July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on the Medicaid Community Engagement Interim Final Rule

On behalf of Grantmakers In Health (GIH) and our undersigned Funding Partners, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Interim Final Rule (IFC) implementing Medicaid community engagement requirements.

Background

GIH is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. In that work, GIH supports policies that promote access to high quality health care and strengthen the nation's health care safety net.

We are concerned that the provisions in this rule will create barriers to coverage for eligible individuals and families, while imposing significant administrative burdens across the Medicaid ecosystem, including for beneficiaries, community-based organizations (CBOs), and health care providers.

Administrative Burden on Enrollees

The Interim Final Rule introduces new reporting, verification, and documentation requirements that increase the risk that eligible individuals will lose Medicaid coverage because of administrative barriers rather than changes in eligibility. Evidence from Arkansas's prior implementation of Medicaid work requirements indicate that coverage losses often resulted from missed reporting deadlines, difficulty navigating online reporting systems, or confusion about requirements—rather than true ineligibility.

Arkansas implemented Medicaid work requirements in June 2018, requiring certain adults to complete at least 80 hours per month of work or other qualifying activities and report compliance through an online system to maintain coverage. Within the first year of implementation, the policy led to approximately 18,000 adults losing Medicaid coverage due to failure to meet reporting requirements, including individuals who may have otherwise qualified or met exemption criteria. Analyses of the policy consistently found that coverage losses were not accompanied by increases in

employment, indicating that the policy did not achieve its stated workforce participation goals. At the same time, researchers documented significant confusion among beneficiaries about program requirements, with many individuals unaware of the policy or uncertain about whether it applied to them, and others unable to successfully navigate the reporting process.[1] These findings suggest that administrative complexity played a central role in driving coverage losses, raising concerns that similar requirements could result in procedural disenrollment of eligible individuals across the country under current policy. What is more, a KFF study found that significant numbers of Arkansans with a disability lost coverage due to the work requirement, despite the purported exemptions and safeguards in place.[2] The coverage losses occurred despite the State using "existing data sources when possible" to confirm disability status.[3]

Additionally, the need to regularly document and verify qualifying activities introduces new "churn" risks, in which eligible individuals experience gaps in coverage due to procedural or administrative issues rather than changes in underlying eligibility. Over time, these dynamics may contribute to a cycle of coverage loss and re-enrollment that undermines continuity of care and creates instability for both enrollees and the providers who serve them.

These concerns are further reinforced by national projections. The Congressional Budget Office (CBO) estimates that the 2025 reconciliation law[4] will increase the number of uninsured individuals by approximately 10 million by 2034,[5]including an estimated 5.3 million people who will lose coverage due to the Medicaid community engagement requirements.[6]

Recommendations:

- GIH encourages CMS to amend the rule to allow states to accept self-attestations for all exemptions. In addition, CMS should encourage states to adopt the short-term hardship exemptions. Maximizing the utilization of statutory flexibilities and exemptions is critical to reducing procedural disenrollments.
- Additionally, GIH encourages CMS to provide states with good faith effort exemptions to delay implementation of the community engagement requirements. GIH encourages CMS to

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[1] https://www.nejm.org/doi/full/10.1056/nejmsr1901772#; Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care; Coverage losses, substantial confusion in Arkansas following implementation of Medicaid work requirements | Harvard T.H. Chan School of Public Health

[2] MaryBeth Musumeci, Kaiser Fam. Found., *Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018* (2019), https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/. Another study found that adults with chronic conditions were more likely (than adults without) to lose coverage for failure to comply with the work requirements. *See* L. Chen & B.D. Sommers, *Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018*, 110 AM. J. PUB. HEALTH 1208 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7349442/. Evidence from other public benefit programs with similar exemptions confirms that, in practice, individuals with disabilities are often not exempted as they should be. *See, e.g.*, Anna Baily & Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Medicaid Work Requirements Don't Protect People with Disabilities* (2018), https://www.cbpp.org/sites/default/files/atoms/files/11-14-18health.pdf; MaryBeth Musumeci & Julia Zur, Kaiser Fam. Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-workrequirements-lessons-from-the-tanf-experience/; Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low Income Working-Age People with Disabilities* 4, 14 (2014), https://www.researchgate.net/publication/274006096_Impact_of_the_Work_Requirement_in_Suppl emental_Nutrition_Assistance_SNAP_on_Low-Income_Working-Age_People_with_Disabilities; Andrew J. Cherlin et al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 SOC. SERV. REV. 387, 398 (2002) (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health") (attached); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REV. 199 (2008).

[3] Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas,* 381 N. ENG. J. MED. 1073, 1080 (Sept. 2019), https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[4] https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.pdf

[5] https://www.cbo.gov/publication/61367#data; https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/

[6] https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/#2ca666ac-5d15-4454-8973-241566e22bb5

approve good-faith implementation delays for states that require additional time to operationalize these requirements. The compressed implementation timeline, combined with the extensive operational changes required under the IFC, increases the risk of inconsistent implementation, procedural disenrollment, delayed care, and higher uncompensated and emergency care costs.

Administrative Burden on People with Disabilities

Work requirements will exacerbate health disparities and ignore the fact that the vast majority of people eligible for Medicaid expansion coverage are already working or cannot work due to chronic health conditions or caregiving responsibilities.[7] Research shows that individuals with a disability that would not affect their job performance are 26% less likely than people without a disability to be considered for employment.[8] In addition, compared to people without a disability, people with a disability are more likely to work part-time because they cannot find a job with more hours or their hours have been cut back.[9] Individuals with a disability often do not receive necessary supports or reasonable accommodations.[10] All told, the unemployment rate for people with a disability remains about twice that of individuals with no disability.[11]

Work requirements will also exacerbate racial disparities in health coverage. As states expanded Medicaid after enactment of the Affordable Care Act, the gap in uninsured rates between White and Black adults shrunk by 51% in expansion states, compared with a 33% decrease in non-expansion states.[12] The gap between White and Hispanic adults shrunk by 45% in expansion states, but only 27% in non-expansion states.[13] Work requirements threaten to roll back those gains because people of color are more likely to be living with certain chronic health conditions, such as diabetes, which requires ongoing screening and services, and research has shown that adults with chronic conditions were more likely (than adults without) to lose coverage for failure to comply with the work requirements.[14].

Administrative Burden on Community-Based Organizations

Community-based organizations (CBOs) serve as critical partners in connecting Medicaid enrollees to services, including workforce supports, social services, and care coordination. Under the IFC,

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[7] Rachel Garfield et al., Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements, Kaiser Fam. Found. (Feb. 11, 2021), https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/.
[8] Mason Ameri et al., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior* (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198.
[9] U.S. Bureau of Labor Stats., *Persons with a Disability: Labor Force Characteristics Summary* (Feb. 25, 2025), https://www.bls.gov/news.release/pdf/disabl.pdf.
[10] *See* U.S. Bureau of Labor Stats., *Persons with a Disability: Barriers to Employment and Other Labor-Related Issues News Release* (Mar. 30, 2022), https://www.bls.gov/news.release/archives/dissup_03302022.htm; Vidya Sundar et al., *Striving to Work and Overcoming Barriers: Employment Strategies and Successes of People with Disabilities*, 48 J. VOCATIONAL REHAB. 93 (2018), https://kesslerfoundation.org/sites/default/files/2019-07/Striving%20to%20Work%20JVR.pdf.
[11] U.S. Bureau of Labor Stats., *Persons with a Disability: Labor Force Characteristics Summary* (Feb. 25, 2025), https://www.bls.gov/news.release/pdf/disabl.pdf.
[12] Jesse Cross-Call, Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care, Ctr. on Budget & Pol'y Priorities, at 1 (Oct. 21, 2020), https://www.cbpp.org/research/health/medicaidexpansion-has-helped-narrow-racial-disparities-in-health-coverage-and.
[13] Id. at 1-2
[14] American Indians/Alaska Natives (13.6%), non-Hispanic Blacks (12.1%), Hispanics (11.7%), and non-Hispanic Asians (9.1%) make up the populations with the highest rates of diagnosed diabetes, compared to 6.9% of non-Hispanic Whites. HHS, CDC, Nat'l Diabetes Prevention Prog., CDC 2022 National Diabetes Statistics Report (May 15, 2024), https://www.cdc.gov/diabetes/data/statistics-report/index.html. *See* L. Chen & B.D. Sommers, *Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018*, 110 AM. J. PUB. HEALTH 1208 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7349442/.

many CBOs may need to document, track, and verify volunteer hours or other community engagement activities.

These responsibilities represent a significant expansion of CBOs' traditional roles. Many organizations operate with limited staff, grant-based funding, and minimal technology infrastructure, making it difficult to implement new compliance and reporting systems.

Requiring CBOs to collect, validate, and report participation data could divert limited resources away from service delivery, outreach, and community engagement. Smaller and rural organizations may be particularly affected because they often lack the administrative capacity needed to meet these requirements. Without dedicated funding and technical assistance, some organizations may be unable or unwilling to participate.

Recommendation:

- GIH encourages CMS and states to provide standardized templates, technical assistance, and other resources to support documentation while minimizing reporting requirements for CBOs.

Administrative Burden on Health Care Providers

The IFC also introduces new documentation responsibilities for health care providers, particularly in determining whether individuals qualify for exemptions based on medical frailty, disability, or other criteria. Providers are likely to receive increased requests to document functional limitations, verify treatment participation, and support exemption determinations, positioning them as a key source of information in eligibility processes.

Determining medical frailty may require providers to assess not only whether a patient has a qualifying condition, but whether that condition significantly impairs the individual's ability to satisfy the community engagement requirement. These assessments may require additional forms, attestations, and responses to follow-up requests from state agencies or health plans. Providers are also likely to receive repeated requests to update documentation during ongoing eligibility reviews. These responsibilities extend beyond traditional Medicaid eligibility processes and may require health systems, physician practices, and community health centers to develop new workflows and administrative procedures, increasing demands on both clinical and administrative staff.

Recommendations:

- GIH encourages CMS and states to rely on qualifying diagnoses and self-attestations to make medical frailty determinations, rather than requiring additional documentation demonstrating how a condition impacts an individual's ability to work.
- As articulated above, GIH encourages CMS to amend the rule to permit self-attestation of medically frail status when states cannot determine medically frail status on an ex parte basis.
- GIH encourages CMS to provide clearer guidance regarding providers' responsibilities and documentation expectations and to support providers in managing these new administrative requirements.

Challenges in Verifying Caregiver Exemptions

The caregiver exemption in the IFC presents significant implementation challenges, especially given the nature of unpaid and informal caregiving in many communities. A substantial portion of caregiving in the United States is provided by family members, friends, or neighbors without formal documentation, employment classification, or third-party verification. As a result, qualifying for a caregiver exemption may require individuals to provide documentation that does not consistently exist in practice.

States may be required to confirm not only the existence of a caregiving relationship, but also the nature, frequency, and duration of care provided. In some cases, this may include demonstrating that caregiving activities meet specified thresholds or documenting hours of care provided on a regular basis—requirements that may be difficult to standardize or verify, particularly for individuals engaged in intermittent or shared caregiving arrangements.

These challenges may be compounded for individuals providing care in non-traditional contexts, such as caregivers who do not reside with the individual receiving care, those supporting multiple family members, or those balancing caregiving responsibilities with part-time or variable employment. For these individuals, documenting caregiving activities in a way that meets verification standards may require additional coordination, repeated documentation submissions, or reliance on third-party attestation, all of which may introduce additional administrative burden.

The complexity of verifying caregiving responsibilities also raises the potential for inconsistent determinations across states and cases, particularly where documentation standards, definitions of caregiving, and evidentiary requirements vary. Without clear national standards, states may adopt different documentation requirements and evidentiary standards, creating inconsistent eligibility determinations for similarly situated caregivers.

Recommendations:

- GIH encourages CMS to maximize statutory flexibilities and minimize documentation requirements for individuals seeking caregiver exemptions or documenting caregiving hours.
- GIH also recommends that CMS provide additional guidance on how caregiver exemptions will be defined and verified within the broader eligibility framework.
- Finally, GIH encourages CMS to consider how individuals will be supported in demonstrating eligibility for this exemption given the variability and informality of caregiving arrangements.

Conclusion

GIH appreciates the opportunity to comment on this Interim Final Rule. As outlined above, the rule introduces substantial new administrative responsibilities for Medicaid beneficiaries, community-based organizations, health care providers, and state agencies while increasing the risk that eligible individuals will lose coverage for procedural reasons rather than true ineligibility.

As CMS finalizes implementation guidance, GIH and the undersigned organizations encourage the agency to maximize statutory flexibilities, minimize unnecessary documentation and reporting requirements, and support states in developing implementation strategies that preserve coverage, reduce administrative burden, and maintain access to care.

Thank you for your consideration of these comments. Should you have any questions, please reach out to Ann Rodgers at arodgers@gih.org.

Sincerely,

Cara V. James
President and CEO
Grantmakers In Health

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Alliance Healthcare Foundation
Asset Funders Network
Colorado Health Foundation
Community Health Commission of Missouri
Craig H. Neilsen Foundation
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