July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Comment on CMS-2454-IFC, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP); Implementing Medicaid Community Engagement Requirements for Certain Individuals; RIN 0938-AV20**

Dear Secretary Kennedy and Administrator Oz:

Colorado Center on Law and Policy submits these comments in opposition to the Interim Final Rule, "Medicaid Program; Community Engagement Requirement for Certain Individuals," CMS-2454-IFC (hereinafter "the IFR.")

Colorado Center on Law and Policy (CCLP) is a statewide antipoverty organization that advances the rights of all Coloradans. We focus on systems-level change, supporting long-term, sustainable upward mobility for our communities. To achieve those goals, we use research and administrative advocacy, support legislative solutions and engage in strategic litigation. Since August 2025, CCLP has convened a workgroup of community-based organizations, health providers and clinics, community members, and government partners to discuss implementation of community engagement requirements. These comments are informed by that workgroup, as well as by conversations with partners in the healthcare industry and in government, among advocates and legal partners, and with individual Coloradans.

The IFR imposes an enormous number of complex requirements – on individuals, employers, educators, clinics and hospitals, and states – that are absent from H.R.1. Where there is opportunity for simplification and alignment, the Centers for Medicare and Medicaid Services (CMS) has instead opted to complicate procedures, contradict existing law,[1] and increase inequities.[2] In areas where H.R.1 language permits flexibility for states, the IFR inappropriately forecloses it. Arguably by design, CMS's rule makes errors more likely. It sets states up for failure and ultimately for

[1] The Medicaid Act and relevant federal regulations exhort states to minimize the burden on individuals, to simplify administration, and to provide clear, timely and accessible information. Soc. Sec'y Act 1902(a)(5); 42 CFR 435.902, 42 CFR 435.905(b)

[2] "Study to Identify Methods to Assess Equity: Report to the President." Office of Management and Budget, July 20, 2021. https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-Report-on-E013985-Implementation_508-Compliant-Secure-v1.1.pdf.

financial penalties that are likely to contribute to even more Americans losing coverage than the 7.8 million originally forecast by the Congressional Budget Office.[3]

We ask that the rule be withdrawn and revised to comply with HR1. With revision, the rule could establish consistency with existing federal law that requires application and renewal processes to be minimally burdensome for enrollees; provide a graduated and supported on-ramp for development of work program, work, school and volunteer data systems; clarify vague and ambiguous language; eliminate due process violations in the notice and eligibility determination process; and restore flexibility to states to determine how best to meet community need within the parameters of HR1.

## I. The Community Engagement IFR will not achieve its stated goals of increased employment and better health. Instead, it is likely to undermine the health and economic wellbeing of affected populations.

The IFR's premise is that by requiring community engagement as a condition of receipt of Medicaid, many in the relevant population will become employed and will thus benefit from the "improved physical and mental health outcomes" that come from "obtaining and maintaining stable employment."[4]

However, data is clear that people are more likely to get and maintain employment when they have access to training, education, and supportive services. As Arkansas' Medicaid work requirements experiment showed, simply imposing work requirements had no perceptible impact on job attainment, Arkansas adults experienced none of the improved health outcomes that might arise from access to more income. Instead, many or most Arkansans who lost Medicaid reported serious problems with medical debt, delays in obtaining care, and delays in accessing medication.[5]

CMS's reasoning is flawed. It fails to consider established facts, and the sanction on community members - loss of coverage – is disproportionate. This is especially true because we can expect, based on Colorado's experience, that most who lose coverage will do so because they can't navigate confusing requirements and comply with paperwork burdens. Most Coloradans who lost coverage during the Public Health Emergency Unwind experienced administrative denials.[6]

Notwithstanding the language of H.R.1, the primary purpose of Medicaid is to provide health coverage for those who cannot afford it and to provide services that will

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[3] "Information Concerning Medicaid-Related Provisions in Title IV of HR1." Congressional Budget Office, June 24, 2025. https://www.cbo.gov/publication/61510

[4] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91. Fed. Reg. 33348, 33350 (June 3, 2026).

[5] Benjamin D Sommers, Lucy Chen, Robert J Blendon, E John Orav, Arnold M Epstein. "Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." Health Affairs, Sept. 2020. https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/

[6] Medicaid/CHIP Monthly Enrollment Tracker, State Data – Archived. KFF, July 2026. https://www.kff.org/medicaid/medicaid-enrollment-tracker/#26dff2de-6ba1-40eb-89e9-2c7a6ea53f3f

help families and individuals "attain and retain" their ability to be independent and provide self-care.[7] Coverage is the precondition for attaining and retaining employment – not the reverse.[8]

The majority of adults enrolled in Medicaid coverage are already working.[9] Others face barriers to enrollment that the IFR fails to consider. Throughout the IFR, CMS mischaracterizes cited research, obscuring the lack of reasoned support for these policies and ultimately failing to establish the "rational connection between the facts found and the choice made" that the Administrative Procedures Act requires.[10]

Throughout the IFR, CMS cites research for the proposition that requiring people to engage in work or other activities improves health, but findings are systematically misrepresented. None of the studies cited addresses whether making benefits contingent on work results in more households being economically self-sufficient. Instead, those studies typically identify the benefit of having higher household income.[11] In fact, one recent study demonstrated that providing universal basic income not only did not deter engagement in work, but actually supported job advancement.[12]

Therefore, if the question is how to ensure people have more income and greater financial stability, we already have our answer. Providing people with comprehensive low-cost coverage leads to increased financial stability and reduces debt for low-income

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[7] 42 U.S.C.S. 1396 et seq. requires that participating states use reasonable standards for determining eligibility for the Medicaid program. The primary objectives of the program are to provide medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services and to furnish rehabilitation and other services to help such individuals attain and retain capability for independence or self care. *V.L.v. Wagner,* 669 F.Supp.2d 1106, 1117 (N.D. Cal. 2009). This mandate is typically applied to Medicaid enrollees in non-MAGI programs who are at risk of institutionalization, but the underlying principle applies equally to the tens of thousands of Coloradans in the Expansion category whose ability to provide self-care and remain independent is contingent on their access to free or low-cost health services.

[8] *Gresham v. Azar,* 950 F.3d 93 (D.C. Cir. 2020)

[9] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz, and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update." KFF, May 30, 2025. https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/. *See also*, Jennifer Tolbert, Sammy Cervantes, Gary Claxton, "Different Data Source, But Same Results: Most Adults Subject to Medicaid Work Requirements Are Working or Face Barriers to Work." KFF, Jun 25, 2025. https://www.kff.org/medicaid/different-data-source-but-same-results-most-adults-subject-to-medicaid-work-requirements-are-working-or-face-barriers-to-work/

[10] *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.,* 419 U.S. 281, 285 (1974). See also *California v. Dep't of Ed.,* 132 F.4th 92, 98 (1st Cir. 2025).

[11] The IFR cites a 2024 study, "Economic Strain and Recovery Trajectories in Mental Health," as establishing that employment improves income and ultimately health. However, the authors themselves acknowledge that the study does not establish whether employment causes financial stability or that either employment or financial stability causes improved health. The study is also limited to mental health trajectories.

[12] "The real effects of basic income." German Institute for Economic Research, April 2025. https://www.pilotprojekt-grundeinkommen.de/en

households.[13] [14] It stands to reason that taking away coverage will have the opposite effect.

## II. The IFR fails to account for the fact that, in many states, IT infrastructure, database limitations and county administration add to implementation challenges. §§ 435.557(a), (e)(i); 435.916(a)(2)

Like many states, Colorado has a legacy IT system that limits the rate and volume of programming changes. Colorado's vendor for the Colorado Benefits Management System (CBMS), Deloitte, has been unable to implement recommended programming changes on a timely basis.[15] Deloitte, which serves as the contractor for at least 25 states, is annually paid hundreds of millions of state dollars while also making fundamental programming errors in public benefit systems.[16] However, with the rushed timeframe for implementation, states like Colorado have no choice but to work with the vendor they have. CCLP's review of contracts shows that Deloitte's work on CBMS over the past decade has cost the state $30-40 million per year.

Programming changes are both extraordinarily time-consuming and expensive, with higher federal matching rates contingent on approval and not always available.[17] States with legacy systems like Colorado's have programming backlogs, with needed changes added to a queue that can stretch into multiple years. The additional changes required by the IFR cannot be completed in 12 months, let alone 6, if states are to adequately plan, do user testing, and debug systems. With the passage of H.R.1 and the new requirements in the IFR, planned projects that would have improved efficiency and accuracy have been tabled to make way for the extensive list of changes related to the IFR.

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[13]Redwan Bin Abdul Baten, Abdullah Noman, Mohammad Nakibur Rahman, Affordable Care Act Medicaid expansion, access to health care, and financial behavior of the United States adults. J. Public Health Policy. 2024 Sep 23;45(4): 740-756. doi: 10 .1057/s41271-024-00522-0; Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, Ashley Wong. The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," J. Public Econ. 2018 May 7; 163:99-112. doi: 10.1016/j.pubeco.2018.04.009.

[14] Rose C. Chu, Christie Peters, and Thomas Buchmueller. "Medicaid: The Health and Economic Benefits of Expanding Eligibility." Assistant Secretary of Planning and Evaluation (ASPE). Sept. 2024 Eligibility. https://aspe.hhs.gov/sites/default/files/documents/effbde36dd9852a49d10e66e4a4ee333/medicaid-health-economic-benefits.pdf

[15] In 2024, HCPF reported an estimated backlog of 57 CBMS projects, which Deloitte estimated would take 175,500-250,000 hours over two years to complete. CBMS 2024, Joint Technology Committee Briefing, July 2024. https://content.leg.colorado.gov/sites/default/files/images/hcpf_dhs-cbms_presentation.pdf

[16] Rachana Pradhan, Samantha Liss, Kate Wells, "Deloitte-run systems denied Medicaid to disabled people. New laws could make it worse." NPR, July 20, 2026. https://www.npr.org/2026/07/20/nx-s1-5896359/medicaid-disabled-patients-denied-deloitte-michigan

[17] Design, development and installation of certain IT systems are eligible for a 90 percent federal match, if CMS approves, but maintenance and operations are matched at a lower rate (75 percent). P.L. 92-603; SSA §1903(a)(3)(A) and (B); 80 *Federal Register*75819 (December 4, 2015).

Interoperability between systems is an important factor that is also limited because of CBMS's age and structure. [18] The IFR makes unfounded assumptions about states' ability to connect to existing and new databases, as well as their ability to pay steep prices for access to databases. Colorado is fortunate to have a system that includes multiple public programs. Nevertheless, Colorado will be unable to comprehensively identify populations that should be excepted or excluded from work requirements because connections to many external databases cannot be fully automated. Even interoperability between CBMS and the online member portal, PEAK, is incomplete, with discrepancies between data in the two systems.[19]

Timing imposes an important dilemma. When considering medical frailty and eligibility for exclusions to community engagement requirements, states will be accessing information in MMIS billing systems. This will be challenging in Colorado due to lack of interoperability between CBMS and MMIS. Colorado's claims system does not interface directly with its eligibility system, and staff will need to use a partially manual method to gather relevant information. In any state, claims are unlikely to be sufficiently current; a 12-month lookback on adjudicated claims may yield little to no information for some enrollees. This is because the run-out on claims may be several months, and providers are only obligated to enter claims within 12 months of the date of service.

Even where interoperability is established, limitations in the databases will make it difficult to get timely, accurate information. As is true in many states, Colorado's state system collects earnings information on a quarterly basis. Earnings information from January will only be accessible in late April. Hence a person with an April 1 renewal may have insufficient basis to show they have met the $580 standard. Even data from the Federal Data Services Hub (FDSH) is not necessarily current. For example, IRS data is derived from the most recent tax filing, reflecting income that may be a year old or more.[20]

Cost also represents a significant drawback, since some FDSH data is prohibitively expensive. Equifax's The Work Number, part of the FDSH, may have current access to W-2 wage information, but access is expensive for the state and costs have risen rapidly. Equifax reportedly made over $2 billion from its earnings verification programs due to its dominance in the market and is currently embroiled in anti-trust litigation. [21] Over the past four years, Equifax has increased Colorado's "per ping" rate 126 percent, but lack of viable alternatives leaves Colorado and other states at the mercy of Equifax's attempts to profit off of these federal changes.[22] (States like Colorado with a

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[18] "Summary Report: When Policy Moves Fast, We Build Responsibly: Responding to Medicaid Work Requirements with Purpose." Prime Health, p. 14. https://www.primehealthco.com/workrequirements

[19] Id. at pp. 10, 14.

[20] Mathias Rechtzigel. "Ex Parte Explained: The Mechanics of Medicaid Eligibility." National Association of State Medicaid Directors, June 30, 2026. 2026. https://medicaiddirectors.org/resource/ex-parte-explained-the-mechanics-of-medicaid-eligibility-automation/

[21] *Greystone Mortgage Inc. v. Equifax Workforce Solutions LLC*, No. 2:24-cv-02260-JFM (E.D. Pa. Feb. 18, 2025).

[22]s Sarah Kliff, Margot Sanger-Katz and Asmaa Elkeurti, "Senators Accuse Equifax of 'Price-Gouging' Medicaid Programs. The New York Times, Feb. 4, 2026. https://www.nytimes.com/2026/02/04/health/equifax-medicaid-states-senators.html

50 percent federal match are hit harder than other states by such cost increases). Allowing states greater flexibility in how they verify income would allow states to rely on internal data and maintain scarce state dollars for the benefit of state residents, not for-profit and arguably monopolistic vendors.

Where interoperability is limited and the time available is insufficient to update systems and improve interoperability, Colorado and other states will need to resort to manual workarounds. Hands-on staff time that is necessary to painstakingly process cases for the foreseeable future will receive only the 50 percent federal match. Those scarce state funds are unrecoverable.[23]

From CCLP's point of view, the group that will suffer the most harm is the Expansion population. CCLP's tracking during the PHE unwind revealed that system limitations were a primary cause of coverage loss. From that experience, we know that multi-step manual processing is a factor in creating backlogs and causing unnecessary terminations. In fact, data demonstrates that most Coloradans who lost coverage during the universal renewals after the end of the Public Health Emergency in 2023-2024 (hereafter "the PHE unwind") were terminated for procedural reasons.[24] CCLP received many calls throughout that year from community members who had diligently submitted information on time through the online PEAK app, in-person or by mail, only to be terminated from coverage because of processing delays.

Colorado's history of honoring local control aligns with its use of county administration for public benefits. But there is a growing understanding of the inefficiencies of that system, particularly when staff are challenged by hard-to-use and outdated technology. The PHE unwind provided ample evidence of the impact of county administration, with counties struggling to hire and train staff and to manage backlogs.[25] In recognition of those challenges, Colorado has initiated a process of restructuring its eligibility system to be more centralized and efficient.[26] However, completion of that program is years away.

Contradicting its own data collected from states during the PHE unwind process, CMS has vastly underestimated the impacts of administrative or procedural denials related to community engagement requirements. In the IFR, CMS estimates "that 7 percent of applicable individuals who may be working, enrolled in school, or otherwise performing activities in line with community engagement requirement, or qualify for a

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[23] *RENEW Ne. V. United States Dep't of Interior,* 2026 WL 1078282 at *30 (D. Mass. Apr. 21, 2026).

[24] Between May 2023 and May 2024, two thirds of enrollees were terminated for procedural reasons on average, according to state data. "Continuous Coverage Unwind Reports," Colorado Department of Health Care Policy and Financing. https://hcpf.colorado.gov/ccu-reports

[25] Katherine Wallat, "Lessons from the Public Health Emergency Unwind in Colorado." Colorado Center on Law and Policy, Feb. 17, 2026. https://copolicy.org/news/lessons-from-the-public-health-emergency-unwind-in-colorado/; "HCPF PHE Unwind Update to the Joint Budget Committee," Colorado Department of Health Care Policy & Financing, Sept. 19, 2024. https://content.leg.colorado.gov/sites/default/files/hcpf_phe_medicaid-09-19-24_.pdf

[26] During the 2026 legislative session, the Colorado legislature passed HB26-1429, "County Administration Public Assistance Programs," which begins the process of creating a streamlined service model with no more than 12 hubs, rather than the current 64-county system. https://leg.colorado.gov/bills/HB26-1429

mandatory exception or short-term hardship exception that deems them as demonstrating community engagement, would lose coverage due to administrative or procedural reasons (or in the case of a new applicant, may have their application denied and thus not enroll)."[27]

In Colorado, under simpler and more standardized renewal processes during the PHE unwind, the percentage of people terminated for procedural reasons, out of all people due for renewal, was over 35 percent in July and August 2023 and remained over 11 percent in August 2024, even as that process was winding down.[28] When considering procedural denials as a percentage of all those who lost coverage, states on average terminated 31 percent for cause, but 69 percent for procedural reasons.[29]

Colorado is diligently working on improving the IT system and creating a path to a more streamlined eligibility system, rather than a fully county-administered system. However, implementing those efforts will take two to four years.[30] The final product and eligibility structure should be far more cost-efficient, easy to use, and accurate. However, the transition itself may well put Colorado at a disadvantage during implementation.

## III. The IFR hampers states' ability to identify specified excluded individuals, causing loss of coverage due to administrative burden and potentially catastrophic health impacts.

### *A. The definition of "medical frailty" is overly restrictive. §§ 435.554, 435.557(f)*

Limitations imposed by the IFR that exceed the parameters of H.R.1 will put thousands of medically frail people at risk of loss of coverage. Moreover, these limits will burden community members, providers, and eligibility workers with excessive paperwork.

The IFR imposes restrictions that are contrary to statute. H.R. 1 excludes from work reporting requirements people who are medically frail or otherwise have special medical needs, including but not limited to five categories. The IFR would permit only medically frail people who fit within those five categories to qualify, limits the lookback period for evidence of qualifying conditions. It then goes a giant step further by adding a requirement that people show that their condition significantly impairs their ability to work. That standard is unclear, burdensome and difficult to document.

States know best what data is accessible and how their Medicaid program serves specific populations. They each need to determine how best to identify medical frailty

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[27] IFR at 33460.

[28] Continuous Coverage Unwinding Reports, Colorado Department of Health Care Policy & Financing. Retrieved July 28, 2026. https://hcpf.test.colorado.gov/ccu-reports

[29] Ibid.

[30] Funding Request for the FY 2026-27 Budget Cycle. Colorado Department of Health Care Policy and Financing. Jan. 2026. https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY27%2C%20S-08%20BA-08%20Changes%20to%20Federal%20Policy_Final.pdf

and the appropriate lookback period. Rather than giving states that flexibility, the IFR ties their hands based on speculation or without justification:

> "[W]e are not providing States with the option to add additional categories of people to the definition of medical frailty for community engagement purposes."[31]
> "[W]e believe that having a standard medically frail definition provides States with a more streamlined approach to medical frailty that will be easier to implement.[32]

Contrary to the broad intentions reflected in H.R.1, the IFR prevents states from thoroughly reviewing medical history for information about medical frailty. H.R.1 imposes no limit on the time period under review, while the IFR imposes a requirement that states consider only the prior 12 months of medical records based on an unfounded assumption that older information has no relevance to current conditions.[33] Infrequent visits may be a medical best practice, when a condition is chronic or congenital, or may reflect provider shortages, which limit how frequently an enrollee can see specialists.[34] A rural heart patient who sees a team of specialists only once every three years but is maintained primarily on medication may well be missed despite ongoing symptoms.

The IFR provides no basis provided for its assertion that "older information may not reflect the individual's current condition." [35] A person experiencing heart failure, an amputee, a person with debilitating arthritis or others with chronic conditions will not be re-diagnosed at regular intervals. Despite symptoms that limit functionality, they may take no medication or a medication that would not by itself provide sufficient evidence of medical frailty. This leaves states with no evidence in billing records to identify the severity, or even the existence, of their condition.

Identifying the medically frail population through diagnosis and service codes is difficult in Colorado, as it is in many states. Lag times are long between service delivery and its appearance in MMIS, [36] and Colorado (like many states) only requires that

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[31] IFR at 33373.

[32] Ibid.

[33] IFR at 33405.

[34] In the IFR, CMS seems to assume quick and easy access to a medical appointment despite ample evidence to the contrary. Christopher Weaver, Anna Wilde Mathews, Tom McGinty. "Medicaid Insurers Promise Lots of Doctors. Good Luck Seeing One." Wall Street Journal, Nov. 17, 2025. https://www.wsj.com/health/healthcare/medicaid-insurers-doctor-networks-appointments-72f9c11f; Jane M. Zhu, Ruth Rowland, Daniel Polsky, Inga Suneson, Simon F. Haeder, Deborah J. Cohen, K. John McConnell, "Medicaid managed care organizations' experiences with network adequacy." Health Affairs Scholar, Mar. 13, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC11970020/

[35] IFR at 33405.

[36] Kinda Serafi, "How Health Information Exchanges Can Identify Medically Frail Work Requirements Exemptions." Manatt, Feb. 18, 2026. https://www.manatt.com/insights/newsletters/health-highlights/how-health-information-exchanges-can-identify-medically-frail-work-requirement-exemptions

providers submit a claim within 12 months of service delivery.[37] [38] Thus, a service received 8 months before an enrollee's renewal may not appear in MMIS until many months later, and recent diagnoses or service needs that relate to the enrollee's current health status are likely to be unavailable.

In addition, states have been carefully developing data sets for diagnoses and service use that for months; these are now in question because of the new limitations in the IFR, creating additional workload for clinical, administrative and programming teams and jeopardizing *ex parte* processes. Staff not only has to revise those processes on very short notice, but must also figure out with minimal notice how to bring in "multiple domains" rather than relying on a code alone.[39] We see no way for states to adhere to those complex requirements while also honoring the requirement to minimize the need for enrollees to submit extra documentation.[40]

To add another layer of complication, lack of interoperability between CBMS and Colorado's Medicaid Management Information System (MMIS) means that use of MMIS information to exclude the medically frail will require a partly manual process and take scarce staff time. Notwithstanding the notion in the Community Engagement IFR that "reliable information available to the state" includes both information actually available and whatever information the state "should" have available,[41] it would take millions of dollars and many months of programming time to give Colorado's eligibility system easy access to current diagnoses and service use. Rather than limiting how states identify medical frailty, CMS should give states the flexibility and time to develop other methods that are reliable and will safeguard patient information.

The added IFR requirement that individuals show that their condition significantly impairs their ability to comply with community engagement requirements will prevent *ex parte* determinations for most medically frail enrollees. This adds an additional layer to the administrative burden on individuals and states. A likely concern of Congress, when including this exclusion, was to preserve coverage for people who faced increased risk of harm, disability, pain, or death if they were to lose Medicaid. Ignoring the consequences of coverage loss, the IFR instead adds to paperwork requirements. Enrollees who are already burdened by a medical or behavioral health condition will need to understand what is needed to show medical frailty and impairment in the ability to comply, and submit attestation or, no later than 2028, medical documentation.

States may propose to designate list of conditions that could indicate medical frailty and be presumed to significantly impair the ability to comply. But CMS signals

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[37] "Medicaid Timely Filing Limits by State: MCO and State Rules with Compliance Tips. Medicaid Claim Submission Deadlines By State." Medstates, https://www.medstates.com/medicaid-claim-filing-deadlines-2025/#MC3

[38] General Provider Information Manual, Colorado Department of Health Care Policy and Financing. https://hcpf.colorado.gov/gen-info-manual#TimelyFiling

[39] IFR at 33405.

[40] 42 USC 1396a(xx)(5).

[41] IFR at 33393.

that it may or may not agree, and it declines to include its own list in rule.[42] A more efficient and humane solution would have been to designate such a list in the IFR for categories of individuals who would face catastrophic outcomes if coverage were terminated.[43] This list might include, but is not limited to, people diagnosed with late-stage cancers, dialysis patients, transplant candidates, insulin-dependent diabetics, and people who have sickle-cell disease. Otherwise, faced with that uncertainty and threats of audit, states may end up requiring most or all who are potentially medically frail to attest separately or document, that the condition substantially impairs their ability to comply with work requirements.

Obtaining that medical documentation will pose separate challenges for both enrollees and providers. Enrollees will need to understand what is required, obtain necessary forms, promptly arrange for an appointment and then find transportation. They will also need to understand how to submit their documentation. Getting an appointment to document the condition and the level of impairment, as discussed earlier, can be difficult and may involve a wait of weeks or months.[44]

Providers will get no compensation for the time they will need to spend evaluating patients and filling out paperwork. If their judgment is questioned during a CMS audit, there is uncertainty about whether their enrollment as a Medicaid provider could be jeopardized or they could even risk allegations of fraud. This is not a phantom threat. [45]

A further complication is that the standard of significant impairment is unclear, and could refer to inability to work at all, inability to work 80 hours in any month, inability to work 80 hours consistently, inability to understand requirements, or inability to navigate complex reporting requirements. Under the threat of audits and financial penalties, states will be hard-pressed to adopt a standard that protects enrollees' coverage.[46]

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[42] IFR at 33376.

[43] Rather than including sickle cell disease in a list of conditions that satisfy requirements for medical frailty, and seemingly without regard for the debilitating effects of chronic pain and need for regular treatments, CMS specifically excludes it. IFR at 33375. "Stroke Rates Increasing in Individuals Living with SCD Despite Treatment Guidelines," American Society of Hematology, Sept. 20, 2024. https://www.hematology.org/newsroom/press-releases/2024/stroke-rates-increasing-in-individuals-living-with-scd-despite-treatment-guidelines

[44] Colorado's wait times for appointments are reportedly long, but national data similarly shows significant and increasing waits for new patients. Alex Caldwell, "Colorado's Unmet Demand for Specialty Care." Colorado Health Institute. July 16, 2019. https://www.coloradohealthinstitute.org/research/colorados-unmet-demand-specialty-care; *see also* "Daily Briefing. Charted: Wait for a doctor's appointment is longer than ever." Advisory Board, June 2, 2025.

[45] CMS proposes that it will determine which provider types can assess frailty and the screening criteria and method used by providers, and could re-examine the decision-making of the provider or the state when determining medical frailty and ability to comply with requirements. IFR at 33405-6.

[46] IFR at 33350, 33376, 33377, 33395, 33400, 33410.

### B. *People with behavioral issues, substance use disorders and mental health diagnoses face particular challenges.* §§ 435.554(5)(i)(B); 435.554(8)

SUD diagnosis is one of the five conditions that indicate medical frailty in H.R.1 and in the IFR. However, the IFR imposes an additional limitation regarding the period of stable recovery. CMS states that the exclusion is only available for those who are not in stable recovery; the citation provided for the proposition that someone in recovery for five years is necessarily in stable recovery is mischaracterized.[47] States will inevitably struggle to identify accurately when "stable recovery" began, since a person who has been sober for 3 years and whose last substance-related emergency department visit was 6 years ago may falsely appear to be in stable recovery. The arbitrary decision to impose a limitation based on "stable recovery" should not stand.

The shortened lookback for codes relevant to mental health and SUD issues will present particular challenges for people who struggle with those conditions. Stigma and national shortages in treating providers contribute to less access to treatment.[48] Behavioral health provider shortages exist statewide in Colorado but are worst in rural areas. There, 49 percent of residents report inadequate access to behavioral health providers, versus 40 percent for urban Coloradans. Rural Colorado patients also report being more likely to skip treatment due to stigma.[49] Stigma deters people from self-identifying a diagnosis when self-attestation is an option, and it is precisely that stigma that spurred Congress to establish the privacy protections codified in 42 CFR Part 2. This makes it even more important that states can consider diagnosis and billing codes from a longer time span.

Without a longer time lookback period, states will be hampered in their attempt to use patient records to identify and exclude enrollees with these conditions. The 5-year lookback period should be removed, with states having the option to consider a SUD diagnosis at any point in a patient's history, and to consider mental health or behavioral diagnoses within longer timespans if the state deems appropriate.

The exclusion for people engaged in a drug treatment or alcohol treatment program remains important, despite the option for this population to qualify as medically frail, because these individuals will not have to demonstrate significant impairment to their ability to comply with community engagement. However, that separate exclusion also includes unnecessary hurdles. Individuals should not be expected to know whether their treatment program fits the rigid definition of "program":

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[47] The cited article reiterates the definition of addiction from the National Institute on Drug Abuse ("addiction is a chronic, relapsing disorder") and focuses its recommendations on workforce supports for people with SUD. Michael R. Frone, L. Casey Chosewood, Jamie C. Osborne, and John J. Howard. "Workplace Supported Recovery from Substance Use Disorders: Defining the Construct, Developing a Model, and Proposing an Agenda for Future Research." *Occupational Health Science,* Oct. 24, 2022. *https://doi.org/ 10.1007/ s41542-022-00123-x*.

[48] Deborah Steinberg, "CMS Approach to Work Reporting Requirements Won't Work for People with Substance Use Disorders and Mental Health Conditions." Georgetown University Center for Children and Families, July 9, 2026. https://ccf.georgetown.edu/2026/07/09/cms-approach-to-work-reporting-requirement-wont-work-for-people-with-substance-use-disorders-or-mental-health-conditions/

[49] "Snapshots of Rural Health in Colorado," Colorado Rural Health Center, April 2026. https://coruralhealth.org/wp-content/uploads/2013/10/CRHC_Snapshot-2026-2026-01-07_DIGITAL.pdf

CMS should expand the definition to include for-profit treatment programs, many of which contract with Medicaid programs, after-care programs, methadone or other systems that involve medication-assisted treatment, and community-based programs like Alcoholics and Narcotics Anonymous.

### *C. The complex, multi-factor definitions for caregivers make it hard to understand and identify who is eligible and they make it hard for caregivers to qualify. § 435.554(a).*

Caregiving is a principal reason that people leave the paid workforce either temporarily or permanently.[50] In coming years, more people will be called upon to provide care, considering that the 80+ population is expected to increase by more than 50 percent in the next ten years.[51] People with disabilities also continue to live longer lives. Congress recognized the need for this exclusion, but the IFR as written prevents states from efficiently identifying eligible individuals.

Caregiving arrangements must retain flexibility to meet a recipient's needs while also preventing unnecessary institutionalization of people with disabilities and seniors. These needs do not align with the restrictive definitions in section 435.554(a). It is undeniable that managing medications, accompanying family to appointments, dealing with medical emergencies, arranging for paid care, and regular meal-preparation or other homemaking activities interfere with regular employment.

The definitions in the IFR that concern parents, caretaker relatives, guardians and family caregivers fail to address the full spectrum of caregiving. Caretaker relatives would be unable to qualify even if their role was essential, such as providing overnight care while a parent is at work, and even if they did not have or could not document "primary" responsibility for the person's care. Guardians would have to seek new documentation from a court, if existing paperwork did not reflect their caregiving responsibilities. Anyone caring for a person with disabilities would need to seek consent to share medical or other documentation to verify the person's disability, potentially threatening a relationship where the person receiving care is unaware of or reluctant to identify limitations.

Consider the family who cares for an older relative who can no longer regularly cook, clean, or manage medications. The elder needs transportation to appointments and help understanding a provider's instructions, but that person, understandably, may be unwilling to describe or document their limitations. The verification requirements in the IFR would violate that person's privacy and dignity, and put the people providing care in an untenable position, while also jeopardizing their Medicaid coverage and even their ability to continue caring for the older relative.

Unlike the RAISE Act definitions, which recognize the fluid, individualized relationship between family caregivers and those who receive care, the IFR creates a complex set of definitions and differing requirements for documentation. H.R.1

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[50] "Caregiving pressures top factor pushing women out of the workforce, Catalyst finds," Catalyst, Jan. 29, 2026. https://www.catalyst.org/en-us/about/newsroom/2026/caregiving-pressures-women-workforce

[51] Dustin Shandri, "The Impending Age Wave," NIC MAP, May 1, 2026. https://www.nicmap.com/blog/the-impending-age-wave-navigating-the-urgent-need-for-senior-housing/

language is inconsistent, referencing RAISE while limiting who can receive care and how care is provided. To be consistent with RAISE, potential recipients must include individuals with chronic or other health conditions, disabilities, or functional limitations. In addition, nothing in the RAISE definition or H.R.1 would require that a non-relative family caregiver provide a minimum amount of assistance to qualify.

During CCLP's July workgroup meeting about this exclusion, people asked challenging questions that highlighted the barriers to qualifying and the IFR's failure to establish a clear rubric:

- How would they know which subcategory they might fall into, and will they be required to know the appropriate subcategory when renewing?
- What state entity or system would sort out whether a person was a caretaker relative or family caregiver?
- How, in the absence of an employer or pay stubs, could it be documented that someone worked a particular number of hours, or was the primary caretaker?

The IFR definitions of those who receive care are also inappropriate. All caregivers who provide care to a person with disabilities would need to verify that the person meets the Americans with Disability Act level of disability. Having caretakers attest to that factor would be asking people to make legal and medical judgments they are not equipped to make. Requiring medical documentation would exclude all who could not arrange for an assessment by a qualified professional, and even qualified professionals might be reluctant to make what is essentially a legal determination.

While the definition of a child is more straightforward, identifying people who care for children is not. Except where a child under the age of 14 is part of the Medicaid household, states will be unable to make *ex parte* determinations of caregiver status, shifting the paperwork burden onto households and county staff who process renewals and applications.

In general, *ex parte* verification of caregivers will be difficult or impossible, despite federal requirements to maximize renewal processes that reduce burdens on individuals.[52] No person caring for a person with disabilities can be identified *ex parte*, because of the need for separate verification of the care recipient's disability, residence and other factors. Even when tapping sources of data that go beyond the usual state sources, researchers in Colorado were unable to identify potential caretakers.[53]

We oppose any limitations to self-attestation for caregivers, oppose the 80 hour requirement for family caregivers, and ask that states be given authority to create a simplified, layman's definition of disability.

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[52] 42 CFR 435.916.

[53] Rachel M. Everhart, Sarah Gillespie, Marcella Maguire, Sarah A Stella, Rebecca Hanratty, Tracy L Johnson, "Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients." Health Affairs Scholar, July 2026. https://doi.org/10.1093/haschl/qxag162

### *D. Overall, the multi-step process of qualifying as a "specified excluded individual" prevents states from renewing enrollees ex parte. The complicated process will lead to large-scale coverage loss for people who should not be required to comply with community engagement requirements.*

Requirements for identification and treatment of specified excluded individuals are contradictory and confusing. They create informational and logistical barriers for states and enrollees that will undermine their eligibility for coverage under H.R.1. Inevitably, in complying with verification requirements for exclusions, states may be violating requirements to minimize necessary documentation and maximize *ex parte* processing. Consider the following:

- "Because specified excluded individuals are not applicable individuals, States may not require such individuals to demonstrate or be deemed as demonstrating community engagement…" [54]
- "Section 1902(xx)(5) of the Act, implemented at § 435.557(b), requires States to conduct *ex parte* verification of compliance and deemed compliance with the community engagement requirements, and qualification as a specified excluded individual."[55]
- "[B]efore assessing compliance, the State must first attempt to confirm that the individual is an applicable individual as defined at § 435.551."[56]
- "[S]tates [must] verify if an individual meets the definition of a specified excluded individual at the time of application or renewal . . . "[57]
- "States must establish processes and use reliable information available to the State without requiring, where possible, additional information to verify that an individual meets the definition of a specified excluded individual."[58]

In the IFR, and as confirmed in recent guidance, states are required to conduct *ex parte* renewals under H.R.1.[59] This mandate includes an initial review of whether an applicant or renewing enrollee qualifies as a specified excluded individual. However, multi-step requirements for caregivers and the medically frail make early identification impossible. States are also told to refrain from requiring excluded individuals to demonstrate community engagement, but notice timelines within a six-month eligibility period make it impossible for them to delay collection of information on community engagement until after questions about excluded status are resolved. Specified excluded status hinges on conditions at the time of application or renewal, but *ex parte* processes and early identification must be done 2-3 months prior to an eligibility date, in order to

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[54] IFR at 33391.

[55] IFR at 33392.

[56] IFR at 33393.

[57] IFR at 33402.

[58] IFR at 33402.

[59] SMD#26-001. Re: Implementation of "Eligibility Redeterminations, Section 71107 of the "Working Families Tax Cut Legislation (Public Law 119-21)" CMS. March 6, 2026. https://www.medicaid.gov/federal-policy-guidance/downloads/smd26001.pdf

assess whether the person is a specified excluded individual, and if not, to leave sufficient time to collect information on community engagement.

*Ex parte* renewals are unlikely for the targeted population, leaving most Expansion enrollees with a set of complicated rules and multiple verifications. Arkansas' experience from 2019 is clear. During the operation of the waiver, advocates stated that "Individuals who aren't required to work to be begin with are losing their coverage because they failed to report, or to report adequately."[60] Notably, Arkansas's requirements were less burdensome than those established in the IFR. They included: 1) the ability to report exemptions at any point during the eligibility period; 2) no reporting requirement for people over the age of 50; 3) automatic exemption if someone had a prior determinations of medical frailty, with no need for additional paperwork.[61]

## IV. The IFR's inflexibility on mandatory and short-term exceptions will make it hard for individuals to qualify and hard for states to implement. §§ 435.553, 435.554.

Rather than interpreting this aspect of H.R.1 to align with other parts of the law, the IFR creates a scheme for mandatory exceptions that requires duplicative processes. These cumbersome requirements will confuse enrollees, and will make accurate noticing more difficult. The mandatory exceptions cover people who were either specified excluded individuals or were in a different eligibility category in the prior eligibility period. A more efficient, less burdensome way to implement these provisions would be to establish that renewing enrollees do not have to demonstrate community engagement in their first eligibility period as an Expansion adult, or in the first eligibility period after their status as a specified excluded individual is over.

The provision on release from incarceration within the prior 3 months could also have been modified in the context of 435.554(9), to clarify that individuals who were inmates at any point in the prior eligibility period would not have to demonstrate community engagement. Congress clearly signaled its intent to provide safeguards for incarcerated individuals, recognizing that months following a carceral stay are a period of transition and instability where health coverage is crucial. The rule, by creating confusing, overlapping exceptions and exclusions, would unnecessarily jeopardize coverage.

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[60] Loretta Alexander, "Losing Coverage: State Medicaid Work Reporting Requirements Stripping 18,000 Arkansans of Coverage in 2018." Arkansas Advocates for Children and Families, March 2019. https://www.aradvocates.org/wp-content/uploads/AACF.ArkWorks2B.webfinal.3.26.19.pdf.

[61] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Requirements Should Not Be a Model." Center for Budget and Policy Priorities, Aug. 8, 2023. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

The IFR provisions on optional short-term exceptions similarly complicate implementation and add limitations that go beyond the language of H.R.1. States do not have real-time information on hospitalization and will be unable to notify hospitalized people of the opportunity for a short-term exception. Hospitalized individuals, people who may be in the ICU or sedated or in pain, cannot be expected to inform the state of their status or request the exception. Loss of coverage would be catastrophic both in terms of the person's health and their finances.

The language in the IFR makes short-term exceptions immensely more complicated to obtain and to grant than H.R.1 allows. In H.R.1, the national disaster exception alone triggers the exception; in the IFR, states must show the disaster affects ability to comply with community engagement. In H.R.1, an exception is granted when a person or their dependent must travel out of the area for treatment of a serious medical condition; IFR imposes many additional conditions, including a demonstration that the dependent's need for out-of-area care interferes with the ability to comply with community engagement.

H.R.1 gives states authority to determine the process for requesting a short-term exception for hospitalization or medical travel; the IFR essentially takes away that authority. In H.R.1, there are no explicit notice requirements, and for good reason, since these short-term exceptions involve unpredictable events; without providing any rationale, the IFR requires notices about the availability of an exception, whether the exception is granted and when it ends. Almost by definition, it is impossible to provide advance notice of an unexpected event or to know with any accuracy when a hospitalization or period of out-of-state treatment will end.

## V. If the intended goal is to have Medicaid recipients attain stable work, a system that connects people to education, training and work and provides related work supports is necessary, but the IFR fails entirely to provide any such system. § 435.552

The IFR proposes that tens of thousands more people will need to connect to education, work and training but provides no guidance to states about how to do so. Nor is there sufficient time or funding for states to independently develop referral and support systems. At the same time, current budget proposals aim to slash funding further for workforce.[62] In contrast, other public benefits with mandatory work components have designated staff and systems that support access to work.

- People on TANF sign a contract that spells out intended employment goals and the county or contracted organization provides case management, often childcare, provides limited support services such as a bus pass or car repair, a cell phone or internet connection, etc.

[62] Megan Evans. "Partisan Funding Bill Proposes Deept Cuts to Workforce and Education Programs in FY27," NSC News, June 16, 2026. https://nationalskillscoalition.org/blog/news/partisan-funding-bill-proposes-deep-cuts-to-workforce-and-education-programs-in-fy27/

- SNAP Employment and Training, known as Employment First in Colorado, also helps with certain support services and job or education connections, though only half of Colorado's counties offer the program due to local match requirements.

The Medicaid program has no background in employment, no relationships with local employers, and no experience with systems that connect people with jobs and training. Overwhelmed and underfunded Workforce Centers in Colorado do not satisfy IFR requirements for a structured work program because they are largely focused on self-directed job search. To make matters worse, the population subject to community engagement requirements is many times greater than the relevant TANF and SNAP populations.

Rural areas often lack supports and infrastructure such as transportation, childcare and stable housing. These deficits pose serious obstacles to work and to community engagement. As stated by a rural county economic development professional, "I see firsthand that employers are hiring, but factors beyond an individual's control constrain our workforce pipeline. We continue to struggle with an extreme shortage of licensed childcare, limited housing options for workers, and transportation barriers that are unique to rural communities. These systemic challenges make workforce participation difficult and adding administrative work requirements to Medicaid risks creating another obstacle rather than helping people become employed." At a moment when rural communities and Colorado's farm economy are struggling with the impacts of drought[63] and federal cuts to programs that support rural Americans,[64] the IFR will effectively penalize families who have no pathway to sustainable employment.

Older workers also face unique challenges. First, they typically need more time to find a job.[65] Even in a tighter job market, it takes people over 55 twice as long to secure work than those who are 20-24. Men over 55, compared to women, face even longer stretches of unemployment.[66] Existing training or apprenticeship opportunities tend to be focused on younger workers and career entry, rather than on retraining older workers. Despite these challenges and the extension of work requirements in SNAP and Medicaid to 64, the Trump Administration has targeted for funding cuts one of the few

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[63] Tom Hesse, "Colorado producers look to cut losses and stay afloat, in extreme drought." CPR News, Jul. 15, 2026. https://www.cpr.org/2026/07/15/colorado-drought-farmers-struggle/

[64] Bob Bragg, "Farm News & Views: USDA staffing cuts, crop input costs and new farm technology." KSJD. July 14, 2026. https://www.ksjd.org/podcast/farm-news-views/2026-07-14/farm-news-views-usda-staffing-crop-costs-farm-technology

[65] Chuck Tanowitz. "Older workers are left behind by today's job market. They need a safety net." Harvard Kennedy School Student Policy Review. January 14, 2026.https://studentreview.hks.harvard.edu/older-workers-are-left-behind-by-todays-job-market-they-need-a-safety-net/

[66] Labor Force Statistics from the Current Population Survey. U.S. Bureau of Labor Statistics. https://www.bls.gov/web/empsit/cpseea36.htm; Megan Wilkins, "Unemployment Duration in the COVID-19 Pandemic: A Look at Jobseeker Demographics." U.S. Bureau of Labor Statistics, Dec. 2024. https://www.bls.gov/spotlight/2024/unemployment-duration-in-the-pandemic-a-look-at-jobseeker-demographics/home.htm

programs that serve older adults – WIOA's Senior Employment Services, which provides transitional jobs and work-based learning for seniors with low incomes.[67]

During their longer periods of unemployment, older Expansion enrollees would be more likely to lose access to much-needed healthcare. As group, they experience rates of chronic conditions that are higher than average – with two-thirds having at least one chronic condition, and almost one-third having two or more.[68] It is no surprise that the likelihood of having a chronic condition increases with age.[69]

## VI. The rule makes it difficult to comply with community engagement requirements through education and training, cutting off Medicaid enrollees from routes to better-paying jobs and financial stability. §§ 435.552(b),(c).

### *A. Rules for college students are overly complicated.*

The IFR requires that low-income students in community colleges and 4-year institutions learn a complex set of rules and submit extra documentation to maintain their coverage. *Ex parte* renewals would be few because Colorado, like many states, does not directly access information from the National Student Clearinghouse (NSC). Even states that do have access will need to contend with limitations in the NSC data set.[70] There are justified concerns about educational activities that the IFR omits and about privacy. For example, as Colorado educators pointed out in recent stakeholder meetings, community college students may also have dedicated basic skills tutoring hours which would not be captured by the formula for credit hours.[71] To the extent data is shared through databases, Colorado students express justified concerns about data privacy.[72] For their part, educators have questioned requests to share data, considering FERPA limitations on sharing without student consent.[73]

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[67] "NAWB Statement on House Appropriations Bill: A Call to Protect Workforce Development," National Association of Workforce Boards. Sept. 11, 2025. https://www.nawb.org/nawb-statement-on-house-appropriations-bill-a-call-to-protect-workforce-development/

[68] Percent of U.S. Adults 55 and Over with Chronic Conditions. Centers for Disease Control, Sept. 2009 https://www.cdc.gov/nchs/data/health_policy/adult_chronic_conditions.pdf. Newer government data shows that among adults 35-64, more than 75% have at least one chronic condition."About Chronic Disease," Centers for Disease Control, May 14, 2026. https://www.cdc.gov/chronic-disease/about/index.html

[69] Xingon Li, Caitlin Dreisbach, Carlina M Gustafson, Komal Patel Murali, Theresa A Koleck, "Estimated prevalence of multiple chronic conditions throughout adulthood using data from the *All of Us* Research Program. medRxiv [Preprint]. Oct. 18, 2024. Doi: 10.1101/2024.10.17.24315661.https://pmc.ncbi.nlm.nih.gov/articles/PMC11527047/

[70] "Summary Report: When Policy Moves Fast, We Build Responsibly: Responding to Medicaid Work Requirements with Purpose." Prime Health. https://www.primehealthco.com/workrequirements

[71] Ibid. at p. 18.

[72] *Case Summary of State of California v. U.S. Department of Health and Human Services,* Civil Rights Litig. Clearinghouse, https://clearinghouse.net/case/46754/ (last updated 4/6/2026). Prime Health p. 17.

[73] Ibid., p. 17.

More than half of Colorado college students attend part-time,[74] meaning most will need to work with their school or institution to ascertain whether they meet the half-time threshold; if they don't, they must understand how to calculate countable hours, and then also report work or volunteer hours. At the same time, approximately half of Colorado college students are reportedly facing hunger and housing insecurity.[75]

### *B. Provisions for adult learners are inadequate, considering the range of needs and the lack of current funding.*

The language in H.R.1 ("an educational program") includes, at a minimum, institutions of higher education and programs of career and technical education, and the rules inappropriately exclude individuals who face the biggest obstacles to a sustainable wage. We appreciate that the rules add high school equivalency programs as an approved education activity, but many adults do not have skills sufficient to enter a High School Equivalency (HSE) program. Students who are too far away from finishing high school require classes in Adult Basic Education or English as a Second Language (ESL). The IFR can and should align with SNAP, which in Colorado considers hours spent in Adult Basic Education, Literacy Instruction, and ESL as countable education hours.

Inconsistency between education rules in SNAP and Medicaid also create increased burdens. No apparent effort is made in the IFR to simplify reporting for low-income students. As one example, a low-income college student who attends a four-year college full-time can enroll in Medicaid but is ineligible for SNAP due to their full-time enrollment in school. This student must instead rely on food pantries or food banks while enrolled, and would now also have to manage additional paperwork to maintain their Medicaid enrollment. Reducing their credit load and getting employment could allow for receipt of SNAP but would then add to the administrative burden and jeopardize Medicaid enrollment. All such impediments slow graduation, increase dropout rates, and generally encumber society.

Access to adult education is insufficient to meet existing need, let alone the need generated by requirements in the IFR. In Colorado, the already paltry state funding for Adult Education was cut by one-third, down to $2 million per year from $3 million per year. While we appreciate that the rules explicitly add high school equivalency programs, we urge inclusion of all forms of Adult Education, including those that serve adults who do not have skills sufficient to enter a High School Equivalency (HSE) program. Would-be students are who are too far away from finishing high school are generally referred to an Adult Basic Education Class or an English as a Second Language class. In Colorado, Colorado SNAP considers hours spent in Adult Basic Education,

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[74] Joint Release, Colorado House Democrats, June 6, 2026. https://www.cohousedems.com/news/joint-releasepercent3A-icymipercent3A-governor-polis-signs-bill-to-modernizepercent2C-improve-higher-education-funding-formula

[75] Jenny McCoy, "A Growing Number of College Students in Colorado Are Facing Food Insecurity," The Colorado Trust, Collective Colorado. Jan. 10, 2024. https://collective.coloradotrust.org/stories/a-growing-number-of-college-students-in-colorado-are-facing-food-insecurity/Social Determinants of Student Success: Housing." Presentation, 2022. https://cdhe.colorado.gov/sites/highered/files/Housing.pdf

Literacy Instruction, and English Language courses as countable education hours.[76] Medicaid should do so as well.

It is also worth noting that Colorado does not "approve" Adult Education Classes. 435.552(b). The State Department of Education funds some Adult Education Classes and has certification for individual teachers, but 3rd party tests like GED® or TABE® - document or assess the outcomes. States must be given the flexibility to identify appropriate providers of adult education.

### *C. Education is an important step toward a sustainable income, but the IFR fails to consider or reduce current barriers to education.*

There are also practical obstacles to accessing education. By definition, the expansion population has income at or below 138 percent of the federal poverty level, which is not enough to meet basic needs in any county in Colorado for housing, food, transportation and healthcare.[77] With no funding provided for education or other work supports in HR1, few in this population will be able to access educational programs, regardless of how essential they are to job entry and advancement. As CCLP discovered in focus group discussions, many individuals living in poverty have exhausted their Pell eligibility on previous training that failed to yield employment, or are facing student debt that impairs their ability to get additional aid.[78]

## VII. Most Medicaid enrollees already work, but narrow definitions, data limitations and cumbersome reporting requirements for work and volunteering will prevent accurate reporting and result in wrongful terminations. § 435.552

We support broad definitions of work and community engagement. However, verification requirements in the IFR will result in widespread denials – despite people's engagement in designated work activities. In pat, this is because gig and occasional work is difficult to document, data lags limit access to data, states lack reporting systems for volunteering, and community-based organizations are inadequately staffed for supervision of volunteers.

Existing earnings databases are inadequate and costly. The state earnings database and The Work Number do not have earnings information for the many enrollees who do gig work, contract work, or occasional work. Costs to use The Work Number have risen stratospherically in past years, siphoning off scarce public dollars for

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[76] Description of Employment First Components. Colorado Office of Economic Security, Division of Economic & Workforce Support. Retrieved Jul. 31, 2026. https://drive.google.com/file/d/1vvdIhpriXhDpudFU6l-PROqcLKPCNLxJ/view.

[77] Anna Kucklick, Lisa Manzer, and Alyssa Mast. "The Self-Sufficiency Standard for Colorado 2022." Center for Women's Welfare, University of Colorado. Prepared for the Colorado Center on Law and Policy, Nov. 2022. https://selfsufficiencystandard.org/wp-content/uploads/2022/11/CO22_SSS.pdf

[78] Michelle Webster, "Surviving to Thriving. Pathways to Opportunity for Low-Income Women." Colorado Center on Law and Policy, Jan. 2015. https://copolicy.org/wp-content/uploads/2015/01/SurvivingtoThriving-2015.pdf

the benefit of a for-profit entity. [79] If the IFR is to require robust verification practices, states need affordable access to earnings data. Colorado's earnings database is a more affordable way to assess earnings for W-2 workers. However, employers submit data quarterly, meaning that little or no relevant data will be available for Medicaid members subject to 6-month renewals.[80]

Consider a July renewal where the member made over $580 in each month from February through May, more than satisfying community engagement requirements in Colorado.

- *Ex parte* review for earnings data must occur in April. Because of the 6-month eligibility period and communication and notice requirements, this leaves the state with a maximum of three to four months of earnings to assess out of the relevant six-month period.
- Colorado employers do not submit earnings data for the months January through March until April 30.
- As a result, the state system may have no earnings data from the relevant months, making *ex parte* renewal impossible.

An estimated quarter of Colorado's workers participate in the gig economy.[81] No system yet exists for verifying gig work earnings or for gig work hours. The IFR provides no guidance about how states should validate gig work hours.

Similarly, no system exists for the reporting of hours spent as a volunteer or in an apprenticeship, internship or non-credit educational experience, though stakeholders are collaborating on potential solutions. Current practices vary widely, with minimal or no tracking. Volunteer organizations in Colorado have identified the need for "comprehensive resources, clear guidelines, hotline support, multilingual materials, and trauma-informed supervisors."[82] Unless implementation is delayed and the IFR is revised to provide clearer guidance, those important needs will not be fulfilled.

## VIII. Without justification, the IFR requires verification to an extent that will prevent enrollees from qualifying for an exclusion or demonstrating community engagement.

Documentation requirements imposed in the IFR are excessive. Nearly all exclusions have multiple factors that must be proven through documentation; to

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[79] Kelly Mehorter, "Equifax Facing Class Action Lawsuit Over Allegedly 'Unacceptable' Price Increases for The Work Number." ClassAction.org, updated Jan. 21, 2025. https://www.classaction.org/news/equifax-facing-class-action-lawsuit-over-allegedly-unacceptable-price-increases-for-the-work-number

[80] "Wage Reporting," Colorado Department of Labor and Employment. https://cdle.colorado.gov/employers/unemployment-insurance-premiums/wage-reporting

[81] "How many gig workers are there?" Gig Economy Data Hub. https://gigeconomydata.org/basics/how-many-gig-workers-are-there

[82] "Summary Report: When Policy Moves Fast, We Build Responsibly: Responding to Medicaid Work Requirements with Purpose." Prime Health, p. 12. https://www.primehealthco.com/workrequirements

demonstrate community engagement may similarly require multiple documents to show time spent training, volunteering and working.

No justification has been provided in the IFR for the many verifications required or the refusal to accept self-attestation. Nowhere in the IFR does CMS even argue that accepting self-attestation might result in fraudulent enrollment. (In fact, fraud by beneficiaries is rare.[83]) The notion that most documentation is available electronically, and will not have to be individually identified and submitted, is wishful thinking. What is clear, though, is that with every piece of additional paperwork required, it will be harder for people to show community engagement or show they should be excluded; it will also be harder for states to timely renew people or process new applications; and states will be at greater risk of being penalized for missing documentation.

A household with a parent who has a heart condition, but is self-employed as a hair stylist, and with a young adult who takes classes, interns, and babysits on weekends is clearly working toward greater self-sufficiency. However, those two adults will be hard-pressed to navigate the verification requirements for all their different activities. County eligibility staff would have to process renewal packets and multiple verifications for work, school, and volunteering.

The submission process is itself is far more challenging than CMS acknowledges in the IFR. Lack of digital skills, lack of access to a computer or smartphone, lack of a digital connection or an adequate data plan – any or all of these things can make getting or keeping employment much harder. In addition, those issues make it difficult even to submit documentation and complete online forms. One of the few mentions of digital needs in H.R.1 is the elimination of counting internet service fees as an income deduction in SNAP – a step that makes it even less likely that low-income households can afford digital connection. Multiple forms of verification may be necessary to show compliance with community engagement, requiring multiple trips to a library or county office for a senior who lacks facility with an electronic interface, or a rural enrollee who lacks broadband.

Arkansas's experience shows that lack of internet access was a major factor in failure to comply with reporting requirements, even when the enrollee was working or met the requirements for an exemption.[84] Several primarily rural areas in Colorado similarly lack reliable broadband access. These complex reporting requirements will be a challenge.[85]

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[83] Eric Schurer, "Just How Wrong is Conventional Wisdom about Government Fraud?" The Atlantic, Aug. 15, 2013. https://www.theatlantic.com/politics/archive/2013/08/just-how-wrong-is-conventional-wisdom-about-government-fraud/278690/

[84] Benjamin D. Sommers, Anna L. Goldman, Robert J. Bendon, E. John Orav, Arnold M. Epstein, "Arkansas's Medicaid Work Requirements Contributed to Higher Uninsured Rate and No Change in Employment." The Commonwealth Fund, June 19, 2019. https://www.commonwealthfund.org/publications/journal-article/2019/jun/arkansas-medicaid-work-requirements-higher-uninsured-rate

[85] Ashton Cain, Emma Ward, James Murdoch, and Neel Chakraborti. "A Snapshot of Broadband Access in Rural Communities." 2m Research, OPRE, Dec. 2022. https://acf.gov/sites/default/files/documents/opre/broadband_special_topic_brief_jan2023.pdf

## IX. Enrollees will be deprived of due process.

### *A. Communications and notice requirements oblige states to send out multiple, potentially conflicting communications. Inevitably, this will prevent people from taking appropriate action, understanding the reason for termination, and being able to prepare for an appeal.*

Communications and notice requirements in the IFR would result in multiple communications with overlapping deadlines, preventing enrollees from understanding their obligations and complying with requirements.

Required factors:

- To maximize access to information that can facilitate more *ex parte* renewals, as the IFR and other federal regulations require, states must not send out renewal forms prematurely, i.e. no more than 8-10 weeks prior to the end of the eligibility period.
- Because of the need for verifications (including self-attestation, as available), few renewals will be *ex parte*.
- Renewal forms must include the opportunity to identify status as a specified excluded individual, a mandatory exception, or, where applicable, a short-term exception.
- Renewal forms are due to be returned to the county at least two weeks prior to the end of the eligibility period.
- After a renewal form is returned, requests must be sent to households seeking outstanding documentation that could establish eligibility for exclusions or exceptions or compliance with community engagement activities.
- Notices of noncompliance with community engagement must be sent to households at least one month prior to the end of the eligibility period.
- Notices of action must be sent at least 10 days prior to the end of the eligibility period.

The household described above on page 22 might receive and respond to communications from the state on the following timeline, if both adults responded promptly to requests for information and the county promptly processed documents received.

- July 1: Renewal packets received by the household, soliciting standard renewal information and information about potential exclusions, exceptions and community engagement activities. Those packets will be lengthy.
- July 25: Renewal packets mailed to the county or uploaded to PEAK, 3 weeks prior to the August 15 due date. The parent's packet contains some information about the parent's heart condition and income earned. The young adult's packet contains some information about school, her internship and her occasional babysitting.
- July 25: The notice warning of noncompliance with community engagement requirements is mailed, prior to receipt or processing of the renewal packets.

- August 1: The parent and young adult receive notices of noncompliance. (It is not possible for them to know whether the notice is an indication that information provided in the renewal packets was inadequate or whether information was not received.)
- August 2: The county sends a request for information to the parent, asking for documentation on her health condition and about her ability to comply with community engagement; they also request information on hours worked during each month of the eligibility period. The county also sends a request for information to the young adult, asking for documentation showing the number of volunteer hours for the internship and for school records showing the number of credits earned and documentation showing credits necessary for half-time enrollment.
- August 3: The parent and young adult re-send their renewal packets. (We saw this frequently during the PHE unwind, when it was not clear whether documentation had been received.) The county must also review these second packets to assess whether changes were made.
- August 6: The parent and adult child receive requests for information. The parent attempts to get documentation from her provider about her heart condition.
- August 10: The parent and adult child send documentation that they believe satisfies the requirements for documentation of work and school. The parent is unable to get documentation from her physician showing her diagnosis.
- August 14: Extra documentation received at the county.
- August 15: Prior to processing documentation, a notice of action terminating Medicaid is mailed to the parent and the young adult, stating that coverage is terminated. The termination notice to the parent may state that she failed to show qualification as a specified excluded individual, or may state that she failed to comply with community engagement requirements. The parent and young adult do not know whether information mailed on August 10 would be sufficient to change that outcome, or not.

This scenario illustrates how, even with the most responsive and engaged enrollees and timely mail service,[86] the compressed timeline and verification requirements will lead to poor outcomes. It will result in potentially excepted or excluded individuals being asked to provide duplicative or unnecessary documentation, violating federal requirements.[87] When people are receiving simultaneous demands for information about exclusions, exceptions and community engagement compliance, confusion is inevitable. And those inconsistent demands themselves violate federal and state rules that require communications to be clear and understandable.[88] States will be

[86] Adding to the challenge, Colorado's U.S. Postal Service has struggled with accurate, on-time delivery since privatization and since involvement of the Department of Government Efficiency (DOGE), particularly in rural areas. "Neguse, Bennet, Hickenlooper Call on USPS to Ensure Reliable Mail Delivery in Western Slope Communities, Prevent DOGE from Interference." Press Release, Apr. 16, 2025. https://neguse.house.gov/media/press-releases/neguse-bennet-hickenlooper-call-usps-ensure-reliable-mail-delivery-western

[87] 42 CFR 435.916(b)(2)(v)

[88] 42 CFR 435.902, 435.905(b); 10 CCR 2505-10 8.057

put in the position of having to issue notices of action that include multiple reasons with complex criteria regarding why a person has not qualified for an exception or exclusion as well as reasons that they fall short of compliance with community engagement requirements. In attempting to comply with the IFR, state actions will defeat the requirement that notices enable recipients to understand the reason for a termination, whether to appeal, and how to prepare a rebuttal.[89]

Considering Colorado's well-documented problems with providing accurate notices[90] and documented notice deficiencies in other states,[91] along with the many complex new communication requirements, there is little to no chance that notices will be error-free and clear. In fact, Colorado's existing plans to devote programming capacity to notice improvements will need to be set aside to accommodate the many new IFR requirements.

### *B. During reconsideration periods, due to the IFR's conflicting rules for applicants and renewing enrollees, thousands of renewing enrollees will be subjected without notice to new community engagement standards.*

Longstanding federal rules treat a renewing enrollee as an applicant during the reconsideration period.[92] When eligibility rules for renewing and new applicants are the same, data suggests that half of those seeking reconsideration can have coverage reinstated.[93] However, by establishing different community engagement criteria for renewing enrollees and new applicants, the IFR will subject renewing enrollees who end up in a 90-day reconsideration period to a new set of rules, without advance notice, that will make it more difficult to regain coverage.

The failure to provide notice of the new standards that apply during a reconsideration period interferes with people's ability to provide pertinent information. People faced with the need to provide multiple documents related to medical condition, caregiving, volunteering or work may be unable to collect and submit all documents

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[89] The Fourteenth Amendment establishes due process requirements that courts have consistently interpreted as requiring clear, accurate, individualized notices in public benefits cases. *Goldberg v. Kelly,* 397 U.S. 254 (1970)*; Ortiz v. Eichler,* 794 F.2d 882 (3d Cir. 1986). *Rodriguez ex rel.Corella v. Chen,* 985 F. Supp. 1189, 1194-95 (D. Ariz. 1996). *Chianne D v. Harris,* 3:23-cv-00985-MMH-LLL (M.D. Fla.).

[90] Medicaid Client Correspondence Performance Audit, State of Colorado Office of the State Auditor. Sept. 2020. https://content.leg.colorado.gov/sites/default/files/documents/audits/1936p_medicaid_client_correspondence_-_september_2020.pdf; Medicaid Correspondence Performance Audit, Colorado Office of the State Auditor, Sept. 2023. https://content.leg.colorado.gov/sites/default/files/documents/audits/2261p_medicaid_correspondence.pdf

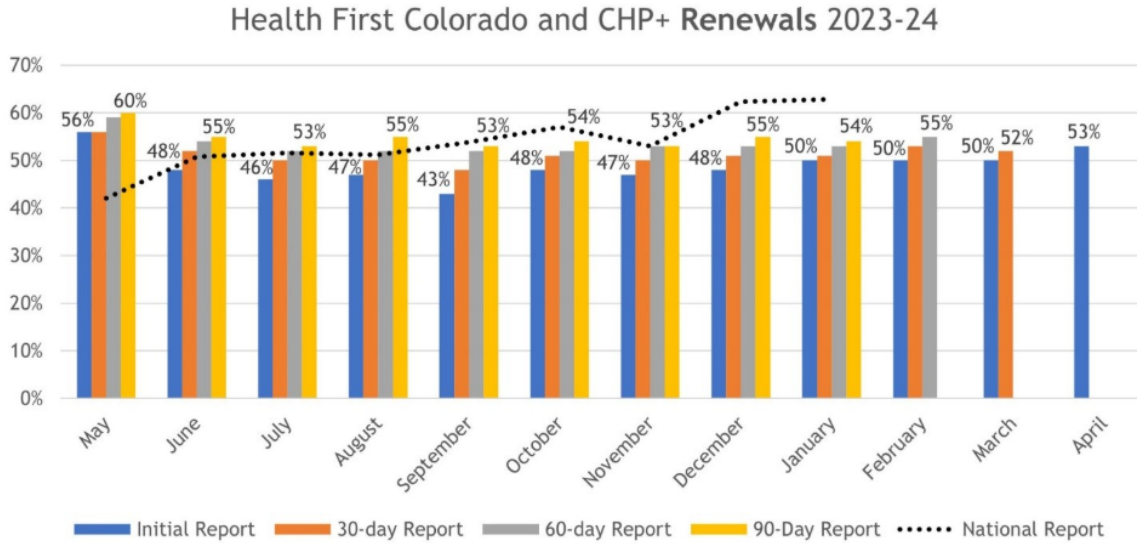
[91] *Case Summary of Chianne D. v. Weida,* Civil Rights Litig. Clearinghouse, https://clearinghouse.net/case/47624/.

[92] 42 CFR 435.916(a)(3)(iii).

[93] Arizona reported that half of individuals who were reconsidered for coverage during the 90-day period after termination were ultimately found eligible for Medicaid. Bradley Corallo, Amaya Diana, Jennifer Tolbert, Anna Mudumala, and Robin Rudowitz, "Unwinding of Medicaid Continuous Enrollment: Key Themes from the Field." KFF, Jan. 10, 2024. https://www.kff.org/medicaid/unwinding-of-medicaid-continuous-enrollment-key-themes-from-the-field/

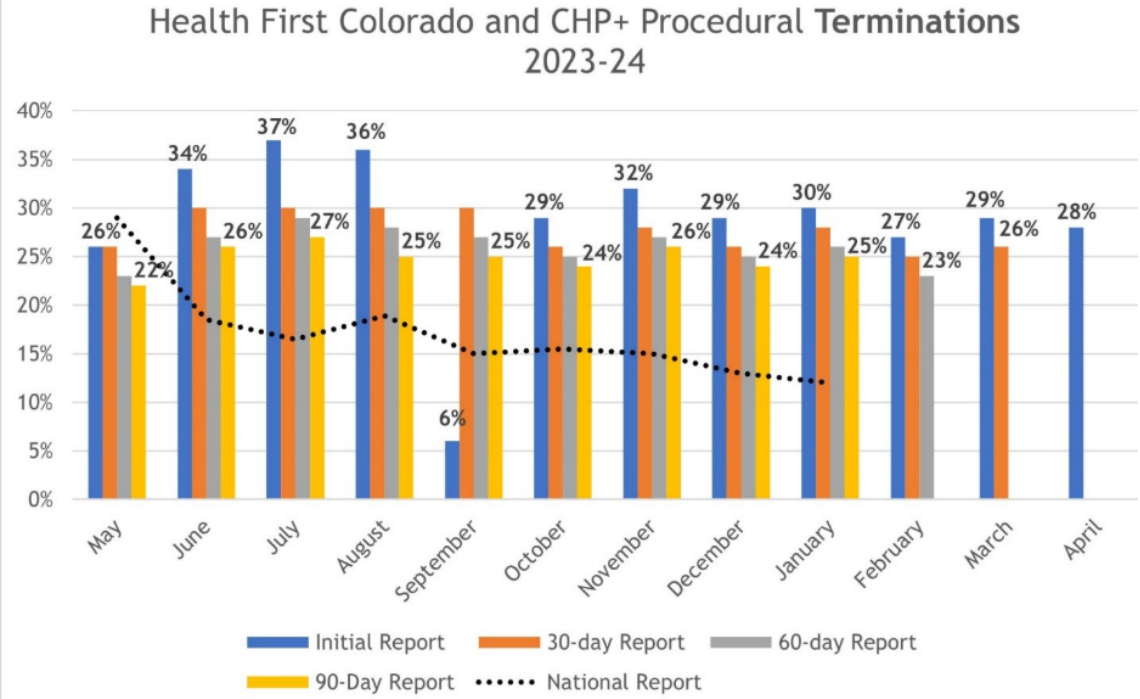
prior to the end of the eligibility period; once the person is in the reconsideration period, documents already submitted may be irrelevant.

Colorado's reconsideration rates during the PHE unwind were particularly high, suggesting that a large percentage of Expansion enrollees could be subjected to this sudden change in rules. The blue bars in the graph below show that between 43 percent and 56% of renewals were approved as of the eligibility end date.[94] The yellow bars show that many Coloradans regained coverage during the 90-day reconsideration period, increasing renewals by 4 to 10 percent each month. The national averages are represented by the dotted line.




A chart showing the converse, specifically the rate of termination and how that was affected by the reconsideration period, follows. Here, too, the national averages are represented by the dotted line.

[94] Colorado Department of Health Care Policy and Financing, October 2024. Archived from hcpf.colorado.gov/ccu.




Data from Colorado suggests that even people who submit information in a timely manner may end up in a reconsideration period and risk termination under the new applicant standards. During the PHE unwind, overworked county staff fell weeks or months behind in processing renewal packets that members had submitted.[95] Some of those packets were submitted through PEAK, the online portal, but many others were mailed in or dropped off at county offices. Some were date-stamped promptly but many others were not, as paper renewals piled up and waited to be scanned into the system.

A host of reasons contributed to shifting Coloradans into the 90-day reconsideration period during the PHE unwind. Renewal packets and documentation that enrollees upload through the online public benefits app, PEAK, do not automatically upload into the state's public benefits management system. Instead, county staff are required to take extra steps to review and process that documentation. When limited county staffs were unable to promptly process documents submitted by mail or in person or uploaded through PEAK, coverage sometimes terminated automatically on the renewal date. CCLP continues to hear that failure to process documentation results in termination, even when documents have been submitted prior to a renewal deadline.

As discussed at length above, IFR requirements are more stringent than HR1 allows, limiting the types of verification that can be accepted and expanding the number of factors that require verification. Those requirements will vastly increase the amount of paperwork involved in a renewal. Individuals in a variety of circumstances will end up subject to reconsideration and shifting eligibility rules. These include individuals who

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95 "HCPF PHE Unwind Update to the Joint Budget Committee," Colorado Department of Health Care Policy & Financing, Sept. 19, 2024.
https://content.leg.colorado.gov/sites/default/files/hcpf_phe_medicaid-09-19-24_.pdf

submit documents on time, but whose counties are backlogged; individuals who submit documents by mail in areas of the state where mailings are delayed; individuals who submit documents after the end of the eligibility period. Without notice, people seeking to demonstrate they qualify for exclusions or exceptions or that they comply with community engagement activities, will be subjected to more stringent requirements.

- An enrollee who meets requirements for renewal because their child was 13 earlier in the prior eligibility period would be ineligible when being considered under the rules for new applicants during the reconsideration period, where only the prior month is considered.
- A person who met the federal income standard in each of the months one through five of their six-month renewal period would be ineligible when being considered under the rules for new applicants during the reconsideration period, where only the month prior to their last submission is considered.

To avoid violating the due process of renewing enrollees, the IFR must allow Expansion enrollees to qualify during reconsideration using the same standard that applies at renewal.

## X. The human and economic impact of these policies is immense and will have disproportionate impacts on older people, people with chronic conditions, and people who face barriers to work.

Forecasts made prior to publication of the IFR suggested that tens of thousands of Coloradans and millions of eligible Americans would lose coverage due to reporting burdens and work requirements. With the changes and additions imposed in the IFR, we expect those numbers to be substantially higher. HR1 did not allow states adequate time to prepare for the fundamental system changes needed, and the IFR – by introducing new and different requirements only months before noticing begins – makes it still more difficult for states to prepare systems, ensure that eligibility units are adequately staffed, refine notices, and reprogram benefits management systems.

Coloradans with disabilities and chronic conditions, people with substance use disorders, people with unstable housing, and older people will be hit hardest. Many thousands will experience coverage loss, medical debt, and reduced access to healthcare. It is common sense that a caretaker's loss of Medicaid will affect their ability to care for a parent, or that dropping out of school affects a student's self-sufficiency later in life. Personal impacts will be devastating.

And the increasing number of uninsured Coloradans will also affect the financial viability of clinics and hospitals.[96] For patients with private and employer-based coverage, access to care will be reduced. Colorado has been through this before: after steep coverage losses related to the PHE unwind, Colorado saw direct impacts on its safety net that affected all community members seeking access to care.[97] Already,

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[96] Ellen O'Grady. "The Big Ugly Threat to Safety Net Hospitals." Public Citizen, March 31, 2026. https://www.citizen.org/article/big-ugly-threat/

[97] Jennifer Brown, "Jobs, programs are cut at two Colorado mental health centers amid Medicaid 'unwind'." The Colorado Sun, Oct. 2, 2024. https://coloradosun.com/2024/10/02/mental-health-center-

coverage loss in the ACA marketplace related to HR1 has resulted in more uninsured and underinsured patients being unable to cover medical costs. As stated by Laura Kaiser, the chief executive of one hospital group, "What that tells me is that there are patients who are completely unable to pay.... We're really crushing people who are desperately trying to pay their bills."[98] Executives at HCA Healthcare reported that formerly insured patients were now without coverage, and the company warned investors that they would see "roughly $1 billion less in operating profits this year."[99]

In conclusion, we urge CMS to withdraw this rule and make necessary changes to prevent irreparable harm to the health and economic wellbeing of Medicaid enrollees and their families. Any revised rule must align with HR1. It must give appropriate consideration to barriers to work or other forms of engagement. It must provide a reasonable route to excluding or excepting people from requirements due to health challenges, caretaking responsibilities, and other factors identified in HR1. Due process failings must be addressed. And it must alleviate the enormous administrative burdens on enrollees and state staff, along with the considerable impact on state budgets. Given appropriate flexibility in the first 1-2 years of implementation and with simplified requirements thereafter, states will be able to both protect their residents' wellbeing and comply with the law.

If you have any questions regarding these comments, please contact Bethany Pray, bpray@copolicy.org.

Sincerely,

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cuts/; Dustin Moyer, "Saving Our Medicaid Safety Net." Aspen Times, Nov. 22, 2024. https://www.aspendailynews.com/opinion/article_a07aa7b0-a97e-11ef-98c5-5ff6da1f37cf-429cd2c5

[98] Reed Abelson, "Uninsured Patients Rise Sharply, Hospitals Report, Citing Obamacare Cuts." The New York Times, July 30, 2026. https://www.nytimes.com/2026/07/30/business/aca-obamacare-health-insurance.html

[99] Ibid.