July 27, 2026

Re: Public Comment in Response to Medicaid Program; Community Engagement Requirement for Certain Individuals

I write as the Executive Director of the CT Health Policy Project to express significant concerns about several aspects of the Center for Medicaid and Medicare Services' (CMS') interim final rule (IFR) regarding HR-1. The rule creates significant uncertainty and complicates an already chaotic and condensed implementation process for HR-1's Medicaid work reporting requirements. The CT Health Policy Project is a non-partisan, non-profit organization dedicated to improving access to quality, affordable healthcare for every Connecticut resident. We have submitted more detailed input to our state's Department of Social Services.

- Many Medicaid enrollees who can, are already working. The new red tape and frequent recertifications will lead to incorrect procedural termination errors for low income people who are occupied during working hours.
- At this late stage of the implementation process, states have already begun systems updates and designing new workflows to implement work reporting requirements and the introduction of more stringent and complex rules will almost certainly result in the disenrollment of hundreds of thousands of eligible Medicaid members in Connecticut and across the US.
- Work reporting requirements have been tried before and they do not increase employment or hours worked. They will add to Connecticut's uninsured population, increase medical debt, and uncompensated care for providers leading to massive disruption to communities and healthcare systems already struggling to meet the need.
- These requirements disproportionately negatively impact those who most need healthcare coverage.
- These requirements create excessive red tape for people experiencing medical crises, adding more stress and burden to a cancer diagnosis or the aftermath of a serious accident.

Specifically, I am concerned about the following:

Medical Frailty Exemptions

The IFR provides requirements for a "medical frailty" exemption to the work rules that is considerably narrower than either the statutory language or preliminary guidance provided by CMS to states in the months since H.R. 1 passed. The IFR provision that an exemption must "significantly impair" an individual's ability to comply with the work reporting requirements is not included in the H.R.1 statute. The IFR doesn't provide clear guidance to states on how to administer this provision but does include a warning for noncompliance. Further, this provision is not a standard requirement in any other federal program. This new requirement is not only more stringent, but it also requires an entirely new system of

documentation and makes it impossible for states to rely on the diagnoses and health care utilization data they already collect.

Trying to work with a serious illness is complicated and it's difficult to prove who can and can't. Health conditions change often. Somedays may be fine, but when conditions flare up, patients can't work. They need time off for medical appointments and use up sick leave quickly. They need accommodating workplaces, understanding bosses, and patient coworkers. Jobs like this are often not available to low-income Medicaid members who may not have professional degrees that allow desk jobs and flexible work schedules. For medically frail people, the ability to continue working relies heavily on access to healthcare, which is at risk from these regulations.

It's extremely difficult to determine who can and can't work. The federal regulators didn't give states any guidance on how to determine if someone is able to work, but if a federal audit finds that "there is frequent approval of individuals as medically frail with little to no support for the conclusion" the state will "not be in compliance with the regulation" risking significant state fiscal consequences.

In addition, this change in complex Medicaid rules is being rushed into place with few resources, risking mistakes with very bad outcomes. States are expected to implement this mandate just a few months after the regulations were published. In contrast, states were given significantly more resources and two years to implement the Affordable Care Act Medicaid changes and three years to unwind COVID Medicaid protections.

The changes place a massive new burden on state Medicaid agencies that are struggling to keep up. By January 1st, they must reprogram eligibility systems, find reliable data sources for verification, redesign the consumer portal and applications, update user manuals and train staff, and educate members on who is affected and what they need to do. There must be enough time to test that the system works to avoid errors. Also starting in January, states must review each members' eligibility every six months rather than the current one-year rule. States, including Connecticut, are already facing staff shortages.

People losing coverage will still need healthcare. A national study recently published in JAMA found that 87% of Americans subject to Medicaid work requirements have at least one chronic condition; that number rises to 97% for those ages 50 to 64 years. They will delay and ration care, waiting until health problems are more difficult and more costly to treat. ER overcrowding, already a massive problem, will only get worse for every patient. Uncompensated care costs will increase significantly for providers and health systems.

Self-attestation, look-back periods, and "sufficient documentation"
The IFR restricts states' ability to rely on "self-attestation" to factors that are difficult to document and would exempt them from work reporting requirements after 2027. Beginning in 2028, states must require documentation sufficient to meet the exemption.

- The IFR creates requirements for documenting one's ability to work in ways that are not captured in routine data collection for most conditions in most states. This means that Medicaid enrollees will need to repeatedly request documentation of their condition by their providers.
- Further compounding the demand on enrollees and their providers, when states are unable to verify compliance with the work reporting rules, H.R. 1 mandates that states send a notice to enrollees noting that the enrollee must demonstrate compliance within 30 days of receipt of the notice. If the enrollee is unable to do this within the 30 days, H.R. 1 requires the state to disenroll the individual from Medicaid no later than the last day of the month following the end of the 30 day period. This entire process must be completed before the end of the enrollee's current eligibility period, which the IFR acknowledges typically begins 60-90 days before the renewal date. In most cases, this means people would have to prove their FUTURE compliance
- Understaffed providers frequently lack the time or are unable to assist with uncompensated "extras," such as completing documentation of an exemption, even when the patient clearly meets the exemption. This will mean many hours of uncompensated labor for providers who agree to help their patients stay enrolled.
- If documentation doesn't exist, states must require other verification and must document their standards and related processes. If, for example, a Medicaid enrollee is providing informal care to an elderly relative, it is unlikely they will have documentation of this work available beyond their own attestation to their situation.
- People with chronic and acute illnesses like cancer, substance use disorder, HIV, etc. can no longer be deemed exempt based on their diagnosis but will need to document their inability to work in a manner that has not yet been defined.
- The lookback periods are confusing and will require careful design if states are to avoid dire unintended consequences. For example: If in June a person is hit by a truck and left unable to work and in need of hospital care, they would be found ineligible for Medicaid unless they were working in May. The IFR would require this person to demonstrate that they were either meeting the work rules or exempt from them for at least one month prior to applying for Medicaid. This one month requirement will cause people with critical health needs to go without necessary medical care or incur catastrophic debt.

Short-term extensions

Given the late and complicating nature of the IFR, good faith waivers should be provided to any state that requests such a waiver. More time is crucial now that states must revise many of the systems changes they have already contracted for as well as workflows and communications they have begun to develop. Without intentional and well-planned implementation, the new processes contemplated by this IFR will cause coverage losses for people the statute explicitly exempted from work reporting requirements.

Thank you for considering these comments. I can be reached at andrews@cthealthpolicy.org.