of its own invention. As demonstrated above, these aspects of CMS's Rule cannot be reconciled with the plain text of the governing statute.

2. The Statute Emphasizes E*x Parte* Determinations; the "Significant Impairment" Requirement and Self-Attestation Limitations Render the *Ex Parte* Language Meaningless.

The inability to work ("significant impairment") overlay in the Rule also cannot be squared with the verification framework Congress enacted in H.R. 1's community engagement requirements. Section 1902(xx)(5) of the Act directs States, when determining whether an individual is a specified excluded individual under paragraph (9)(A)(ii), to "establish processes and use reliable

[14] *Id*.
[15] *Id*.
[16] *Id*.
[17] *See* Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024).
[18] 91 Fed. Reg. at 33,373.
[19] *Id.*
[20] 91 Fed. Reg. at 33375.
[21] 91 Fed. Reg. at 33374.

information available to the State (such as payroll data or payments or encounter data [. . .]) without requiring, where possible, the applicable individual to submit additional information."[22] Congress thus contemplated that medical frailty would ordinarily be verified *ex parte*, using administrative data the State already has. The statute's own examples—specifically, payments and encounter data—can show that an individual has a diagnosis or has received services; they cannot show whether a condition "significantly impairs" that individual's capacity to work or volunteer 80 hours per month. In fact, there is no *ex parte* data that can show that an individual has a substantial impairment in their ability to work or volunteer, other than a Social Security disability determination (which is only one of the five categories of medical frailty). By defining the exclusion in terms of a functional judgment that administrative data cannot answer, the Rule renders the *ex parte* pathway Congress prioritized unavailable in precisely the cases it was designed to serve, and forces States to use the very "additional information" Congress told States to avoid "where possible." An interpretation that defeats the statute's chosen verification method is not a permissible statutory interpretation.

Finally, the Rule's restrictions on self-attestation contravene the flexibility Congress expressly preserved for states in H.R. 1 as they implement work requirements. Section 1902(xx)(3)(A) of the Act permits States to "elect to not require an individual to verify information" in order to deem specified excluded individuals—including the medically frail—compliant. The Rule nonetheless bars States, beginning January 1, 2028, from accepting a statement under penalty of perjury to establish medical frailty more than once "during the beneficiary's period of enrollment,"[23] and otherwise requires documentation whenever it is "reasonably available." More specifically, after the one time the state is permitted to verify using self-attestation, the State must verify using reliable information available to the State (e.g., claims or encounter data). When that information is insufficient, which CMS concedes may be the case for determining whether someone's condition "significantly impairs" their ability to work, the state must use documentation submitted by the individual or their provider.[24] Neither the "once-per-enrollment" cap nor the open-ended "period of enrollment" construct appears in the statute. These limits override a discretion the statute affirmatively conferred on the States and are contrary to law for that additional reason.

3. The Rule's Restrictive Eligibility Policies Conflict with Title XIX's Overarching Purpose of Providing Health Coverage and Other Key Title XIX Provisions.

[22] Section 1902(xx)(5) of the Social Security Act.
[23] 42 C.F.R. § 435.557(f)(1)(ii); 91 Fed. Reg. at 33476.
[24] In the Rule, CMS acknowledges that "States may use an approach that relies on lists of qualifying diagnosis codes combined with utilization data and other factors, such as severity of conditions, to determine medical frailty or otherwise having other special medical needs. However, in some cases, reliable claims information may not be available to the State for individuals who are medically frail or otherwise have other special medical needs, particularly in cases where an individual recently obtained a diagnosis and medical services, but the claims data are lagging." 90 Fed. Reg. at 33406.

The Rule's restrictive eligibility policies are in tension with the purpose of Title XIX as a whole and various individual provisions contained therein. One need look no further than to one of the first sections of Title XIX—its appropriations provision—to understand that the principal objective of Medicaid is providing health care coverage.[25] This provision describes the purpose of Medicaid as:

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.[26]

Looking at the basic definition of "medical assistance" confirms this point. The statute defines "medical assistance" as "payment of part or all of the cost of the following care and services or the care and services themselves."[27]

The Affordable Care Act's expansion of health care coverage[28]—which has withstood consistent attempts to repeal it—remains an eligibility group under Title XIX to which Medicaid's general purpose of furnishing health care coverage continues to apply with equal force. Although this group must now comply with the work requirements mandated by H.R. 1, CMS is not free to implement it in a way that disregards the Medicaid program's purpose or other provisions of Title XIX.

For example, the implementation of the "significantly impairs" test for individuals with serious or complex medical conditions is in tension with the basic structure of Medicaid's eligibility and enrollment requirements, which operate like no other form of health coverage and permit people to enroll whenever they have a need for health care, rather than at fixed open enrollment time periods.[29] The fifth category of specified excluded individuals (i.e., individuals with serious or complex medical conditions) aligns with Medicaid's statutory requirement that embraces those whose serious health needs are the reason for application (i.e., individuals wishing to file an application have an ability to do so and receive a prompt eligibility determination and retroactive eligibility where applicable under sections 1902(a)(8) and (34) of the Act). But, by requiring that a State conduct or await an individualized capacity-to-work assessment before it can resolve eligibility for a person who has just presented with a new cancer diagnosis or cardiac event, for

[25] Section 1901 of the Social Security Act. See also *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020). Although *Gresham* addressed the Secretary's authority in the context of a demonstration project under section 1115 of the Act, the opinion's underlying principle — that CMS's exercise of any delegated discretion (here, the discretion to *define* 'medically frail) must be exercised consistent with Medicaid's coverage-furnishing purpose — applies with equal force here

[26] Section 1901 of the Social Security Act.

[27] Section 1905(a) of the Social Security Act.

[28] Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

[29] Section 1902(a)(8) of the Social Security Act. See also section 1902(a)(34) of the Social Security Act (providing for retroactive eligibility which permits coverage of health care utilization preceding the date of application).

example, the Rule delays the "reasonably prompt" determination section 1902(a)(8) requires and jeopardizes the retroactive coverage section 1902(a)(34) guarantees for care already received.

As another example, the "significantly impairs" test and its accompanying verification requirements are in tension with the requirements in section 1943 of the Act. Added by the Affordable Care Act, section 1943 imposes a free-standing, preexisting obligation on all Medicaid eligibility and enrollment processes. Separate from section 1902(xx), section 1943 requires such processes to be streamlined and simplified. Such processes must coordinate with state health insurance exchanges and "to the maximum extent practicable . . . determine [] eligibility on the basis of reliable third-party data."[30] Similar to the arguments in section I.A.2 immediately above, the "significantly impairs" overlay also cannot be squared with this verification framework Congress enacted for Medicaid eligibility and enrollment overall. Because the "significantly impairs" test cannot be verified through such data, the Rule's documentation and clinician-attestation requirements are inconsistent with the streamlined, exchange-coordinated processes section 1943 demands.

Finally, a core tenet of the Medicaid statute that states must adhere to—and that CMS cannot disregard—is section 1902(a)(19) of the Act. A longstanding cornerstone of Title XIX, this provision is a mandate to " . . . assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."[31] The "significantly impairs" test and its broad application is antithetical to the requirement to be simple to administer and will significantly harm Medicaid's most vulnerable beneficiaries, as discussed in extensive detail in sections II and III of this comment.

From the first provisions in Title XIX defining the purpose of the Medicaid program to detailed and technical eligibility provisions to broad programmatic safeguards, the requirements of the Medicaid statute are clear that CMS cannot enact roadblocks to eligibility and enrollment where Congress has not explicitly authorized them, particularly where Congress has spoken directly and unambiguously to the precise question. The Rule's "significantly impairs" ability to work test is the most egregious example of such an unauthorized roadblock.

B. The Rule Is Arbitrary and Capricious Because it Ignores the Important Operational Consequences, Disregards Evidence of Predictable Coverage Loss, and Fails to Justify the Agency's Reversal of Position.

In addition to its illegality for exceeding the delegated statutory authority, the Rule—and particularly the medical frailty framework—is arbitrary and capricious for numerous reasons.

1. CMS Failed to Adequately Explain and Justify its Policies in the Rule.

[30] Section 1943 of the Social Security Act; Section 1413(c)(3) of the Affordable Care Act.
[31] Section 1902(a)(19) of the Social Security Act.

The Rule shows that the agency has failed to engage in the reasoned decision-making required by the Administrative Procedure Act. More plainly, CMS's justifications in support of its overly restrictive requirements lack evidence and do not withstand scrutiny. For example, to defend its reverification requirements, including the one-time-only limit on statements under penalty of perjury for medical frailty exemptions, CMS asserts that requiring documentation "will motivate individuals to access care."[32] That rationale is arbitrary for several reasons. First, it has no basis in the statutory text, which excludes the medically frail from the requirement rather than using their exclusion as a motivator for certain behavior. Second, it is unsupported by any study or data showing that conditioning an exclusion for work requirements on documentation causes medically frail people to seek care. Moreover, it is contradicted by the Rule's own recognition that many medically frail individuals "may not identify themselves as having a condition that could qualify them" even after completing a screening tool. If individuals do not recognize their qualifying conditions, documentation requirements cannot rationally be expected to "motivate" care-seeking; the predictable result is instead that eligible people will lose coverage.

The 12-month lookback for claims and encounter data is likewise arbitrary. The Rule directs States to verify medical frailty using "reliable information available to the State," but forbids consideration of any claims or encounter data older than 12 months on the theory that "older information may not reflect the individual's current condition."[33] CMS never grapples with the mismatch between that cutoff and the realities of Medicaid claims processing (e.g., lags among service, billing, and adjudication mean recent care is frequently not yet reflected in the data) nor with permanent conditions, such as quadriplegia, that require no recent treatment yet plainly qualify under the statute.[34] The limitation is especially irrational because CMS's own data systems use far longer reference periods. For example, its Transformed Medicaid Statistical Information System (T-MSIS) and its Chronic Conditions Warehouse rely on windows of roughly 24 months or more.[35] Adopting a 12-month cutoff that CMS's own program experience contradicts, without reasoned consideration of the drawbacks and impacts, is arbitrary agency action.

The once-per-enrollment cap on self-attestation for the medical frailty exemption is also arbitrary for related reasons. Because "period of enrollment" is not time-limited, an individual who attests to one qualifying condition may be barred from ever attesting again, including to a new and unrelated serious condition, for as long as she or he remains continuously enrolled. A beneficiary who attests to a malignant melanoma could not, years later, attest to a newly diagnosed breast cancer, though the statute would plainly exclude her. At the same time, because the Rule imposes no lockout on reapplication, a disenrolled individual may attest anew upon reapplying. In other words, the cap accomplishes little except to generate coverage churn, administrative cost, and

[32] 91 Fed. Reg. at 33406.
[33] 91 Fed. Reg. at 33405; 42 C.F.R. § 435.557(f).
[34] 91 Fed. Reg. at 33409.
[35] Centers for Medicare & Medicaid Services. (2025, June). Time Required for Complete TAF Data. https://www.medicaid.gov/dq-atlas/downloads/supplemental/3051-TAF-Data-Run-Out.pdf

interruptions in care. CMS did not reconcile these consequences with its stated goals, and its assumption that States will "generally . . . be able to reverify on an *ex parte basis*" once a beneficiary accesses care[36] rests on the same flawed premise that claims data can demonstrate functional impairment.

2. CMS Ignored the Rule's Provider Burdens, Predicable Coverage Losses, and Flawed Economic Assumptions.

CMS's inadequate and contradictory justifications demonstrate that CMS failed to consider important aspects of the problem the rule is intended to address. As just one illustrative example, nowhere in the Rule does CMS contend with the burden the Rule's "significantly impairs" test imposes on providers and State agencies. More specifically, because administrative data cannot establish that a condition impairs the ability to work, the test will in practice require clinician documentation and/or individualized State assessments of each beneficiary's capacity to work. These determinations are likely to resemble Social Security's complex disability adjudications, and yet CMS supplies no standard, no definition of "significant impairment," and no consideration of who will perform the assessments or how they will be funded. The Rule threatens States with penalties, including under the enhanced PERM audit program, if they approve medical frailty without sufficient support for a significant-impairment finding,[37] while entirely failing to provide guidance needed to make that finding. Providers are frequently unwilling or unable to complete such attestations—as New Hampshire's experience with a comparable requirement showed[38]—and the documentation workload is enormous: analyses estimate the requirement could cost health care facilities roughly $300 million per year and consume on the order of three million provider hours annually.[39] There is no indication in the Rule that CMS meaningfully considered any of this, and its failure to contend with the operational and provider burden of the *ultra vires* test it created is independently arbitrary and capricious.

Furthermore, as demonstrated by the discussions of substantial research about the impacts of administrative burdens and coverage loss in sections II and III, CMS either did not consider, or without explanation disregarded, extensive evidence that the administrative burdens it is imposing will predictably cause eligible people to lose coverage. Experience with Medicaid work requirements in Arkansas—where roughly 18,000 people lost coverage in seven months, an

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[36] 91 Fed. Reg. at 33407.
[37] 91 Fed. Reg. at 33377.
[38] Hill, I., Burroughs, E., & Adams, G. (2020, February). *New Hampshire's Experience with Medicaid Work Requirements*. Urban Institute. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf
[39] Ku, L., Orgera, K., Kwon, K. N., Gorak, T., Krips, M., & Cordes J. J. (2026, June 9). *H.R. 1 Funding Cuts Will Overshadow Gains from the New Rural Health Transformation Program*. Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2026/jun/hr-1-funding-cuts-rural-health-transformation

estimated 95% of whom had met the requirement or qualified for an exemption[40]—and in Georgia, where enrollment reached only a small fraction of those eligible amid pervasive procedural denials[41], bears directly on the effects of the Rule's far harsher and more demanding regime. Based on the text of H.R. 1—not the more restrictive language of the Rule—the Congressional Budget Office estimated that at least [42] will lose Medicaid by 2034 due to added administrative steps alone,[OBJ] and CBO and the Urban Institute projected total coverage losses on the order of 5.2 to [43], the great majority of whom are working or exempt.[OBJ][44]Taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[OBJ] The Rule neither confronts this evidence nor explains why its individualized-assessment approach—more restrictive than any prior State's work requirement program—will avoid the same results. An agency that ignores the predictable, well-documented consequences of its action has not engaged in the reasoned decision-making required by law, and therefore its action must be set aside.

Along these same lines, the Rule's economic analysis is deeply flawed and arbitrary and capricious. More precisely, the Rule provides no evidence for its claim that Medicaid work requirements have a positive impact on employment and earnings. Indeed, the two analyses cited in the Rule regarding the impact of the Rule are both deeply inaccurate in their estimates and assumptions.

CMS released its regulatory impact statement quantifying the benefits and costs of Medicaid work requirements, as required by federal rules.[45] The regulatory impact statement is a required element of federal regulations, intended to demonstrate to the public that the government

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[40] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*, *39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538

[41] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker; Thomas, G. (2024, September 5). *Georgia Pathways to Coverage*. Georgia Department of Community Health. https://dch.georgia.gov/document/document/comprehensive-health-coverage-meeting-slide-deckdch-presentation-002/download; Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[42] Congressional Budget Office. (2025, October 28). *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*. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[43] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461; Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work

[44] Boozang, P.M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034*. Mannatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034

[45] 91 Fed. Reg. at 33348.

seriously considered potential benefits and costs of its regulation, in order to minimize harm. Analyses conducted by an independent researcher at George Washington University Milken Institute School of Public Health[46] found that CMS overestimates the benefits of Medicaid work requirements, underestimates the harm (or "costs"), and fails to acknowledge that 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.[47]

Specifically, the CMS impact statement claims that about five million additional Medicaid beneficiaries will engage in work because of the new rules, and estimates that this will increase incomes and tax revenues. However, as cited in the GW analysis, CMS does not provide any evidence as to where five million additional jobs will come from. In 2025, the US only created 181,000 new jobs. [48] Opportunities for low-income Medicaid beneficiaries are also in less demand, with new job growth favoring those with higher education and specialized job skills.[49] A large body of research has established that Medicaid and SNAP work requirements are unable to significantly increase employment or incomes; instead, the most consistent effects of work requirements are to cause upwards of 50% of targeted recipients to lose health or nutrition benefits.[50] [51] [52] [53] [54]

The CMS impact report also underestimates how many individuals will lose Medicaid coverage. CMS' estimate that 3.1 to 3.3 million individuals will lose coverage is far below expert estimations. Based on the text of HR 1, CBO, RAND, and Urban Institute estimated coverage

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[46] The analysis was led by Leighton Ku, Ph.D., Professor and Director of the Center for Health Policy Research at the George Washington University Milken Institute School of Public Health, who is also an individual signatory to this comment.

[47] Ku, L. (2026, June 29). *Commentary: The Administration's Flawed and Misleading Claims About Medicaid Work Requirements*. The George Washington University Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/commentary-administrations-flawed-and-misleading-claims-about-medicaid-work-requirements

[48] Kopack, S. (2026, February 11). *U.S. had almost no job growth in 2025*. NBC News. https://www.nbcnews.com/business/economy/january-jobs-revisions-trump-rcna258398

[49] Center on Education and the Workforce. (n.d.). *Projections of Jobs, Education, and Training Requirements through 2031*. Georgetown University McCourt School of Public Policy. https://cew.georgetown.edu/cew-reports/projections2031/

[50] Congressional Budget Office. (2022, June 9). *Work Requirements and Work Supports for Recipients of Means-Tested Benefits*. https://www.cbo.gov/publication/57702

[51] Han, J. (2022). The impact of SNAP work requirements on labor supply. *Labour Economics*, *74*, 102089. https://doi.org/10.1016/j.labeco.2021.102089

[52] Gray, C., Leive, A., Prager, E., Pukelis, K., & Zaki, M. (2023). Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply. *American Economic Journal: Economic Policy*, *15*(1), 306–341. https://doi.org/10.1257/pol.20200561

[53] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*, *39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538

[54] Gangopadhyaya, A., & Karpman, M. (2025). The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data. *Health Services Research*, *60*(5), e14624. https://doi.org/10.1111/1475-6773.14624

loss among five to seven million individuals.[55] [56] [57] The Rule's more restrictive approach to determining "medical frailty"—requiring applicants to demonstrate that their conditions will "significantly impair" their ability to work or volunteer—is likely to increase the number who lose Medicaid coverage, and may exceed the CBO, RAND, or Urban Institute estimates of coverage losses.[58] Indeed, taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[59] Compared to the CBO estimates, CMS also estimates 34% less in federal funding losses due to work requirements.[60] Last, CMS' impact report ignores the enormous economic fallout of Medicaid work requirements. (See Section III, Part E in this comment for more on this.)

Second, the Office of the Assistant Secretary for Planning and Evaluation (APSE) released a report in June 2026—simultaneous with the release of the Rule—that claims that new Medicaid work requirements will improve household earnings and move 1.6 million to 2.9 million people out of poverty.[61] However, these estimates rest upon deeply flawed assumptions and estimates.[62] ASPE's claim that "work requirements can remove 2.9 million out of poverty" is based on the assumption that the nearly six million people who will be subject to work requirements but are not currently meeting these requirements can *immediately* increase work hours to comply with requirements. ASPE's claim that "work requirements can remove 1.6 million people out of poverty" is based on the assumption that half of these individuals (3.3 million) can immediately increase work hours to comply. Both estimates assume that employment will be immediately available to millions of individuals, despite the numerous social and economic barriers that

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[55] Congressional Budget Office. (2025, June 4). *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*. www.cbo.gov/publication/61461

[56] Rao, P., Baker, L., Girosi, F., Li, E., Kerber, R., & Eibner, C. (2026, June 18). S*tate-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*. RAND. https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html

[57] Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work?&utm_source=newsletters&utm_id=health_and_health_care&utm_campaign=HPC

[58] Wagner, J., & Orris, A. (2026, June 3). *Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/administrations-last-minute-restrictions-likely-to-worsen-impact-of-medicaid-work

[59] Boozang, P.M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034*. Mannatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034

[60] Congressional Budget Office. (2025, July 21). *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*. https://www.cbo.gov/publication/61570

[61] Berman, D., Burnszynski, J., Ghertner, R., Macartney, S., Swenson, K., Mulligan, C. B., & Bai, G. (2026, June 1). *Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce Poverty*. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/medicaid-work-requirements-should-incentivize-employment-reduce-poverty

[62] Frank, R. G., & Glied, S. (2026, June 12). *ASPE's Analysis Of Medicaid Work Requirements: Argument By Assumption*. Health Affairs Forefront. https://www.healthaffairs.org/do/10.1377/forefront.20260611.20123

individuals face in finding employment and increasing hours. Many of these barriers are named by ASPE themselves in a 2021 report: lack of employment opportunities, lack of sufficient hours available, lack of transportation, lack of internet access, lack of sufficient education or job training, and more.[63] Moreover, both estimates assume that states will face no implementation challenges—which previous studies have shown is an impossible unsupportable assumption.

The ASPE report cites four studies as evidence that work requirements will have a positive impact on employment and earnings. However, ASPE misuses and misconstrues the findings from the studies. First, none of the cited studies focus on Medicaid work requirement programs; cited studies evaluate work requirements associated with TANF, housing benefits, and welfare-to-work programs.[64] [65] [66] [67] Second, all four studies focus on work requirements accompanied by intensive work supports—such as employment case management, job search support, subsidized employment, childcare, or transportation assistance—which are not included as part of implementation of the Medicaid community engagement requirement in H.R. 1 and the Rule. ASPE also misconstrues findings from the studies they cite; for example, ASPE claims that the Temporary Assistance for Needy Families (TANF) work requirements in Alabama resulted in increases in employment and earnings; however, they fail to mention that these increases resulted from a surge of families exiting the TANF program after the work requirements started.[68]

3. CMS Failed to Consider Significant Reliance Interests.

An agency that changes course must "display awareness that it is changing position" and account for the "serious reliance interests" its prior policy engendered.[69] For nearly a year before the Rule, CMS told the States that it would define medical frailty consistent with its longstanding medical frailty requirements in 42 C.F.R. § 440.315(f), that diagnoses and claims or encounter data could establish the exclusion, and that auditable self-attestations were acceptable when data

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[63] Office of the Assistant Secretary for Planning and Evaluation. (2021, March 11). *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/ecb3c24c41fa4cc18b6ad0243e197c05/medicaid-waiver-evidence-review.pdf

[64] Rohe, W. M., Webb, M. D., & Frescoln, K. P. (2016). Work Requirements in Public Housing: Impacts on Tenant Employment and Evictions. *Housing Policy Debate*, *26*(6), 909–927. https://doi.org/10.1080/10511482.2015.1137967

[65] Congressional Budget Office. (2023, March 9). *The Effects of Work Requirements on the Employment and Income of TANF Participants: Working Paper 2023-03*. https://www.cbo.gov/publication/58867

[66] Research Evidence on the Impact of Work Requirements in Need-Tested Programs. (2026, July 23). https://www.congress.gov/crs-product/R45317

[67] Office of the Assistant Secretary for Planning and Evaluation. (n.d.). *Technical Methodology for Comparing the Impact of Work Promotion Strategies in Health and Welfare Programs*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/appendix-medicaid-work-requirements-study

[68] Congressional Budget Office. (2023, March 9). *The Effects of Work Requirements on the Employment and Income of TANF Participants: Working Paper 2023-03*. https://www.cbo.gov/publication/58867

[69] FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515 (2009); Encino Motorcars, LLC v. Navarro, 579 U.S. 211, 221–22 (2016); Dep't of Homeland Sec. v. Regents of the Univ. of Cal., 591 U.S. 1, 30 (2020).

were unavailable. States designed their eligibility systems in reliance on that guidance.[70] Beneficiary advocates, providers, and other community and public health organizations also relied on this information to plan their beneficiary outreach strategies.[71] Contrary to CMS's preliminary guidance, the Rule abruptly changed direction and imposes a functional-impairment test and self-attestation limits that appear nowhere in the prior guidance. Nothing in the Rule acknowledges the agency's changed position, nor does it explain why the earlier approach was abandoned or address the reliance and implementation costs its reversal imposes on the States and the larger public health community. That failure alone renders the Rule arbitrary and capricious.

II. The Work Requirement Rule Creates Unnecessary Administrative Burdens That Will Cause Millions of People Who Are Otherwise Eligible for Medicaid to Lose Necessary Coverage.

Any work requirement creates administrative and compliance burdens. However, the Rule's particularly restrictive requirements (including imposing an individualized ability to work assessment for the medical-frailty exclusion, limiting self-attestation, and restricting the lookback period to 12 months) compound those burdens far beyond what the statute requires. None of these requirements outlined in the Rule are compelled by the statutory text; in fact, they are inconsistent with the text of the statute and inconsistent with Congress' clear intent to minimize unnecessary administrative burdens. Instead, through the Rule, CMS has chosen to maximize these administrative burdens, which will lead to coverage denials far worse than even the significant losses that have previously occurred in other work requirement experiments.

The Rule's definition of medical frailty—especially the additional requirement to show that a condition "substantially impairs" one's ability to work or volunteer—imposes harsh administrative burdens on potential enrollees and current beneficiaries, which will lead to widespread loss of Medicaid coverage for people who need and are otherwise entitled to access this critical source of health care. The medical frailty determination will require an individualized assessment, making the Rule more restrictive and burdensome than any previous state-imposed work requirement.

Data, studies, and first-hand accounts show that Medicaid work reporting requirements impose burdensome administrative barriers, also known as red tape. This "red tape" leads to denials of or loss of Medicaid coverage for individuals who meet the substantive work requirement or exemption criteria, and therefore should remain enrolled or eligible to enroll. Some of these

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[70] Tolbert, J., Diana, A., Mudumala, A., Brooks, T., Yafimenka, Y., & Lin, A. (2026, April 30). *An early look at policy decisions as states get ready to implement work requirements: Results from the 2026 Medicaid eligibility, enrollment, and renewal policies annual survey.* KFF. https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/

[71] Brykman, K. (2026, April). Data and analytic approaches for medical frailty exemptions to federal Medicaid work requirements. Center for Health Care Strategies. https://www.chcs.org/media/Data-and-Analytic-Approaches-for-Medical-Frailty-Exemptions.pdf; McIntyre, A., Ne'eman, A., & Sommers, B. D. (2026). How to minimize avoidable coverage losses under Medicaid work requirements. JAMA Health Forum, 7(5), e262321. https://doi.org/10.1001/jamahealthforum.2026.2321

barriers are caused by confusing notices and procedures, challenging exemption documentation, limited administrative support for beneficiaries, complex reporting systems, and more. A 2021 report from ASPE found that "large-scale difficulties with meeting reporting requirements have posed risks of coverage loss for many beneficiaries across multiple states implementing work requirements."[72] Further, a report by the Robert Wood Johnson Foundation analyzing experience with work requirements noted that "[m]any studies find that the red tape is often prohibitive and strips people of vital benefits."[73] CMS even recognized the substantial paperwork burdens of the work requirement and estimated that beneficiaries will need to spend *two hours every six months* on paperwork and the value of lost consumer time would be more than $500 million per year.[74]

These burdens fall particularly hard on individuals with chronic illnesses, who are more likely to report experiencing these administrative burdens when applying for Medicaid. A 2025 report found that 29% of people with a chronic illness report a compliance burden with Medicaid, compared to 19% of people without a chronic illness.[75] Reports also highlight how people with disabilities are more likely to experience administrative burdens that result in coverage losses when trying to comply with work reporting requirements.[76] Procedural hurdles and administrative burdens also disproportionately impact Black and Hispanic people trying to receive and maintain coverage under public benefit programs.[77] Additionally, Black and

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[72] Office of the Assistant Secretary for Planning and Evaluation. (2021, March 10). *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence

[73] Robert Wood Johnson Foundation. (2023, May). *Work Requirements: What Are They? Do They Work?* https://stateofchildhoodobesity.org/wp-content/uploads/2023/05/rwjf473381.pdf; Hahn, H. (2018, April). *What Research Tells Us About Work Requirements*. Urban Institute. https://www.urban.org/sites/default/files/publication/98425/what_research_tells_us_about_work_requirements_21.pdf

[74] 91 Fed. Reg. at 33434 (Table 15).

[75] Roll, S., Despard, M., & Chun, Y. (2025). *The experience of administrative burdens in SNAP and Medicaid: New evidence from a nationally representative survey of low-wage workers* (CSD Research Brief No. 25-52). Washington University, Center for Social Development. https://doi.org/10.7936/htq4-vt81

[76] Machledt, D. (2024, December 16). *How Medicaid Work Requirements Hurt People with Disabilities*. National Health Law Program. https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2/; Machledt, D., & Lav, J. (2025, December 3). *Recommendations for Mitigating Harms to People with Disabilities, Older Adults, and Caregivers from Medicaid Work Requirements*. National Health Law Program. https://healthlaw.org/resource/recommendations-for-mitigating-harms-to-people-with-disabilities-older-adults-and-caregivers-from-medicaid-work-requirements/; Sachar, A., Diana, A., Burns, A., & Tolbert, J. (2026, July 29). *What could Medicaid work requirements mean for SSI applicants?* KFF. https://www.kff.org/medicaid/what-could-medicaid-work-requirements-mean-for-ssi-applicants/. Although CMS in the Rule acknowledges that the Americans with Disabilities Act, section 504 of the Rehabilitation Act and section 1557 of the Affordable Care Act provide these individuals with rights to reasonable accommodations related to work requirements, 91 Fed. Reg. 33407, the Rule does nothing more. It entirely fails to contend with what this means or provide states with any guidance about how such accommodations could be ensured in light of the rules overly restrictive requirements (e.g., prohibitions on attestations after 2028).

[77] Haeder, S. F., & Moynihan, D. (2023). Race And Racial Perceptions Shape Burden Tolerance For Medicaid And The Supplemental Nutrition Assistance Program. *Health Affairs*, *42*(10), 1334–1343. https://doi.org/10.1377/hlthaff.2023.00472; *See also* Herd, P., Hoynes, H., Michener, J., & Moynihan, D. (2023).

Indigenous people report significantly higher rates of disability, which further compounds the impacts on people of color with disabilities.[78]

In October 2025, the CBO estimated that at least 2.8 million people will lose Medicaid coverage by 2034 solely due to administrative burdens from HR 1 work requirements; this number is in addition to coverage loss estimates from other provisions in the bill.[79] The CBO report notes that most of these people who lose coverage under the community engagement requirements will remain uninsured because they are unable to get insurance elsewhere.[80] To understand the likelihood of widespread coverage loss due to administrative burdens under the Rule, one can look to examples of how these types of burdens have resulted in coverage loss in similar situations and the impact on individual and population health outcomes. Specifically, data from state-level work requirements in Arkansas and Georgia, early implementation of HR 1 in Nebraska, and post-COVID-19 Medicaid unwinding demonstrate the harms of administrative burdens facing people who will be trying to meet the work requirements under the IFC in order to enroll in or maintain Medicaid coverage.

A. The Process Outlined in the Rule Cultivates the Same—or Even More—Administrative Barriers that Contributed to Widespread Coverage Loss under Arkansas's and Georgia's Medicaid Work Requirement Programs.

From 2018 to 2019, Arkansas implemented work requirements in its Medicaid program,[81] and in 2023, Georgia began implementing its Medicaid work requirement program[82] that is still in effect. In both Arkansas and Georgia, current and potential beneficiaries reported numerous barriers to Medicaid enrollment due to complex work rules and burdensome application processes.[83]

Introduction: Administrative Burden as a Mechanism of Inequality in Policy Implementation. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, *9*(4), 1. https://doi.org/10.7758/RSF.2023.9.4.01; Michener, J. (2020). Race, Politics, and the Affordable Care Act. *Journal of Health Politics, Policy and Law*, *45*(4), 547–566. https://doi.org/10.1215/03616878-8255481

[78] Machledt, D. (2024, December 16). *How Medicaid Work Requirements Hurt People with Disabilities*. National Health Law Program. https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2/

[79] Congressional Budget Office. (2025, October 28). *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*. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[80] *Id*.

[81] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*, *39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538

[82] Rayasam, R., & Whitehead, S. (2024, September 13). *The First Year of Georgia's Medicaid Work Requirement Is Mired in Red Tape*. KFF Health News. https://kffhealthnews.org/health-care-costs/georgia-medicaid-work-requirement-red-tape/

[83] Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care*. Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care; Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and

1. Current Enrollees Who Are Eligible to Receive and Are Currently Receiving Medicaid Will Wrongly Lose Coverage and Access to Healthcare Due to Administrative Barriers Under the IFC.

When Medicaid work requirements were in effect in Arkansas, enrollees who were working or should have been exempt lost coverage due to administrative errors and confusion. The processes outlined in the IFC run the same risk of causing individuals who meet Medicaid's eligibility requirements to wrongly lose coverage. Over 18,000 people lost Medicaid coverage in Arkansas during the seven months that its work requirement was in effect.[84] This amounts to one in four individuals who were subject to Arkansas's work requirement losing their health insurance coverage.[85] Of the individuals who lost coverage in 2018, only 11% reapplied for and regained coverage the following year,[86] with many likely remaining uninsured.

Arkansas relied heavily on data-matching to attempt to determine whether enrollees met the work requirements or qualified for an exemption.[87] Arkansas's data matching program was supposed to exempt workers, caregivers, students, or disabled individuals, but failed to identify many of these individuals for exemptions.[88] According to CMS, Arkansas was only able to automatically identify work hours or exemption status for 69% of enrollees, leaving over 30% of enrollees with the burden of having to manually report their activities.[89] Of the nearly 18,000 people who lost coverage over seven months the work requirements were in place, an estimated 95% had met the work requirement or were exempt and therefore should have remained enrolled.[90] A May 2026 study found that when beneficiaries are required to manually report their

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Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

[84] Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[85] Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be; *see also* Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[86] Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[87] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

[88] Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

[89] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

[90] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*, *39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538

work status, they are much more likely to be deemed noncompliant.[91] Researchers estimated that if all individuals in Arkansas' program were required to manually report, "noncompliance" would rise to 98%.[92]

Importantly, Arkansas spent months building its data-matching system and still failed to reach almost a third of enrollees.[93] The Rule gives states even less time to build out an even more complex data matching infrastructure. Due to the accelerated implementation of the Rule, many states will not be able to have reliable systems in place for accurate data matching to identify exempted individuals. As a result, with this Rule, states are likely to experience even lower rates of automated data matching, with an even larger share of beneficiaries having to go through the manual reporting process that is shown by various reports to be strongly correlated with an improper finding of "noncompliance" resulting in coverage loss.

Confusion about the work requirement in Arkansas was common, with 44% of the target population reporting that they were unsure whether the requirements applied to them.[94] Awareness of the work requirement among enrollees was also poor, even after the work requirement ended, as more than 70% of Arkansans were unsure whether the policy was in effect at that time.[95]

Similar confusion is currently happening in Nebraska, the first state to roll out the new Medicaid work requirements imposed by HR 1. One month into the May 1st rollout of the program, the media has reported that "state Medicaid staffers are having trouble telling enrollees whether they need to comply with work requirements, as the information is not readily available even to people within the government."[96] Similarly, reports are that some enrollees are also receiving inaccurate or conflicting information about their eligibility and experiencing long call center wait times.[97]

In implementing the statute, the CMS IFC requires redeterminations at least every six months, with an allowance for annual redeterminations of exemptions in some circumstances.[98] These frequent redeterminations for Medicaid coverage are risky and often lead to unnecessary coverage loss, as demonstrated in experiences from post-COVID Medicaid unwinding. In

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[91] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089
[92] *Id*.
[93] *Id*.
[94] Sommers B. D., Goldman A. L., Blendon R. J., Orav E. J., & Epstein, A. M. (2019). Medicaid Work Requirements—Results from the First Year in Arkansas. *New England Journal of Medicine*, *381*(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772
[95] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*, *39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538
[96] Johnson, P. (2026, June 1). *Nebraska's Work Requirement Rollout Is a Mess. It's Going to Get Worse*. Health Payer Specialist. https://www.healthpayerspecialist.com/lead/enroll/5170944/734734
[97] *Id*.
[98] 91 Fed. Reg. at 33398.

response to the 2020 COVID-19 outbreak, the Families First Coronavirus Response Act included a provision requiring state Medicaid programs to maintain enrollment in exchange for additional federal funding.[99] In 2023, states went through a process called "Medicaid unwinding," where they were required to redetermine eligibility for all beneficiaries and disenroll those who were no longer eligible or did not complete the renewal process.[100] KFF reports that among people who were disenrolled during Medicaid unwinding, "nearly seven in ten (69%) were disenrolled for paperwork or procedural reasons while three in ten (31%) were determined ineligible."[101] An astonishing 74% of people in Georgia who lost Medicaid during the post-COVID unwinding were disenrolled for procedural reasons and not because they were actually determined to be ineligible.[102] Their inappropriate disenrollment due to administrative barriers has long term consequences. According to a KFF national survey, about a quarter (23%) of people who lost Medicaid during unwinding remain uninsured.[103] In summary, not only do administrative barriers in Medicaid increase the likelihood that eligible beneficiaries lose coverage, they also increase the likelihood that these people will remain uninsured without coverage altogether.

B. Eligible People Applying for Medicaid Will Struggle to Enroll in Coverage Due to Administrative Barriers, Making it Harder to Gain Entry to the Program.

Similar to HR 1, under Georgia's work requirement, applicants must demonstrate compliance before they can enroll in and receive coverage. Unlike Arkansas, Georgia does not use data matching to prove an individual meets the work requirement or qualifies for an exemption and "instead relie[s] entirely on manual reporting."[104] A similar heavy reliance on manual reporting will be required by the IFC's medical frailty definition and the individualized assessment it requires to determine whether a person's condition significantly impairs their ability to work or volunteer. This two-part determination will be extremely hard, if not impossible, to determine from *ex parte* data or medical diagnostic codes alone.

This reliance on manual reporting is important because the medical frailty assessment imposed by the IFR is a harder factual question than the work hour reporting that already proved so burdensome for states to verify. Verifying that someone worked 80 hours in a given month or has a certain medical diagnosis is at least theoretically possible to provide documentation of, whether through providing a pay stub or medical records. By contrast, determining whether a medical condition "significantly impairs" a person's ability to work or volunteer is not the kind of

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[99] Moss, K., Dawson, L., Long, M., Kates, J., Musumeci, M., Cubanski, J., & Pollitz, K. (2020, March 23). *The Families First Coronavirus Response Act: Summary of Key Provisions*. KFF. https://www.kff.org/covid-19/the-families-first-coronavirus-response-act-summary-of-key-provisions/

[100] Lopes, L., Sparks, G., Presiado, M., Tolbert, J., Rudowitz, R., Diana, A., & Kirzinger, A. (2024, April 12). *KFF Survey of Medicaid Unwinding*. KFF. https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/

[101] KFF. (2026, July 1). *Medicaid/CHIP Monthly Enrollment Tracker*. https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8

[102] *Id*.

[103] *Id*.

[104] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

information that easily exists in a database or appears on the face of a diagnosis code. Under the Rule, states will have to push medical frailty determinations into a manual reporting and documentation process similar to (but even harsher than) Georgia's process, which has resulted in low enrollment rates and widespread barriers to coverage.

Georgia's enrollment numbers have consistently been extremely low since its work requirement began. Roughly 20 months into the program, only 7,000 individuals were successfully enrolled, out of the 240,000 uninsured people estimated to be eligible.[105] An interim evaluation of the demonstration found that the "magnitude of difference [between the state's projected enrollment vs. actual enrollment] suggests that many individuals who would be eligible for Pathways are not applying to the program."[106] Application data suggests that in some months, upwards of 40% of people who started applications for Georgia's program gave up.[107] As of April 2026, only roughly 16,700 Georgia residents were enrolled in Georgia's Medicaid demonstration titled "Georgia Pathways to Coverage."[108] After two years of the demonstration project, nearly half of Georgia's counties have 25 or fewer residents ever enrolled in the program, with two counties having zero enrollees.[109] This is likely a major contributor to Georgia's status as the state with the second-highest uninsurance rate.[110]

Focus groups also suggest that many individuals do not feel comfortable applying because they are concerned their application would not be approved, likely due to the complex process and high denial rates in the first year of the program.[111] Georgia Budget and Policy Institute reports

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[105] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker; Thomas, G. (2024, September 5). *Georgia Pathways to Coverage*. Georgia Department of Community Health. https://dch.georgia.gov/document/document/comprehensive-health-coverage-meeting-slide-deckdch-presentation-002/download; Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[106] Public Consulting Group. (2024, December 16) *Pathways Demonstration program interim evaluation report* at A28. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-pa-04282025.pdf (attached as Appendix A to Ga. Dept. of Community Health. Georgia Section 1115 demonstration waiver extension request (April 28, 2025))

[107] Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[108] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker

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

[110] Fortuna Health. (2026, March 30). *What Medicaid Leaders Think About H.R. 1: Themes Across Three AHIP Panels*. https://www.fortunahealth.com/resources/what-medicaid-leaders-think-about-h-r-1-themes-across-three-ahip-panels

[111] *Id.;* Chan, L. (2024, October). *Georgia's Pathways to Coverage Program: The First Year in Review*. Georgia Budget & Policy Institute. https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf

that 22% of application denials and 30% of disenrollments from Georgia's program were due to procedural barriers, such as missing forms.[112]

Nebraska is already seeing similar instances of declines in enrollment; a health center in the state that usually enrolls around 15 people a month enrolled none in May 2026 after Nebraska implemented the work requirement early.[113] That health center's CEO said this drop in enrollment is unheard of for the organization and believes people are not coming in because they think they are not eligible or believe that "it's going to be too overwhelming or cumbersome to try to keep coverage."[114]

III. The Rule Will Cause Significant Harm to Millions of People Who Should be Eligible For Medicaid Under Title XIX But Will Lose Coverage Due to the Additional Barriers Required by the Rule

A. The Rule Will Harm People With Serious, Complex, and/or Chronic Medical Conditions Who Have Gotten Care That Helps Treat and Manage These Conditions Through the Medicaid Expansion.

Nearly half (44%) of Medicaid expansion enrollees have at least one *chronic condition*, defined as conditions that last at least one year and require ongoing medical care or limit daily activities (e.g, heart disease, diabetes, cancer, mental illness, etc.).[115] [116] Medicaid expansion adults experience high rates of both chronic physical and behavioral health conditions: 33% of expansion adults have a chronic physical condition, and nearly a quarter have a behavioral health condition.[117] The number of expansion adults with at least one chronic condition only increases with age: nearly 60% of expansion adults ages 50-64 have a chronic condition.[118]

Medicaid was specifically designed to allow people to enroll at the point of illness, ensuring immediate access to care when health needs are most urgent. H.R. 1 maintained a critical pathway for individuals with serious, complex, or chronic conditions to rapidly access care—consistent with extensive evidence that timely Medicaid access improves coverage, care utilization, and health outcomes for people requiring specialty services. Indeed, numerous studies

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[112] Fortuna Health. (2026, March 30). *What Medicaid Leaders Think About H.R. 1: Themes Across Three AHIP Panels*. https://www.fortunahealth.com/resources/what-medicaid-leaders-think-about-h-r-1-themes-across-three-ahip-panels; Chan, L. (2025, October 13). *Pathways to Coverage: Looking Back Two Years and Into the Future*. Georgia Budget & Policy Institute. https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/

[113] Grabenstein, H. (2026, June 5). *As states face stricter Medicaid work requirements, Nebraska is an early test*. PBS News. https://www.pbs.org/newshour/nation/as-states-face-stricter-medicaid-work-requirements-nebraska-is-an-early-test

[114] *Id.*

[115] Mathers, J., Tolbert, J., Chidambaram, P., & Cervantes, S. (2025, April 25). *5 key facts about Medicaid expansion*. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/

[116] Centers for Disease Control and Prevention. (2026, May 14). *About Chronic Diseases*. https://www.cdc.gov/chronic-disease/about/index.html

[117] Mathers, J., Tolbert, J., Chidambaram, P., & Cervantes, S. (2025, April 25). 5 key facts about Medicaid expansion. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/

[118] *Id*.

have demonstrated that Medicaid expansion *has significantly increased access to specialty care among those with chronic conditions*, including but not limited to: cancer care, heart health care, diabetes care, mental health and substance use disorder (SUD) care, and specialty care for those with disabilities. As discussed above in section I, members of Congress explicitly stated at the time of passage that people with chronic health conditions, like cancer, mental health conditions, and substance use disorders, would unequivocally be excluded from the community engagement requirements.

In contradiction to the language in section 1902(xx) of the Act and Congress' intent, the Rule effectively shuts down access to care for people who need it most. It is also inconsistent with the structure of Medicaid, which allows people to enroll at the moment of illness to ensure access to care at the moment of greatest need. Closing the door on Medicaid coverage for people with serious or complex health conditions is irrational, especially given the overwhelming evidence of expansion's positive impact on coverage, access, and health for this population. Appendix A describes the vast evidence base demonstrating large improvements in access to needed care for people with chronic health conditions like cancer and mental health disorders and people with disabilities following Medicaid expansion, as compared to similarly situated adults in non-expansion states, and the resulting improvements in their health and reduced healthcare costs.

B. The Rule Jeopardizes the Health Care Coverage and Access of Millions of People Who Gained Coverage Under Medicaid Expansions, Particularly Those With Chronic Health Conditions Who Will Experience Increased Health Problems and Unnecessary Deaths.

Since the passage of the ACA, the number of uninsured low-income adults in expansion states has dramatically fallen, from 35% to 15%.[119] In contrast, non-expansion states' uninsured rates remain *double* that of expansion states (30% vs 15%).[120] Decreases in uninsurance in expansion states are largely driven by new Medicaid coverage of low-income adults who previously had not been eligible for coverage.[121] [122]

Medicaid expansion has been profound in its ability to improve health coverage for low-income workers in expansion states—including those with chronic conditions—and thereby protect individuals' health so that they can remain in the workforce or seek employment. From 2013-2022, rates of uninsured low-income workers decreased from 38% to 17% in expansion states.[123]

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[119] Harker, L., & Sharer, B. (2024). *Medicaid expansion: Frequently asked questions.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0
[120] *Id*.
[121] Olfson, M., et al. (2019). *A national survey of trends in health insurance coverage of low-income adults following Medicaid expansion*. Journal of General Internal Medicine. Advance online publication. https://doi.org/10.1007/s11606-019-05409-5
[122] Miller, S., & Wherry, L. R. (2019). Four years later: Insurance coverage and access to care continue to diverge between ACA Medicaid expansion and non-expansion states. *American Economic Association Papers and Proceedings, 109*, 327–333. https://doi.org/10.1257/pandp.20191046
[123] Harker, L., & Sharer, B. (2024). *Medicaid expansion: Frequently asked questions.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0

(In comparison, the uninsured rate among low-income workers in non-expansion states remains at 31%.[124])

The Rule's harsh interpretation of H.R. 1's community engagement requirements will dramatically reverse this trend. Based on the statutory language of H.R. 1, the Congressional Budget Office (CBO) estimated that by 2034, approximately 5.2 million working-age adults will lose Medicaid expansion coverage as a result of H.R. 1's community engagement requirements,[125] with the majority being individuals who should remain eligible because they work but lose access because of administrative barriers. Estimates from other entities such as the Urban Institute place the coverage loss estimates under H.R. 1's statutory language even higher. Urban projected that as many as 7 million people could lose coverage without strong state mitigation measures—the majority of whom should be eligible because they are working or should be exempt.[126] Both CBO and Urban estimates were generated prior to the release of the June 2026 IFR, which substantially narrows statutory exclusion of "medically frail individuals," limits the ability of states to make *ex parte* determination, and limits the ability of individuals to self-attest. Taking into account the more restrictive exclusions in the IFR, estimated Medicaid coverage losses are likely to be even higher than those originally calculated by the CBO and Urban. Indeed, taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[127]

The CBO projects that among the 5.2 million adults who will lose coverage, the vast majority (4.8 million) will become uninsured.[128] [129] This is consistent with research that has found that those who lose Medicaid coverage have no other health coverage options, including among those who are employed. A study evaluating the impact of Arkansas's previous work requirement found that as Medicaid coverage was lost and uninsurance increased significantly, rates of

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[124] *Id*.
[125] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461
[126] Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work
[127] Boozang, P. M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid work requirements rule: A 50-state analysis of additional coverage losses, FFY 2027–2034*. Manatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034
[128] Congressional Budget Office. (2025, June 24). *Estimated effects of Medicaid policies in H.R. 1, the One Big Beautiful Bill Act, on health insurance coverage: Letter for Representatives Arrington and Guthrie* [PDF]. https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf
[129] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461

employer coverage did not substantially change.[130] According to the authors, "Arkansas's experience suggests nearly all adults losing Medicaid would become uninsured."[131]

Low-income working individuals often depend on Medicaid coverage because of the characteristics of their employers. In 2023, 46% of working adults with Medicaid were employed by firms with fewer than 25 employees.[132] These employers "are not subject to ACA penalties for not offering affordable health coverage and are less likely to offer health insurance to their workers than larger firms."[133] For example, in 2022, just over half of employers with fewer than 50 employees offered health insurance to their workers, compared to 99% of employers with 100 or more employees.[134] Additionally, nearly half of working adults with Medicaid are employed in the agriculture and service industries (including construction, leisure and hospitality services, wholesale and retail trade), which have historically low employer-sponsored insurance offer rates.[135] Despite being employed, these workers are likely to rely on Medicaid because their employer does not offer health insurance at all or does not offer insurance that is affordable.

Losing health coverage deeply compromises a person's ability to afford care for chronic conditions. Individuals with chronic conditions are already more likely to have inadequate financial resources, medical debt, a low credit score, and recent bankruptcy—with financial difficulty increasing as the number of chronic conditions increases.[136] [137]

As those with chronic conditions become uninsured, the ongoing cost of managing chronic diseases will become financially catastrophic, and will force many to forgo needed care and treatment. Indeed, studies consistently demonstrate that uninsured individuals forgo necessary healthcare due to cost: three-quarters of uninsured adults have reported skipping or postponing necessary healthcare due to cost, uninsured adults are nearly three times more likely than insured adults to skip or delay prescription medications due to cost, and less than half of uninsured

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[130] Gangopadhyaya, A., & Karpman, M. (2025, April 9). The impact of Arkansas Medicaid work requirements on coverage and employment: Estimating effects using national survey data. *Health Services Research*, e14624. https://doi.org/10.1111/1475-6773.14624

[131] Karpman, M., & Gangopadhyaya, A. (2025, April 23). New evidence confirms Arkansas's Medicaid work requirement did not boost employment. *Urban Institute*. https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment

[132] Tolbert, J., Cervantes, S., Rudowitz, R., & Burns, A. (2025, February 4). Understanding the intersection of Medicaid and work: An update. *KFF*. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/

[133] *Id*.

[134] *Id*.

[135] *Id*.

[136] Davis, V. H., Zhang, G., & Patel, M. R. (2025). Chronic disease and future perceptions of financial control: Results from the Midlife in the United States cohort study. *Medical Care, 63*(5), 353–357. https://doi.org/10.1097/MLR.0000000000002126

[137] Becker, N. V., Scott, J. W., Moniz, M. H., Carlton, E. F., & Ayanian, J. Z. (2022). Association of Chronic Disease With Patient Financial Outcomes Among Commercially Insured Adults. *JAMA internal medicine*, *182*(10), 1044–1051. https://doi.org/10.1001/jamainternmed.2022.3687

individuals had a doctor's visit in the past year.[138] [139] [140] One analysis estimates that upwards of 20 million medical visits and 40 million prescription refills could be disrupted annually, as a result of millions of individuals losing coverage under new work requirements.[141]

As people are forced to skip medically necessary care, several consequences will emerge: not only will individuals experience worsening health conditions and lose their ability to work, but losing access to chronic care treatment can be deadly. Researchers estimate that Medicaid work requirements under H.R. 1 could cause 7,000 to 9,200 preventable deaths per year, as well as hundreds of thousands of cases of uncontrolled diabetes or cardiovascular disease.[142]

C. The Rule Will Cause Millions of People to Lose Access to Treatment That Will Severely Limit Their Ability to Work in Contradiction to H.R. 1 and the Rule's Stated Goal of Increasing Employment for Medicaid Beneficiaries.

Ongoing and uninterrupted healthcare services are necessary to maintain work and seek employment, especially among those with chronic health conditions.[143] Many chronic conditions require routine access to care—including prescription medications, ongoing disease management, and acute care when issues arise. [144] As Medicaid enrollees with chronic conditions lose insurance, they will be forced to choose between catastrophic out-of-pocket costs or delaying/forgoing care. As noted above, the research is well-established that adults who become uninsured are significantly more likely to forgo care, including both preventive and chronic care services. [145]

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[138] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[139] Sparks, G., Lopes, L., Montero, A., Presiado, M., & Hamel, L. (2026, April 30). *Americans' challenges with health care costs*. KFF. https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/

[140] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[141] Ku, L. (2026, June 29). *The administration's flawed and misleading claims about Medicaid work requirements*. Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/commentary-administrations-flawed-and-misleading-claims-about-medicaid-work-requirements

[142] Pandey, A., Ye, Y., Bawden, C., Singer, B. H., & Galvani, A. P. (2025). Quantifying the mortality and morbidity impact of Medicaid work requirements: A modeling study. *The Lancet Regional Health - Americas, 51*, 101232. https://doi.org/10.1016/j.lana.2025.101232

[143] Wen, H., Saloner, B., & Cummings, J. R. (2019, April 1). Behavioral and other chronic conditions among adult Medicaid enrollees: Implications for work requirements. *Health Affairs, 38*(4), 660-667. https://doi.org/10.1377/hlthaff.2018.05059

[144] Musumeci, M., & Zur, J. (2017, August 18). *Medicaid enrollees and work requirements: Lessons from the TANF experience*. KFF. https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/

[145] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key facts about the uninsured population*. KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

Delayed and inadequate healthcare can exacerbate chronic conditions, increase risks of complications, and limit persons' ability to live independently and work. [146] [147] This is especially true for Medicaid enrollees, as "[m]any of the jobs held by people with low incomes involve walking, standing, lifting and carrying objects, repetitive motions, and other physical labor."[148] Indeed, uninsured individuals are more likely to be hospitalized and experience declines in their overall health.[149] Among individuals with chronic conditions, worsening health can significantly erode their capacity to work, leading to lost wages and reduced labor force participation.

Indeed, multiple studies show that expansion supports the ability of enrollees, including those with chronic conditions, to work, seek work, or volunteer . Studies have found that large percentages of expansion beneficiaries report that Medicaid enrollment made it easier to seek employment (among those who were unemployed but looking for work) or continue working (among those who were employed).[150] [151] In Michigan, one study found that nearly 70% of enrollees who were working said they performed better at work once they got expansion coverage. [152] Another study found that nearly half of primary care physicians who were surveyed reported that Medicaid expansion had a positive impact on their patients' ability to work.[153]

National research has found that Medicaid expansion is associated with significant increases in the number of individuals with disabilities reporting employment after expansion, and decreases in the number reporting not working due to a disability.[154] [155] The data showed that from 2013-2017, the percentage of individuals with disabilities in expansion states who reported being employed or self-employed rose from 41% to 47%, and in the same timeframe, the percentage of

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[146] Glied, S., & Ding, D. (2025, June 5). *Any way you look at it you lose: Medicaid work requirements will either fall short of anticipating savings or harm vulnerable beneficiaries*. Brookings Institution. https://www.brookings.edu/articles/any-way-you-look-at-it-you-lose-medicaid-work-requirements-will-either-fall-short-of-anticipating-savings-or-harm-vulnerable-beneficiaries/

[147] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[148] Musumeci, M., & Zur, J. (2017, August 18). *Medicaid enrollees and work requirements: Lessons from the TANF experience*. KFF. https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/

[149] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key facts about the uninsured population*. KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[150] Ohio Department of Medicaid. (2018). *The Ohio Medicaid Group VIII assessment* [PDF]. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[151] Tipirneni, R., et al. (2019). Changes in health and ability to work among Medicaid expansion enrollees: A mixed methods study. *Journal of General Internal Medicine, 34*(2), 272–280. https://link.springer.com/article/10.1007/s11606-018-4736-8

[152] *Id*.

[153] Goold, S. D., et al. (2018). Primary care clinicians' views about the impact of Medicaid expansion in Michigan: A mixed methods study. *Journal of General Internal Medicine, 33*(8), 1307–1316. https://link.springer.com/article/10.1007/s11606-018-4487-6

[154] Hall, J. P., Shartzer, A., Kurth, N. K., & Thomas, K. C. (2018). Medicaid expansion as an employment incentive program for people with disabilities. *American Journal of Public Health, 108*(9), 1235–1237. https://doi.org/10.2105/AJPH.2018.304536

[155] *Id*.

the same population that reported not working because of disability dropped from 32% to 27%.[156] These post-expansion changes were likely due, in large part, to increased access to *supported employment services* funded by Medicaid. However, the IFC explicitly states that "these Medicaid-covered employment services are different from work programs as defined at § 435.552(b) and do not independently satisfy the work program community engagement requirement." [157]

Last, several studies have shown that Medicaid expansion is *not* associated with reduced labor force participation nor reduced efforts to search for employment. [158] [159]

D. CMS's Rule Will Lead to the Loss of Numerous Additional Gains From Expansion, Including Improved Coverage and Health Outcomes Among Other Special Populations like Rural Populations and Communities of Color.

As discussed earlier in this comment, Medicaid expansion has substantially improved coverage, health care utilization, and health outcomes among those with chronic conditions. However, these outcomes have also been realized for the larger Medicaid expansion population, including other special populations that have experienced chronic disparities in health outcomes, such as rural populations and communities of color. The Kaiser Family Foundation (KFF) and the George Washington University have collectively identified over 700 studies from 2014-2026 that demonstrate the enormous positive impacts that Medicaid expansion has had on healthcare access, utilization, health outcomes, and financial well-being among low-income persons. The IFC will lead to the loss of many of these life-saving gains. [160] Examples of the significant gains for two additional special populations—rural populations and communities of color—are summarized below.

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[156] *Id*.
[157] 91 Fed. Reg. at 33356.
[158] Buchmueller, T. C., Levy, H., & Valletta, R. G. (2021). Medicaid expansion and the unemployed. *Journal of Labor Economics, 39*(S1), S575–S617. https://doi.org/10.1086/712478
[159] Lavender, M., & Johnston, E. (2024). Labor force effects of Medicaid and Marketplace expansions: Variation by gender, parental status, and household structure. *Southern Economic Journal, 90*(4), 949–1001. https://doi.org/10.1002/soej.12678
[160] Murphy, C., Laferriere, E., Krips, M., & Rosenbaum, S. (2026, May). *How the Affordable Care Act's Medicaid expansion improved coverage, health care access, and health: An update*. Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/sites/g/files/zaxdzs4421/files/2026-05/Medicaid%20Expansion%20Policy%20Brief_GG%20-%205.27.pdf

First, rural areas have seen profound health coverage gains because of Medicaid expansion.[161] [162] [163] [164] Prior to expansion, rural areas in both expansion and non-expansion states had similar coverage rates, but by 2015, rural adults in expansion states had *double* the coverage rate of rural adults in non-expansion states.[165] Indeed, Medicaid expansion is a large contributor to rural insurance coverage overall: over 20% of adults are now covered by Medicaid in expansion states.[166]

Expansion coverage has also been associated with increased usage of life-saving care in rural areas: rural community health centers in expansion states report significantly increased volume for eighteen of twenty-one types of visits—particularly those for mammograms, abnormal breast findings, alcohol-related disorder, and other substance abuse disorders.[167] The significant loss of Medicaid coverage due to the Rule will reverse these gains.

Second, communities of color have also experienced substantial gains in health coverage, access to care, and health outcomes because of Medicaid expansion. Among persons of color, expansion

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[161] Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., Zapata, D., & Fazlul, I. (2018). The three-year impact of the Affordable Care Act on disparities in insurance coverage. *Health Services Research*. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13077

[162] Soni, A., Hendryx, M., & Simon, K. (2017). Medicaid expansion under the Affordable Care Act and insurance coverage in rural and urban areas. *The Journal of Rural Health*. http://onlinelibrary.wiley.com/doi/10.1111/jrh.12234/full

[163] Agarwal, A., Katz, A., & Chen, R. (2019). The impact of the Affordable Care Act on disparities in private and Medicaid insurance coverage among patients under 65 with newly diagnosed cancer. *International Journal of Radiation Oncology, Biology, Physics*. https://www.redjournal.org/article/S0360-3016(19)30783-7/pdf

[164] Han, X., Yabroff, K. R., Ward, E., Brawley, O. W., & Jemal, A. (2018). Comparison of insurance status and diagnosis stage among patients with newly diagnosed cancer before vs after implementation of the Patient Protection and Affordable Care Act. *JAMA Oncology, 4*(12), 1713–1720. https://jamanetwork.com/journals/jamaoncology/article-abstract/2697226

[165] Foutz, J., Artiga, S., & Garfield, R. (2017, April 25). *The role of Medicaid in rural America*. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

[166] Osorio, A., Alker, J., & Park, E. (2023, August 17). Medicaid's coverage role in small towns and rural areas. *Georgetown Center for Children and Families*. https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/

[167] Cole, M. B., Wright, B., Wilson, I. B., Galárraga, O., & Trivedi, A. N. (2018). Medicaid expansion and community health centers: Care quality and service use increased for rural patients. *Health Affairs, 37*(6), 900–907. https://doi.org/10.1377/hlthaff.2017.1542

is associated with reduced disparity in uninsurance rates, improvements in having a usual source of care, and fewer persons of color forgoing care due to cost. [168] [169] [170] [171]

These coverage and access gains have translated into life-saving health outcomes: among persons of color, expansion is associated significant reductions in hospitalizations, improved timely cancer treatment, greater access to life-saving surgeries and inpatient trauma rehabilitation, and lessening racial disparities in infant mortality and preterm birth.[172] [173] [174] [175]

[168] Baumgartner, J. C., Collins, S. R., Radley, D. C., & Hayes, S. L. (2020, January 16). *How the Affordable Care Act has narrowed racial and ethnic disparities in access to health care*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access

[169] Hayes, S., Riley, P., Radley, D., & McCarthy, D. (2017, August 24). *Reducing racial and ethnic disparities in access to care: Has the Affordable Care Act made a difference?* The Commonwealth Fund. http://www.commonwealthfund.org/publications/issuebriefs/2017/aug/racial-ethnic-disparities-care

[170] Lee, H., Hodgkin, D., Johnson, M. P., & Porell, F. W. (2021). Medicaid expansion and racial and ethnic disparities in access to health care: Applying the National Academy of Medicine definition of health care disparities. *Inquiry: A Journal of Medical Care Organization, Provision and Financing, 58*, 0046958021991293. https://doi.org/10.1177/0046958021991293

[171] Lipton, B. J., Decker, S. L., & Sommers, B. D. (2019, April 27). The Affordable Care Act appears to have narrowed racial and ethnic disparities in insurance coverage and access to care among young adults. *Medical Care Research and Review, 76*(1), 32–55. https://doi.org/10.1177/1077558717706575

[172] Metzger, G. A., Asti, L., Quinn, J. P., Chisolm, D. J., Xiang, H., Deans, K. J., & Cooper, J. N. (2021, December). Association of the Affordable Care Act Medicaid expansion with trauma outcomes and access to rehabilitation among young adults: Findings overall, by race and ethnicity, and community income level. *Journal of the American College of Surgeons, 233*(6), 776–793.e16. https://doi.org/10.1016/j.jamcollsurg.2021.08.694

[173] Adamson, B. J. S., Cohen, A. B., Gross, C. P., Estévez, M., Magee, K., Williams, E., Meropol, N. J., & Davidoff, A. J. (2021, July 19). ACA Medicaid expansion association with racial disparity reductions in timely cancer treatment. *The American Journal of Managed Care, 27*(7), 274–281. https://doi.org/10.37765/ajmc.2021.88700

[174] Eguia, E., et al. (2018, October). Impact of the Affordable Care Act (ACA) Medicaid expansion on cancer admissions and surgeries. *Annals of Surgery, 268*(4), 584–590. https://journals.lww.com/annalsofsurgery/Abstract/2018/10000/Impact_of_the_Affordable_Care_Act__ACA__Medicaid.6.aspx

[175] Bhatt, C., & Beck-Sague, C. (2018, March 7). Medicaid expansion and infant mortality in the United States. *American Journal of Public Health, 108*(4), 565–567. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218

[176] [177] [178] [179] [180] Similarly, the Rule will cause significant harm to these communities of color as they lose access to Medicaid coverage.

E. The Rule Drastically Underestimates Its Negative Economic Impacts; The Rule Will Cause Uncompensated Care to Dramatically Increase Among Hospitals and Community Health Centers (CHCs), Forcing Many to Close and Lay Off Employees.

The Rule's Regulatory Impact Analysis (RIA) does not analyze the Rule's impact on hospitals, community health centers, or other providers at all; it states that its cost-benefit analysis "examines the anticipated benefits for three principal parties implicated by the new requirement: Medicaid applicants and beneficiaries subject to the community engagement requirement, States, and the Federal government."[181] The RIA's only acknowledgment that coverage losses will affect providers appears in a single footnote to its accounting statement, which references transfers to "State or local jurisdictions that reimburse providers for otherwise-uncompensated care"—without any attempt to quantify the scale of that uncompensated care or its effect on provider operations.

Medicaid expansion has played an essential role in protecting hospitals' and community health centers' financial health by reducing uncompensated care (UCC) and improving operating margins. These improvements have been especially profound among safety net hospitals, community health centers, and rural facilities.[182]

Following expansion, hospitals in expansion states report less than half the UCC that non-expansion states experience (2.7% vs 7.3%), with safety-net hospitals experiencing the greatest reductions in UCC (e.g., a $9.5 million UCC reduction at safety net hospitals, versus a $5.8

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[176] Brown, C. C., et al. (2019, April). *Association of state Medicaid expansion status with low birth weight and preterm birth*. *JAMA, 321*(16), 1598–1609. https://jamanetwork.com/journals/jama/fullarticle/2731179

[177] Breathett, K., Allen, L. A., Helmkamp, L., Colborn, K., Daugherty, S. L., Khazanie, P., Lindrooth, R., & Peterson, P. N. (2017). The Affordable Care Act Medicaid Expansion Correlated With Increased Heart Transplant Listings in African-Americans But Not Hispanics or Caucasians. *JACC. Heart failure*, *5*(2), 136–147. https://doi.org/10.1016/j.jchf.2016.10.013

[178] Hanchate, A. D., Abdelfattah, L., Lin, M.-Y., Lasser, K. E., & Paasche-Orlow, M. K. (2023). Affordable Care Act Medicaid expansion was associated with reductions in the proportion of hospitalizations that are potentially preventable among Hispanic and White adults. *Medical Care, 61*(10), 627–635. https://doi.org/10.1097/MLR.0000000000001902

[179] Eguia, E., et al. (2018). Impact of the Affordable Care Act (ACA) Medicaid expansion on cancer admissions and surgeries. *Annals of Surgery, 268*(4), 584–590. https://journals.lww.com/annalsofsurgery/Abstract/2018/10000/Impact_of_the_Affordable_Care_Act__ACA__Medicaid.6.aspx

[180] Mahal, A. R., et al. (2020). Early impact of the Affordable Care Act and Medicaid expansion on racial and socioeconomic disparities in cancer care. *American Journal of Clinical Oncology*. https://doi.org/10.1097/coc.0000000000000588

[181] 91 Fed. Reg. at 33450.

[182] Ku, L., Krips, M., Kwon, K. N., & Jacobs, F. (2025). *Widening holes in the safety net: Community health centers at risk*: Geiger Gibson Policy Issue Brief No. 73). Milken Institute School of Public Health, The George Washington University. https://geigergibson.publichealth.gwu.edu/73-widening-holes-safety-net-community-health-centers-risk

million UCC reduction among non-safety net hospitals). [183] [184] Community health centers—which serve the most underserved and low-income populations and routinely run on razor-thin margins—rely on Medicaid expansion to keeping their centers staffed and margins out of the red. One study estimated that Medicaid expansion increases community health center staffing capacity by 25%, and health center capacity to schedule patient visits by 24%.[185] Expansion is also associated with centers' capacity to open additional sites in chronically underserved areas (27% increase in CHC sites), with a larger effect in rural counties.[186] Similarly, rural hospitals in expansion states have experienced significantly improved operating margins since Medicaid expansion, as compared to their counterparts in non-expansion states.[187]

As millions of patients become uninsured, the Rule will directly harm hospitals' and safety-net providers' financial standing. H.R. 1's community engagement requirements are estimated to decrease expansion state hospitals' operating margins by 12-13%, and safety-net and rural hospitals will bear the brunt of the impact, with operating margins anticipated to fall by 26-30%.[188] Community health centers are especially at risk—with upwards of 72% of Medicaid patients at the centers at risk of losing Medicaid coverage (despite most of these individuals working or qualifying for an exemption). [189] These coverage losses could translate into community health centers experiencing $16-32 billion in reimbursement losses over the next five years—a devastating financial loss that many centers in expansion states may not recover from.[190] The Rule—with its harsh, extra-statutory limitations on medical frailty exemptions and increased administrative burdens—means that these are likely underestimates of the financial impacts on safety net providers.

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[183] Blavin, F., & Ramos, C. (2021). Medicaid expansion: Effects on hospital finances and implications for hospitals facing COVID-19 challenges. *Health Affairs, 40*(1), 82–90. https://doi.org/10.1377/hlthaff.2020.00502
[184] Medicaid and CHIP Payment and Access Commission (MACPAC). (2023). *Annual analysis of Medicaid disproportionate share hospital allotments to states* (Chapter 4). https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf
[185] Jiao, S., Konetzka, R. T., Pollack, H. A., & Huang, E. S. (2022). Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. *The Milbank Quarterly*, *100*(2), 504–524. https://doi.org/10.1111/1468-0009.12560
[186] Paintsil, E. & Linde, S. (2026). State-Level Medicaid Expansion and Hospital, Federally Qualified Health Center, and Rural Health Clinic Availability. *The Journal of Rural Health, 42(2)*. E70159. https://doi.org/10.1111/jrh.70159
[187] Levinson, Z., Godwin, J., & Hulver, S. (2023, February 23). *Rural hospitals face renewed financial challenges, especially in states that have not expanded Medicaid*. KFF. https://www.kff.org/health-costs/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/
[188] Haught, R., Coleman, A., Dobson, A., Richards, C., & McGuire, C. (2025, September 18). *The impact of proposed federal Medicaid work requirements on hospital revenues and financial margins*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/sep/impact-medicaid-work-requirements-hospital-revenues-margins
[189] Rosenbaum, S., Jacobs, F., & Johnson, K. (2025, May 30). *Nearly 5.6 million community health center patients could lose Medicaid coverage under new work requirements, with revenue losses up to $32 billion*. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2025/community-health-center-patients-medicaid-coverage-work-requirements
[190] *Id*.

Additionally, medical documentation required by the Rule's provisions could cost health facilities $300 million each year.[191] One analysis estimates that it may take three million provider hours annually to document medical frailty exemptions consistent with the Rule (assuming three million Medicaid expansion enrollees seek medical frailty exemptions, and that documentation takes 30 minutes every six months). With primary care providers averaging $100/hour, three million provider hours could total $300 million in additional costs for healthcare facilities.

Financial pressures on health facilities caused by the Rule will result in closures and job loss, leading to substantial adverse impacts to state economies. One study used economic modeling to estimate the impact of H.R. 1's community engagement requirements on state economies and found that the requirements will lead to large-scale job loss (including among health care workers), reductions in state economic activity, and reductions in state and local tax revenue.[192] Again, these likely are an underestimate given the additional coverage loss and burdens imposed by the Rule. Another analysis, completed before the legislation was finalized, found that H.R. 1's community engagement requirements alone could induce the loss of 322,000 to 449,000 jobs.[193] Most of the recent job growth in the U.S. has been in healthcare, but the Rule jeopardizes this critical sector of the economy.[194] Large-scale layoffs and negative economic impacts run counter to the stated intent of Medicaid work requirements to increase employment and reduce poverty.

Conclusion

For all the foregoing reasons, the Rule cannot stand. CMS's addition of a "significantly impairs" ability-to-work test exceeds the plain terms of section 1902(xx) of the Act, disregards Congress's deliberate statutory structure, and is inconsistent with the contemporaneous statements of the Rule's own legislative sponsors. The Rule is independently arbitrary and capricious: CMS failed to adequately justify its most consequential policy choices, ignored substantial and readily available evidence of the coverage losses and provider burdens its restrictive medical frailty framework will cause, and reversed course from its own prior guidance without acknowledging the change or accounting for the reliance it invited. Finally, by imposing burdens that go well beyond anything the statute requires or Congress intended, the Rule will strip health coverage from millions of people who remain eligible under the law, disproportionately harming individuals with chronic, serious, or complex medical conditions, straining the hospitals and

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[191] Ku, L., Orgera, K., Kwon, K. N., Gorak, T., Krips, M., & Cordes, J. J. (2026, June 9). *H.R. 1 funding cuts will overshadow gains from the new rural health transformation program*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2026/jun/hr-1-funding-cuts-rural-health-transformatio

[192] Ku, L., et al. (2025, May). *How national Medicaid work requirements would lead to large-scale job losses, harm state economies, and strain budgets*. The Commonwealth Fund. https://doi.org/10.26099/6tcv-fh75

[193] Ku, L., Kwon, K. N., Nketiah, L., Gorak, T., Krips, M., & Cordes, J. J. (2025, March 25). *How potential federal cuts to Medicaid and SNAP could trigger the loss of a million-plus jobs, reduced economic activity, and less state revenue*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/how-cuts-medicaid-snap-could-trigger-job-loss-state-revenue

[194] Kopack, S. (2026, February 11). *U.S. had almost no job growth in 2025*. NBC News. https://www.nbcnews.com/business/economy/january-jobs-revisions-trump-rcna258398

community health centers that serve them, and imposing significant and unnecessary costs on states, providers, and beneficiaries alike.

APHA, Grantmakers in Health, the Jacobs Institute of Women's Health, the National Center for Medical-Legal Partnership, and the individual public health deans and scholars listed below urge HHS to withdraw the Rule in its entirety and, at a minimum, to rescind the medical frailty "significantly impairs" standard, the restrictions on self-attestation and *ex parte* verification, and the 12-month lookback limitation discussed above. Any replacement rule should conform to the plain text of section 1902(xx) of the Act, honor Congress's stated intent to protect individuals who are medically frail or have special medical needs, and reflect the significant health, public health, and economic harms documented in this comment.

We further request that the full text of this comment, together with each of the individual studies, reports, and other supporting materials cited and made available through active links herein, be included in the formal administrative record for this rulemaking for purposes of the Administrative Procedure Act. If HHS is unable for any reason to access or preserve any of the linked materials, we would welcome the opportunity to submit copies of those materials directly for the administrative record.

We appreciate the opportunity to comment on this Rule and welcome the opportunity to discuss these concerns further. If you have questions or need any additional information, please contact Alison Barkoff at Alison.Barkoff@gwu.edu.

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2. Grantmakers in Health
3. Jacobs Institute of Women's Health
4. National Center for Medical-Legal Partnership

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Appendix A

Cancer care: Medicaid expansion has had an enormous impact on expanding access to cancer care and preventing cancer-related mortality and morbidity. Indeed, dozens of studies have found that Medicaid expansion is associated with earlier and increased likelihood of cancer diagnosis, as well as fewer late-stage diagnoses, improved time to treatment initiation, improved access to treatment, and improved likelihood of cancer survival rates among those with breast cancer, cervical cancer, lung cancer, colorectal cancer, endometrial, ovarian, advanced-stage skin cancer, and more.[195] [196] [197] [198] [199] [200] [201] [202] [203] [204] [205] [206]

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[207] [208] [209] [210] [211] [212] [213] [214] [215] [216] [217] Expansion is also associated with lessening racial disparities in coverage and access to cancer treatment.[218] [219] [220]

Cardiovascular care: Medicaid expansion is also associated with increased cardiovascular care among nonelderly adults, including a 38% greater increase in rates of outpatient disease management visits, a 43% greater increase in rates of prescription for cardiovascular disease management, increased vascular-related surgeries, and improved access to regular care for

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individuals with heart disease.[221] [222] [223] Expansion also increased access to heart transplantation, and especially for Black populations.[224] [225]

Care for mental health and substance use disorders: In expansion states, adults with mental illnesses have experienced substantial improvements in access to care, including increased access to prescriptions to treat mental illness and mental health facilities.[226] [227] [228] A significant number of studies demonstrate that Medicaid expansion is associated with increased healthcare access among individuals with SUD, including disorders related to use of alcohol, opioids, methamphetamines, amphetamines. Expansion is associated with an increased likelihood of individuals with SUD having covered care, [229] [230] as well as increased access to critical SUD treatments such as psychosocial services, SUD specialty facilities, therapies, and pharmaceutical treatments, including overall and/or Medicaid-covered medication-assisted treatment (MAT),

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population, Medicaid's services can be particularly life-saving for low-resourced individuals with complex mental health needs, which disproportionately includes those involved in the justice system, those experiencing homelessness, and veterans.[247]

Kidney and diabetes care: Medicaid expansion is associated with improved coverage and healthcare access for individuals with diabetes, including earlier pre-dialysis care.[248] [249] [250] [251] [252] Indeed, following Medicaid expansion, community health centers in expansion states reported greater utilizations of care among adults with abnormal blood glucose, as compared to health centers in non-expansion states.[253]

Care for individuals with disabilities: Medicaid expansion plays an essential role in advancing health access for individuals with disabilities. For example, it fills a critical gap in coverage for individuals undergoing the lengthy (i.e., six or more months to years) and burdensome Supplemental Security Income (SSI) determination process when applicants are frequently unable to work and would otherwise be at great risk of uninsurance. In a recent analysis, KFF found that 42% of new SSI enrollees in expansions states had previously received Medicaid coverage through expansion. KFF also found that previous Medicaid coverage for new SSI enrollees was *twice* as high for individuals in expansion states compared with non-expansion states.[254] These data underline the role expansion plays in helping individuals with disabilities

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maintain health coverage during their SSI process, although new H.R. 1 administrative burdens around "medical frailty" severely threaten these gains.

Medicaid expansion is also associated with improved receipt of primary and preventive care.[255] [256] For individuals with intellectual disabilities, expansion is associated with decreased likelihood of forgoing medical care, specialist visits, or mental health care due to cost.[257] And, among adults who report experiencing limitations caused by a chronic condition, expansion is associated with increased likelihood of having an office visit in the past two weeks.[258]

These increases in care access and utilization have translated into significant health improvements in expansion states, including among people with chronic conditions. For example, Medicaid expansion is associated with reductions in hospital readmissions and complications, improvements in self-reported health, and significant decreases in mortality.

Reductions in hospital readmissions and complications. In Medicaid expansion states, hospitals have reported significant reductions in readmission rates and complications for numerous conditions, including pneumonia, heart attack, heart failure, and cirrhosis, as compared to non-expansion states.[259] [260]

Improvements in self-reported health, including among those with chronic conditions. Following expansion, individuals in expansion states report significant improvements in self-reported health.[261] [262] In fact, studies have found that those with chronic conditions are significantly more likely to report physical and mental health improvements following enrollment in Medicaid

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expansion, as compared to enrollees without chronic conditions.[263] In comparison, individuals residing in non-expansion areas are more likely to self-report poor or fair health.[264]

Significant decreases in mortality. Medicaid expansion is associated with an overall 4% decrease in mortality, which is equivalent to 11 fewer deaths per 100,000 people.[265] Indeed, between 2010-2022, expansion was estimated to be associated with approximately 27,400 saved lives.[266] Expansion has been found to decrease mortality among those with serious physical and behavioral health conditions; for example, Medicaid expansion is associated with decreased in-hospital mortality following surgeries, higher rates of survival among adults with traumatic injuries, and reduced mortality from suicide and overdose.[267] [268] [269] [270] [271] [272] [273] Specifically, expansion has led to a significant reduction in mortality among families of color.[274] [275]

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