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 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.

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[2] will increase the number of uninsured individuals by approximately 10 million by 2034,[3]including an estimated 5.3 million people who will lose coverage due to the Medicaid community engagement requirements.[4]

Recommendations:

- GIH encourages CMS to maximize statutory flexibilities by allowing states to accept self-attestations for exemptions whenever permitted and encouraging 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 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 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, many CBOs may be to document, track, and verify volunteer hours or other community engagement activities.

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

[3] 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/

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

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 substantially limits 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.

Recommendation:

- 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.
- 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.

Recommendation:

- 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, we 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
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Grantmakers In Health