Skills2Compete–Colorado

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Submitted online via Regulations.gov

July 31, 2026

Mr. Mehmet Oz
Administrator
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 Administrator Oz:

Skills2Compete Colorado submits these comments on the interim final rule with comment period titled "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP); Implementing Medicaid Community Engagement Requirements for Certain Individuals," CMS–2454–IFC, RIN 0938–AV20.

I. Introduction and summary of requested actions

Skills2Compete Colorado submits this comment from the perspective of a multi-sector coalition working at the intersection of adult education, postsecondary education, workforce development, business, and anti-poverty advocacy. Coordinated by the Colorado Center on Law & Policy, Skills2Compete Colorado serves as the Colorado affiliate of the National Skills Coalition and works to ensure every Coloradan can pursue employment and upward mobility through skills training and education beyond high school. Because the IFR treats education, training, work program participation, and related activities as central pathways for complying with community engagement requirements, the coalition's experience with adult learners, workforce systems, training providers, community colleges, employers, and community-based organizations is directly relevant to whether the rule can be implemented accurately. Those pathways will require coordination among Medicaid agencies, counties, workforce centers, adult education providers, community colleges, training providers, community-based organizations, employers, navigators, and other public and private partners.

Skills2Compete Colorado recognizes that HR-1 requires states to establish Medicaid community engagement requirements for certain individuals, and this comment does not ask CMS to disregard that statutory directive. Instead, we ask CMS to implement section 1902(xx) in a way that is easy to administer, supported by evidence and prior experiences, and designed with intention to prevent eligible, compliant, excluded, or deemed-compliant individuals from improperly losing Medicaid coverage because of administrative complexity, insufficient notice, program unavailability, inaccessible reporting systems, or other verification failures.

Our comment focuses on the implementation choices that remain within CMS's control. Congress delegated to CMS the authority and responsibility to establish criteria, procedures, standards, reporting requirements, verification rules, notice requirements, and oversight mechanisms necessary to implement section 1902(xx) accurately.[1] The agency's choices will determine whether the community engagement requirement identifies actual noncompliance or instead leads to coverage losses among people who are working, enrolled in education, participating in training, engaged in work programs, providing caregiving, eligible for exclusions or exceptions, or otherwise satisfying the requirements.

Across the sections that follow, we ask CMS to take several actions.

First, CMS should correct unsupported, overstated, or selectively characterized statements in the IFR's discussion of evidence and the rationale underlying this rule. CMS should distinguish direct evidence concerning Medicaid work or community engagement requirements as a policy from general research on employment, income, health, financial stability, and social connection.

Second, CMS should consider directly relevant evidence from Medicaid, SNAP, TANF, and other public benefit programs showing that work requirements often reduce program participation without producing sustained gains in employment, earnings, health, or self-sufficiency. CMS also cites the experiences of Arkansas and Georgia, yet is not clear how they incorporated lessons learned, especially related to procedural disenrollments and employment outcomes, into the rule detailed in this IFR.

Third, CMS should distinguish substantive noncompliance from procedural inability to verify compliance. Missing data, failed data matches, inaccessible reporting systems, delayed records, and nonresponse to confusing notices should not be treated as evidence that a person failed to satisfy the requirement.

[1] Areas include: Compliance with the listed activities must be determined "in accordance with criteria established by the Secretary through regulation." Verification at redetermination must occur "in accordance with procedures specified by the Secretary." Ex parte verification must occur "in accordance with standards established by the Secretary." Noncompliance procedures and notices must operate "in accordance with standards specified by the Secretary."

Fourth, CMS should strengthen the IFR's ex parte verification framework so that states must check all reasonably available data sources and pathways before requesting documentation from the individual or initiating noncompliance procedures.

Fifth, CMS should make education and work program pathways clear and verifiable. States should not be left to make inconsistent determinations about which programs available to individuals subject to the requirements can count without federal guidance.

Sixth, CMS should address whether work program and education pathways are practically available, affordable, accessible, and adequately resourced before treating them as meaningful compliance options.

Finally, CMS should establish monitoring, corrective-action, and pause triggers when state data indicate procedural coverage loss, failed verification, disproportionate impacts, high reinstatement rates, or other signs that state systems are not accurately implementing section 1902(xx).

II. Statutory and legal framework

Despite our fundamental belief that work requirements are not good policy and do not lead to increased employment for those subject to them, Skills2Compete recognizes that section 71119 of HR-1[2] clearly requires states to establish Medicaid community engagement requirements for certain individuals as a condition of eligibility, and that CMS does not have the ability to propose a rule to the contrary. As such, this comment does not ask CMS to disregard section 71119, to waive the community engagement requirement, or to prohibit states from enforcing the requirement against individuals who are subject to it. Instead, we are requesting that CMS implement section 1902(xx) in a way that is consistent with the statute, supported by the record, data and research, and designed, to the extent possible, to prevent wrongful or incorrect denials or terminations of Medicaid coverage for eligible individuals.

In this interim final rule, CMS is making implementation choices that will determine whether states accurately identify who is subject to the community engagement requirements, who is excluded, who is deemed to be in compliance, who has completed a qualifying activity, how compliance is verified, what information Medicaid members must submit, when noncompliance procedures begin, what notices say, and what data CMS collects to monitor implementation. CMS has authority to make implementation choices where section 1902(xx) assigns the Secretary responsibility to establish criteria, procedures, standards, verification rules, reporting requirements, and related implementation choices, so long as those choices remain within the boundaries set by Congress. Although *Loper Bright Enterprises v. Raimondo*[3] requires courts to exercise independent judgment in deciding

[2] PL 119-21
[3] 603 U.S. 871 (2024).

whether an agency has acted within its statutory authority, the Supreme Court recognized that an agency may exercise discretion where the best reading of a statute delegates implementation authority to the agency. Here, many of the safeguards requested in this comment concern the procedures and standards CMS is directed by Congress to establish in order to implement section 1902(xx) accurately.

Furthermore, reasoned decision-making principles should also apply to CMS's implementation choices, even if not required for an interim final rule. In *Motor Vehicle Manufacturers Association v. State Farm*[4], the Supreme Court explained that an agency must examine relevant data and articulate a satisfactory explanation for its action, including a rational connection between the facts found and the choice made. The courts have determined that an agency rule is arbitrary and capricious if the agency fails to consider an important aspect of the problem, offers an explanation that runs counter to the evidence before it, or relies on reasoning so implausible that it cannot be ascribed to agency expertise. We have flagged a number of areas throughout our comment where we feel CMS did not follow this principle.

These principles are important to mention because CMS has invited the public to comment on the IFR and stated that comments received will be considered in deciding next steps. The fact that section 71119 directed CMS to issue an interim final rule and provided that actions taken to implement section 71119 are not subject to 5 USC 553 does not eliminate the need for CMS, having solicited public comments and committed to consider them in deciding next steps, to address significant evidence and provide a reasoned explanation for implementation choices that remain within the agency's control. Accordingly, CMS should treat the issues raised in this comment as significant to the rule's factual basis, implementation design, burden estimates, monitoring, and stated rationale. These issues include whether the evidence CMS cites actually support its claims about loneliness, employment, health, and financial stability; whether prior Medicaid work requirement experiences show coverage loss without employment gains; whether the rule adequately distinguishes substantive noncompliance from procedural inability to verify; whether education and work program pathways are usable and verifiable; whether members will receive adequate notice and meaningful opportunities to correct errors in states' determinations of eligibility; and whether CMS will collect the data needed to monitor procedural loss, reinstatements, fair-hearing outcomes, application drop-offs, renewal drop-offs, and compliance pathways used by those required to meet the community engagement requirement.

For each request in this comment, CMS should do one of three things: adopt the change or requested clarification; identify the specific statutory text that prevents them from doing so; or explain, with evidence and reasoned analysis, why the requested change or clarification is unnecessary for implementing section 1902(xx). Where HR-1 requires a particular rule or

[4] 463 U.S. 29 (1983).

outcome, CMS should say so. Where CMS has discretion, CMS should explain how its choices reflect the evidence in the record, why it rejected alternatives that may be less burdensome for Medicaid members and state and county administrators, and how it will prevent eligible, compliant, exempt, or deemed-compliant individuals from losing Medicaid coverage because of administrative barriers or procedural failures rather than actual noncompliance with Medicaid community engagement requirements.

III. CMS must correct unsupported, overstated, and selectively characterized claims in the IFR.

Congress directed CMS to implement the Medicaid community engagement requirements established in section 1902(xx) of the Social Security Act by HR-1. This statutory directive does not mean that CMS should not describe the evidentiary record it relied on in creating this IFR accurately, acknowledge the limitations and contrary findings of the sources it cites, or explain how the evidence supports the choices made by the agency in this IFR.

Currently, CMS makes a series of claims related to loneliness, employment, income, financial stability, health, and states' prior experiences with work requirements in Medicaid to support the agency's assessment of the expected outcomes and benefits from community engagement requirements. For example, CMS states that the requirements have the potential to help Medicaid members "escape isolation and dependency," build confidence, achieve self-sufficiency, obtain financial stability, and improve their physical and mental health. These statements form an important part of the rule's stated rationale and justification for the decisions made by CMS throughout.

As part of our review of this IFR, we analyzed the sources cited by CMS as support for many of the claims made in the preamble. Appendix A includes the results of this assessment, and how we'd like CMS to address the issues and deficiencies we identified. For instance, some cited sources examine a related subject without providing support for the specific claim made by CMS. Others document associations or relationships that CMS appears to characterize as evidence of causation when they are not. Some sources even contain meaningful qualifications or findings that point towards a different policy conclusion than those made by CMS. It also appears that CMS cited states' prior experiences with implementing work or community engagement requirements without also noting some of the more concerning outcomes related to coverage loss, access to health care, state administrative costs, and lack of evidence these policies resulted in increased employment.

Overall, we ask that CMS revise the preamble to distinguish among three categories of statements or claims it makes in the IFR: findings that are support directly by studies or evaluations of Medicaid work or community engagement requirements; findings that are drawn from general literature on related or adjacent topics such as employment, income, health, or loneliness; and policy assumptions or judgments made by CMS that are not

supported by a cited source or sources. We ask that CMS cite sources that demonstrate the connection between work or community engagement requirements in Medicaid and the outcomes the agency predicts. General associations between related topics, such as income or financial stability, are helpful and provide relevant background, but they do not prove or document that participation in the activities specified in the rule as a condition of eligibility for Medicaid will result in the outcomes or benefits CMS claims.

In the remainder of this section, we discuss specific concerns we have with the way CMS characterized sources in support of the claims it makes in the IFR. We include more detailed concerns in Appendix A, and ask that CMS review and respond to those concerns as well as those raised below.

A. The cited literature on loneliness does not show that Medicaid community engagement requirements will reduce loneliness or dependency on public programs.

CMS states in the IFR that isolation and loneliness have become an epidemic, and that these community engagement requirements may help members escape social isolation and dependency on government benefit programs. The sources the agency cites in support of these claims do establish that loneliness should be an important public health concern, however, they do not establish that the requirements of the IFR will reduce loneliness. In other words, the sources do not provide evidence that the rule, as written, will lead to less loneliness, even if there is a documented relationship between employment and reduced loneliness.[5]

Instead, the sources cited by CMS focus on the prevalence of, correlation to, or health consequences of loneliness. They suggest that factors such as age, mental health status, social anxiety, family and romantic relationships, perceived social support, and satisfaction with social interactions all play a role in the prevalence and severity of loneliness.[6] Some of the cited sources suggest that unemployment is associated with loneliness without testing whether employment causes loneliness to decline.[7] None evaluate if a policy like the one written by CMS in the IFR has a significant effect on loneliness.

In addition, the sources in the IFR make other findings or conclusions that complicate the claims made by CMS to justify this rule. One study finds that social anxiety and difficulty approaching others are among the strongest factors associated with loneliness.[8] The

[5] Bruce, L. D., Wu, J. S., Lustig, S. L., Russell, D. W., & Nemecek, D. A. (2019). Loneliness in the United States: A 2018 national panel survey of demographic, structural, cognitive, and behavioral characteristics. *American Journal of Health Promotion, 33*(8), 1123–1133. https://doi.org/10.1177/0890117119856551.

[6] Bruce et al. (2019); Shovestul, B., Han, J., Germine, L., & Dodell-Feder, D. (2020). Risk factors for loneliness: The high relative importance of age versus other factors. *PLOS ONE, 15*(2), Article e0229087. https://doi.org/10.1371/journal.pone.0229087.

[7] Bruce et al. (2019); Buecker, S., Mund, M., Chwastek, S., Sostmann, M., & Luhmann, M. (2021). Is loneliness in emerging adults increasing over time? A preregistered cross-temporal meta-analysis and systematic review. *Psychological Bulletin, 147*(8), 787–805. https://doi.org/10.1037/bul0000332.

[8] Bruce et al. (2019)

authors recommend social supports, decreasing social anxiety, and promoting healthy daily behaviors as ways to address loneliness—not community engagement requirements. Another study finds that age is the factor that explains more of the measured variation seen in loneliness than other demographic or neighborhood variables.[9] A meta-analysis of the literature on loneliness does show a historic trend of increasing loneliness among "emerging adults"[10]; however, the authors also acknowledge that the broader evidence is inconclusive about whether the growing incidence of loneliness qualifies as an "epidemic".[11] None of the studies suggest or support the idea that requiring 80-hours of specific activities as a condition for Medicaid will address any of the factors contributing to loneliness identified in the cited research.

CMS should narrow its discussion of loneliness in the IFR, and state that the cited literature establishes the importance of social connection while providing no direct evidence that Medicaid community engagement requirements improve social connection. If CMS wants to continue to claim reducing loneliness is one of the anticipated benefits of this rule, the agency should identify evidence showing that work requirements in Medicaid lead to that outcome among those affected by the requirements. We also ask the agency to consider the possibility that a Medicaid community engagement requirement may instead lead to increased stress, anxiety, or isolation for some affected Medicaid members. The cited sources describe a close relationship between loneliness, mental health conditions, stress, and financial insecurity.[12] Yet, the rule does not explain how the threat or actuality of losing health coverage, difficulty finding or enrolling in qualifying activities, or increased reporting requirements and administrative burden might also affect these factors. In some cases, the cited sources suggest this rule may actually cancel out any of the reduction in loneliness that may come from increased employment.[13]

Last, we ask that CMS correct its statement that lacking social connection is "as harmful as smoking 15 cigarettes per day." This comparison is drawn from a chart in a cited source but is from an entirely separate study.[14] Furthermore, the figure in the cited source shows that CMS did not correctly quote the finding—the charts says smoking "fewer than 15 cigarettes", yet was cited in the IFR as just "15 cigarettes".[15] CMS should remove this statement or correct it to accurately reflect what the cited source supports.

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[9] Shovestul et al. (2020).
[10] Individuals between the ages of 18 and 29 years.
[11] Bueker et al (2021).
[12] Zafar, Q., Khan, M. A., Warsi, A. Z., & Iqbal, L. (2024). Economic strain and recovery trajectories in mental health: The role of financial stability in mental health outcomes. *Review of Applied Management and Social Sciences*, *7*(4), 345–358. https://doi.org/10.47067/ramss.v7i4.385.
[13] Zafar et al. (2024).
[14] Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. *American Psychologist, 72*(6), 517–530. https://doi.org/10.1037/amp0000103.
[15] Holt-Lunstad, Robles, and Sbarra (2017).

B. The cited employment and health literature supports, at most, a qualified association between employment and health, not the conclusion that Medicaid community engagement requirements will improve health.

In the IFR, CMS states that employment is an important factor "leading to" long-term health and well-being; and that obtaining and maintaining stable employment improves physical and mental health. The agency also links a well-designed community engagement requirement policy to improvements in Medicaid members' economic, physical, and mental well-being. The cited sources may support a general association between employment and health, but they do not establish that Medicaid community engagement requirements will cause affected individuals to obtain stable employment or experience improved physical or mental health.[16]

They do, however, show that employment and health are associated with one another, and that the relationship likely operates in both directions.[17] When people are healthy they are better able to find work and remain employed. And while people who work may be better able to maintain their physical and mental health, this is not a guarantee.[18] The cited sources also suggest employment's effect on health can depend on factors like wages, job stability, predictability of work schedules, other aspects of working conditions and job quality, socioeconomic status, and other characteristics.[19] Low wages, unstable employment, unpredictable schedules, and poor job quality are likely to substantially offset the identified health benefits that result from employment.[20] For the adult population that is most impacted by section 1902(xx), Medicaid eligibility is generally limited to individuals with incomes up to 133 percent of the federal poverty line. This means the population who will be affected by community engagement requirements is likely to include workers in low-wage, unstable, or irregular employment, calling into question the benefits of this policy purported by CMS.

One cited study is particularly mischaracterized by the agency. Han examines how long-term patterns of standard and nonstandard work schedules are associated with sleep and health near age 50.[21] First, the study does not causally test employment-vs-unemployment and its

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[16] Han, W.-J. (2024). How our longitudinal employment patterns might shape our health as we approach middle adulthood—US NLSY79 cohort. *PLOS ONE*, *19*(4), Article e0300245. https://doi.org/10.1371/journal.pone.0300245; Kim, T. J., & von dem Knesebeck, O. (2016). Perceived job insecurity, unemployment and depressive symptoms: A systematic review and meta-analysis of prospective observational studies. *International Archives of Occupational and Environmental Health*, *89*(4), 561–573. https://doi.org/10.1007/s00420-015-1107-1; Kim, T. J., & von dem Knesebeck, O. (2016). Perceived job insecurity, unemployment and depressive symptoms: A systematic review and meta-analysis of prospective observational studies. *International Archives of Occupational and Environmental Health*, *89*(4), 561–573. https://doi.org/10.1007/s00420-015-1107-1.

[17] Kim and von dem Knesebeck (2016).

[18] Virtanen et al. (2005).

[19] Virtanen et al. (2005); Han (2024).

[20] Virtanen et al. (2005); Han (2024).

[21] Han (2024).

own descriptive results are more nuanced than a simple employment benefit, so the agency cannot cite this study as an example of the benefits that could arise from a community engagement requirement. Instead, its main finding was that volatile and nonstandard work schedules are associated with worse sleep and health, outcomes not discussed by CMS in the IFR. These outcomes were concentrated among workers in disadvantaged social positions, and while the study does not say this directly, one can assume this would include a large share of adults enrolled in Medicaid. CMS cites the study in support of a broad statement about the health benefits of employment, but fails to address the central finding concerning harmful work arrangements and labor-market inequality. Nor does the agency state how the rule considers or attempts to address the fact that beneficial health outcomes appear strongly related to good jobs or stable employment, not simply to employment on its own.[22]

The IFR also fails to consider the other side of the bidirectional relationship between employment and health, despite the agency acknowledging that this relationship exists. The reverse of "employment leads to health" is "health leads to employment"—if so, continued Medicaid coverage may instead help members find employment by providing them with access to health treatment, medications, mental and behavioral health services, and help with managing chronic conditions.[23] Losing coverage due to failure to comply with the requirements in this rule, or due to technical or administrative factors outside the control of the member, also seems likely to reduce the ability or capacity of an individual to work, not improve it. Despite this, CMS does not discuss how its rule will only result in positive outcomes for members, and will avoid any of the negatives that have been noted by researchers.

CMS should revise the preamble and impact analysis to acknowledge that improved health is often only associated with stable, secure, and adequately compensated employment, not with all employment in general. The agency should also acknowledge that the research it cites in support of its statements do not establish that Medicaid community engagement requirements cause affected members to experience the health benefits associated with employment. In fact, there is very little evidence that work requirements lead to higher levels of employment in the first place—something the IFR does not mention or consider at all. The IFR should address how job quality, predictability of work schedules, employment insecurity, wages, caregiving responsibilities, and transportation needs, as identified and examined in the sources the agency cites, affect the agency's claim that this requirement will lead to increased employment, which will in turn lead to improved health among affected Medicaid members.[24]

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[22] Han (2024); Virtanen et al (2005).
[23] Kim and von dem Knesebeck (2016).
[24] Han (2024); Virtanen et al (2005); CMS (2021); Georgia Department of Community Health. (2025, April 28). *Georgia section 1115 demonstration waiver extension request*. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-pa-04282025.pdf.

Congress left CMS with discretion to dictate how states implement many aspects of section 1902(xx). In addition to our other requests, we ask that the agency explain why the choices CMS made in this IFR are expected to improve health or lead to better health outcomes than other choices it could have made in the areas it could have made them. If CMS cannot identify direct evidence to support its claims or the notion that community engagement requirements lead to better health and other benefits, the agency should instead frame these claims as ones CMS hypothesizes to be true, rather than what established research and data suggest to be true.

C. CMS should distinguish employment from income and financial stability as well as address studies that suggest economic supports are solutions.

The justification for this rule, as made by CMS, seems to rest on the following hypothesis: Medicaid community engagement requirements lead to employment; employment results in reliable income and financial stability; financial stability then improves access to housing, nutritious foods, and healthy behaviors; and access to these additional resources leads to improved health. However, the sources cited in the IFR do not establish that each step in this chain occurs, nor does it establish that the rule as written would actually set a Medicaid member on this hypothesized path from employment to health.

One of the issues lies in the way CMS appears to conflate similar yet distinct factors and variables. Several of the cited studies look at the link between income or financial stability and mental health, not employment.[25] Another study analyzes financial stability, employment status, and debt as separate predictors of mental health recovery.[26] It found that financial stability was a much stronger predictor of recovery than employment, which seems to weaken CMS's argument—taking away someone's health care for failure to work 80 hours or earn $580 per month, among other qualifying activities, seems like it would lead to worse financial security rather than improvements. The authors of that study emphasized income supports, wage subsidies, debt assistance, and other forms of economic supports as responses that would have the greatest effect on mental health recovery. This conclusion may support a policy that protects an individual's Medicaid coverage, which in turn may reduce financial strain; but it does not suggest that the policies established in the IFR will increase financial stability, and in turn, lead to improved mental health as CMS claims.

[25] Zafar et al. (2024); Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., Bergeron, A., & Cutler, D. (2016). The association between income and life expectancy in the United States, 2001–2014. *JAMA*, *315*(16), 1750–1766. https://doi.org/10.1001/jama.2016.4226; Kim, S., Lee, B., Park, M., Oh, S., Chin, H. J., & Koo, H. (2016). Prevalence of chronic disease and its controlled status according to income level. *Medicine*, *95*(44), Article e5286. https://doi.org/10.1097/MD.0000000000005286; Brownell, N. K., Richards, A. K., Ziaeian, B., & Jackson, N. J. (2024). Trends in income inequities in cardiovascular health among US adults, 1988–2018. *Journal of the American Heart Association*, *17*(5). https://doi.org/10.1161/CIRCOUTCOMES.123.010111.

[26] Zafar et al. (2024).

A cited study of the link between income and life expectancy found a strong association between being paid more income and longer life.[27] It did not establish whether employment, in general, leads to greater life expectancy, nor whether work requirements lead to higher income. It also noted that local unemployment rates and changes in the labor force were not significantly associated with life expectancy among individuals in the lowest income quintile—those most likely to be income eligible for Medicaid. While CMS cites this source as support for its claims about improved living conditions, healthier food purchases, and healthy behavior, the agency does not seem to consider that the study does not test those specific factors and their relationship with improved health. This is not the only instance where CMS cites a source in support of a claim that source does not address or examine.

The Dutch diet-quality study is another such source.[28] In it, the authors identified educational attainment as the strongest socioeconomic predictor of diet quality. Yet, CMS does not discuss how community engagement requirements fit into that relationship. Another study, of chronic diseases in South Korea, suggests that income-related disparities are associated with increased disease prevalence and discusses how barriers to accessing health services among low-income patients is a major driver of this disparity.[29] This finding seems directly relevant to this rule, yet CMS does not mention it or engage with it at all in the IFR. One other study in the United States found persistent or worsening income inequities were the main drivers of the changes seen in the incidence of cardiovascular disease across different income groups.[30] This directly calls into question the relationship CMS claims between community engagement requirements, employment, and health—in this instance, income inequality appears to be the main influencer of health, not employment.

We mention all of these studies to demonstrate how they do not establish or support the idea that requiring Medicaid members to engage in and report on work or other qualifying activities will lead to the beneficial outcomes claimed by CMS. In fact, some of the sources cited by CMS as support for the IFR seem to contradict the very idea of work requirements as a condition for health supports. Throughout, CMS does not explain or justify how this rule will lead to the outcomes it claims, like stable and higher income.

Clarifying this distinction between employment in general and other related topics, like high wages or educational attainment, matters for this IFR. Several of the activities Congress set forth in statute as pathways for meeting the community engagement requirement, including community service, education, and work program participation, may not immediately raise wages or incomes because an individual is not likely to be earning any income while engaged in those activities. And while education or work program participation should lead

[27] Chetty et al. (2016).
[28] Schoufour, J. D., de Jonge, E. A. L., Kiefte-de Jong, J. C., et al. (2018). Socio-economic indicators and diet quality in an older population. *Maturitas*, *107*, 71–77. https://doi.org/10.1016/j.maturitas.2017.10.010.
[29] Kim et al. (2016).
[30] Bownell et al. (2024).

to higher wages in theory, it is hard to see how an activity like community engagement will lead to higher income or earnings, and thus to the health outcomes identified by CMS. And being employed is no guarantee of high wages. CMS did not consider or acknowledge the possibility the jobs that may be available to Medicaid members affected by community engagement requirements might be low-wage, unstable, temporary, seasonal, or insufficient to cover the cost of insurance purchased through an employer or state health care exchange, let alone cover other basic needs like rent or food.

CMS should revise the preamble to clearly distinguish between findings from studies that look at employment, hours worked, earnings, income, financial stability, self-sufficiency, or another related topic. When making claims about what research shows, the agency should identify which topic the cited source directly addresses and discuss how that study is relevant to Medicaid community engagement requirements. If CMS wishes to stand by its claim that work requirements lead to employment which leads to better health, it should explain how, for example, a study looking at educational attainment is relevant to the rule or this purported causal relationship between community engagement requirements and better health.

The agency should also address whether and how the loss of Medicaid may increase financial insecurity through medical bills, interrupted treatment, cost of prescription drugs, among other costs that are covered or not necessary when enrolled in Medicaid. Where the cited sources recommend income assistance, improved access to health care, or policies addressing aspects of job quality and economic insecurity, CMS should engage with these recommendations and explain how the agency considered these recommendations in the IFR or finalized version of the rule. The agency should also explain how a source ultimately supports its claims when the authors' findings or conclusions do not support the idea that work requirements are an effective policy that leads to the outcomes studied.

D. CMS selectively characterizes states' past experiences with Medicaid work requirements.

CMS states that implementation of work requirement policies in Arkansas and Georgia provided the agency with actionable insights that it could incorporate into the IFR to address challenges like members' awareness of the policy, clarity of the requirements, ease and accessibility of reporting, and overall complexity of administering work requirements. While these are all relevant implementation concerns, the sources cited by CMS also mention additional issues that the agency does not discuss in the IFR.

For example, the MACPAC slide deck cited by CMS notes that observed and projected coverage losses were substantial in states when implementing work requirement policies.[31]

[31] Llanos-Velazquez, J., & Becker Roach, M. (2026, April 9). *Implementing community engagement requirements in Medicaid: Draft chapter and recommendation* [PowerPoint slides]. Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2026/04/01_April-Slides_Implementing-Community-Engagement-Requirements-in-Medicaid.pdf.

It identified lack of member awareness, barriers to finding employment, administrative challenges, and significant costs as concerns that affect the overall feasibility and effectiveness of work requirements. Similarly, CMS's own 2021 letter withdrawing Arkansas's community engagement authority noted more than 18,000 people lost coverage and that monthly coverage-loss rates reached between 20 and 47 percent of those who were required to meet work requirements.[32] This policy was also found to have led to an increase in the state's uninsurance rate and was associated with greater levels of medical debt, delayed care, and delayed use of medication. The letter also states that there was no discernable increase in employment attributable to this policy.

CMS's 2021 letter also discusses how Arkansas's experience was similar to the experiences of states like New Hampshire and Michigan. The IFR cites this letter for the narrow claim that awareness, clarity, reporting access, and complexity can influence compliance. CMS should instead present this source as evidence that work requirement policies lead to coverage loss, challenges accessing care, negligible employment effects, exemption failures, and increased administrative burden, in addition to the outcomes it already notes in the IFR. CMS should also revise the preamble to describe the full evidence contained in its cited implementation sources. It should explain how the IFR responds to the specific failures documented in Arkansas, New Hampshire, Michigan, and Georgia, and in other programs that include work requirements. The explanation should identify the provisions of the IFR or finalized version of the rule the agency included in order to prevent:

1. loss of coverage among people who are already working or otherwise meeting the community engagement requirements;
2. loss of coverage among people who qualify for an exclusion or exception;
3. mass procedural disenrollment caused by reporting, process, or technology failures;
4. medication and treatment interruptions;
5. high state administrative and system costs; and
6. coverage losses without employment or earnings gains.

General references to outreach, reporting accessibility, or state flexibility do not establish that the IFR will prevent these outcomes or that CMS has considered alternative approaches that could result in fewer wrongful denials or terminations. CMS should identify the relevant provisions in the IFR and explain why it expects those provisions to be most effective in light of the evidence it cites and other options it considered or could consider.

[32] CMS (2021).

E. CMS should correct citation errors and disclose the limitations of the studies and materials on which it relies.

Appendix A identifies additional problems concerning citation accuracy. These issues reinforce the need for CMS to review each cited source against the claims or statements for which it is used and withdraw, correct, or qualify any statements the agency makes in the IFR to accurately reflect the findings and conclusions of these sources.

Some sources concern populations or settings that differ substantially from the Medicaid population who will be affected by this rule. These include studies of older adults in the Netherlands,[33] chronic-disease control in South Korea,[34] "emerging adults" across multiple countries and time periods,[35] and workers with long employment histories approaching middle age.[36] Such studies may provide relevant general background that is relevant to the rule. However, CMS should identify limiting factors of these studies, such as their target populations and settings, and explain why the findings reasonably apply to low-income adults subject to a Medicaid work requirement.

For each citation provided in the IFR, CMS should identify:

- the source's research question, population, and design;
- whether the source establishes an association or a causal effect between the factors studied or cited by CMS;
- any material limitations on generalizing the findings or applying them to the Medicaid population subject to work requirements;
- any contrary or qualifying findings relevant to the IFR; and
- whether the claim or statement reflects direct evidence, general background research, or CMS's own policy judgment.

Requested CMS response

Before relying on these claims and statements made in this IFR in support of the rule, CMS should ensure a subsequent final rule or revised interim final rule:

1. Responds to the source-specific issues identified in Appendix A and correct citations that do not support the propositions for which they are used.
2. Distinguishes direct evidence concerning Medicaid community engagement requirements from general research on employment, income, health, and social connection.

[33] Schoufour et al. (2018).
[34] Kim et al. (2016).
[35] Buecker et al. (2021).
[36] Han (2024).

3. Removes or narrows the claim that community engagement requirements will reduce loneliness unless CMS identifies evidence evaluating that policy relationship.
4. Corrects or removes the statement comparing a lack of social connection with smoking 15 cigarettes per day.
5. Revises the employment and health discussion to reflect the bidirectionality of this relationship, unresolved claims of causation made by CMS, and the role of job quality, schedule stability, job security, wages, and socioeconomic conditions in determining health outcomes.
6. Distinguishes employment from related factors like earnings, financial stability, adequate income, and self-sufficiency and is clear about what topic or factors are examined and how they align with or differ from CMS rationale.
7. Addresses whether Medicaid coverage itself supports employment and whether coverage loss may actually impair a member's ability to work or engage in qualifying activities.
8. Presents and engages with the full findings and conclusions of the Arkansas letter, MACPAC materials, and other cited implementation sources, including findings concerning coverage loss, access to care, employment, exemption failures, administrative burden, and costs.
9. Explains which provisions of the IFR respond to the specific harms documented during prior Medicaid work requirement implementation and why CMS expects those provisions to prevent similar outcomes.
10. Clearly identifies which preamble statements are supported by direct empirical evidence, versus those that rely on broader associational literature or represent agency assumptions or policy judgments.

If CMS includes these claims in the finalized rule, it should provide a reasoned explanation connecting the actual findings of the cited sources to the specific implementation choices the agency made in the IFR. If the sources establish only general associations or contain material contrary findings, CMS should qualify its claims and address those findings and contradictions rather than presenting the literature as evidence that the rule will improve employment, financial stability, health, or social connection.

IV. CMS must consider directly relevant evidence on Medicaid and work requirements.

Section IV identifies research, state and federal program experience, and other evidence that CMS did not address in the IFR, but that is directly relevant to the empirical assumptions underlying the rule. Throughout the preamble, CMS asserts that conditioning

Medicaid eligibility on community engagement will help members "escape isolation and dependency," achieve self-sufficiency, and improve health. CMS describes existing SNAP and TANF work requirements as supporting a path to self-sufficiency without citing evidence for that characterization, and frames Arkansas's and Georgia's experience with Medicaid work requirements primarily as evidence that member awareness, reporting access, and administrative complexity affected compliance. Each of these assertions rests on an evidentiary foundation this section shows to be incomplete, contradicted by the sources CMS has itself partially assembled, or unaddressed altogether.

The subsections below proceed as follows. Subsections A through C examine the foundational claims CMS uses to justify the rule: that employment causes better health (A), that work requirements increase employment, wages, or self-sufficiency (B), and that alignment with SNAP and TANF supports this design (C). Subsections D and E turn to the rule's own structure: administrative burden is a predictable, central effect of conditioning eligibility on a reporting requirement, not a secondary implementation detail (D), and the rule's exclusion and exemption categories will not reliably distinguish members who cannot meet the requirement from those who can (E). Subsections F and G examine consequences the IFR does not account for: coverage loss can undermine the same employment and health outcomes the rule is meant to promote (F), and the regulatory impact analysis understates the rule's costs while overstating its savings (G). Subsections H and I show these are not isolated or fixable implementation failures: three states pursuing three different strategies experienced the same pattern of erroneous coverage loss (H), and the same pattern recurs across Medicaid demonstrations that condition eligibility on entirely different administrative requirements (I). Subsection J shows that these effects fall disproportionately on members with chronic illness, disability, and specific racial and ethnic groups. Finally, subsection K explains why CMS's proposed monitoring framework is not equipped to detect any of this once the rule takes effect. A summary of all of the sources we'd like CMS to consider and direction for how they should incorporate them into the rule are also provided in Appendix B. We request CMS read and respond to those requests in the Appendix B as well as those in this section.

We ask that CMS review and incorporate the sources and findings discussed in each subsection into the rule's rationale, its regulatory impact analysis, and the design choices that remain within the agency's discretion. Where CMS declines to do so, we ask that the agency identify, with reasoned explanation grounded in the record, why the evidence discussed below does not warrant a change to the rule as proposed.

A. CMS moves from an association between employment and health to an unsupported causal claim about work requirements.

Much of the justification for this rule rests on a chain of assumptions: that employment reliably produces income and financial stability, and that financial stability reliably produces better health. CMS treats this chain as established fact, using it to claim that community

engagement requirements will improve Medicaid members' health and well-being. But the preamble never establishes the individual links in that chain—it moves directly from a general association observed in the literature between employment and health to a specific policy claim about the effects of conditioning Medicaid eligibility on work, education, or other qualifying activities. CMS's own cited sources do not support that leap.

The literature CMS relies on describes the employment-health relationship as, at best, mixed—the effect of employment on health depends on job quality, stability, pay, and whether the work is voluntary, not on employment status alone. An observed association between employment and health, in other words, does not establish that mandating work will improve health. CMS's own IFR goes further than the literature it cites even allows: it describes the relationship between work and health as "bi-directional," yet the preamble develops only the direction favorable to the rule. It does not address the other direction—that losing Medicaid coverage could interfere with treatment and reduce a person's capacity to work in the first place, a possibility discussed further in subsection F, below. CMS cannot invoke a bi-directional relationship to justify the rule while addressing only one of its directions.

- **The Relationship Between Work and Health: Findings from a Literature Review**[37]**:** Reviewing more than 50 academic studies, systematic reviews, and program evaluations on the relationship between employment, unemployment, health, and health coverage, this issue brief finds that the evidence does not support treating employment as a reliable driver of better health, and that the relationship instead depends heavily on the nature of the job itself
- **Medicaid Work Requirements—English Poor Law Revisited:**[38] Published alongside two studies of Medicaid work-requirement exemption populations, this invited commentary makes the same point CMS's own preamble makes — that the relationship between employment and health runs in both directions — but draws the opposite conclusion: because Medicaid coverage itself helps beneficiaries obtain and keep employment, conditioning coverage on work risks withdrawing the very support that enables it.
- **Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes:**[39] This policy brief reviews evidence on Medicaid coverage, employment, and work

[37] Larisa Antonisse and Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review* (Kaiser Family Foundation, August 2018). https://www.kff.org/medicaid/the-relationship-between-work-and-health-findings-from-a-literature-review/.
[38] Dave A. Chokshi and Mitchell H. Katz, "Medicaid Work Requirements—English Poor Law Revisited," *JAMA Internal Medicine* 178, no. 11 (2018): 1555, doi:10.1001/jamainternmed.2018.4195.
[39] Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes* (Center on Budget and Policy Priorities, August 13, 2018). https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

requirements in other public benefit programs, and concludes that Medicaid coverage functions as a support for employment rather than a reward for it — removing that support, particularly for people managing a chronic health condition, is more likely to undermine work than to encourage it.

CMS should correct the preamble's causal framing of the relationship between work, employment, and health; recognize Medicaid coverage as a potential employment support, consistent with the bi-directional relationship the agency itself invokes; and evaluate whether the specific implementation choices available to it under HR-1 would better preserve, rather than undermine, Medicaid members' ability to obtain and maintain employment.

B. The evidence does not support an assumption that work requirements generally increase employment, wages, or self-sufficiency.

The premise underlying much of this rule—that conditioning Medicaid eligibility on work will increase employment, wages, and self-sufficiency—is not supported by the evidence, including evidence from the very programs and states CMS cites in the IFR. Across benefit programs, work requirements consistently reduce program participation. Their effects on employment, by contrast, are usually absent, small, negative, or confined to narrow subgroups, and their effects on wages are weaker still. This evidence directly contradicts several claims made in the rule: that community engagement requirements will induce substantial numbers of beneficiaries to begin working; that increased activity will produce higher earnings or financial independence; that falling Medicaid enrollment can be read as movement toward self-sufficiency; and that alignment with SNAP and TANF supports this policy (addressed further in subsection C, below).

CMS itself cites Arkansas and Georgia as examples of Medicaid work requirements in practice. Assessments of both states found coverage restrictions with no measurable gain in employment. These findings are not exclusive to Medicaid. The most recent SNAP studies find that work requirements produce substantial benefit losses with little or no employment gain, and TANF's record is, at best, mixed. Some states saw short-term employment gains, but only where work requirements were paired with child care, transportation, employment services, cash assistance, or other supports that HR-1 does not provide, and even those gains tended to fade without consistently improving income or reducing poverty.

The following sources further describe these findings:

- **Medicaid Work Requirements—Results From the First Year in Arkansas:**[40] Using telephone survey data and comparison groups within Arkansas and in Kentucky, Louisiana, and Texas, this study finds that Arkansas's first six months of Medicaid

[40] Sommers, B. D., Goldman, A. L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2019). Medicaid work requirements—Results from the first year in Arkansas. *The New England Journal of Medicine, 381*(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772

work requirements were associated with a significant loss of coverage but no significant change in employment.

- **Consequences of Work Requirements in Arkansas:**[41] Revisiting the same population two years later, this follow-up study finds that the null employment result held over the 18 months the requirement was in effect. The same study documents substantial financial and health-access harm among those who lost coverage, discussed further in subsection F, below.
- **The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment:**[42] Using 2016–2019 American Community Survey data and a difference-in-differences design with randomization inference, this study finds that Arkansas's work requirements were associated with a 4.4 percentage-point increase in uninsurance among the targeted age group, rising to 7.4 percentage points among those below 100 percent of the federal poverty level. The estimated effect on employment was negative, small, and statistically insignificant.
- **Pathways to Coverage: Looking Back Two Years and Into the Future:**[43] Reviewing Georgia's first two years of its Medicaid work requirement program, this brief finds that the program has not meaningfully increased employment or participation in employer-sponsored health coverage, with no change in employment relative to neighboring non-expansion states over the same period.
- **Employed in SNAP? The Impact of Work Requirements on Program Participation and Labor Supply:**[44] Using linked Virginia administrative records and a regression-discontinuity design based on the age-50 SNAP eligibility cutoff, this study finds that work requirements produced large reductions in participation, especially among homeless adults. The authors also finds no measurable increase in employment.
- **The Impact of SNAP Able-Bodied Adults Without Dependents Time Limit Reinstatement in Nine States:**[45] Drawing on interviews with regional SNAP officials, administrative caseload data from nine states, and linked unemployment insurance wage records in Colorado, Missouri, and Pennsylvania, this report finds that

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[41] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Consequences of work requirements in Arkansas: Two-year impacts on coverage, employment, and affordability of care. *Health Affairs, 39*(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538

[42] Anuj Gangopadhyaya and Michael Karpman. (2025). The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data. *Health Services Research 60, no. 5. https://doi.org/10.1111/1475-6773.14624*

[43] Chan, L. (2025, October). *Pathways to Coverage: Looking back two years and into the future*. Georgia Budget and Policy Institute.

[44] Gray, C., Leive, A., Prager, E., Pukelis, K., & Zaki, M. (2023). Employed in a SNAP? The impact of work requirements on program participation and labor supply. *American Economic Journal: Economic Policy, 15*(1), 306–341. https://doi.org/10.1257/pol.20200561

[45] Wheaton, L., Vericker, T., Schwabish, J., Anderson, T., Baier, K., Gasper, J., Sick, N., & Werner, K. (2021). *The impact of SNAP able-bodied adults without dependents (ABAWD) time limit reinstatement in nine states: Final report*. Urban Institute.

reinstating SNAP's ABAWD time limit substantially reduced participation without substantially increasing employment or earnings.

- **Work Requirements and Work Supports for Recipients of Means-Tested Benefits:**[46] This Congressional Budget Office report reviews evidence across TANF, SNAP, and Medicaid, finding substantial but diminishing employment gains from work requirements in TANF, smaller gains in SNAP, and little apparent effect in Medicaid, while benefit reductions matched or exceeded any increase in participants' earnings. The same report finds that supports such as subsidized child care, job-search assistance, and subsidized employment reliably increased employment and income, while job training alone produced mixed results.
- **CBO's estimate of the budgetary effects of Medicaid work requirements under H.R. 2811, the Limit, Save, Grow Act of 2023:**[47] This letter estimates that a federal Medicaid work requirement would reduce federal spending by about $109 billion over 2023–2033 while having a negligible effect on employment or hours worked — and would cause roughly 1.5 million adults to lose federal Medicaid funding, about 600,000 of whom would become uninsured, while shifting approximately $65 billion in coverage costs to states.

Taken together, these sources span three different benefit programs, several distinct research designs, and more than two decades of experience, and they point towards the same finding—work requirements reduce program participation far more reliably than they increase employment. CMS should reconcile the RIA's implicit assumption that this rule will improve employment or self-sufficiency with the absence of evidence for that outcome anywhere in the record CMS itself has assembled. CMS should either provide evidence supporting its assumption that this rule will increase employment and self-sufficiency, or, absent such evidence, remove that assumption from the RIA's projected outcomes.

C. SNAP and TANF provide cautionary evidence rather than straightforward support for the rule.

CMS presents this rule's alignment with SNAP and TANF as administratively useful, stating that the work requirement "will bring Medicaid in line with other public benefit programs, like SNAP and TANF, which have similar work requirements to support beneficiaries on a path to self-sufficiency." The research on those programs does not support that framing.

As discussed in subsection B above, work requirements in SNAP and TANF rarely increase employment. But even where they do, they do not reliably produce self-sufficiency. Beneficiaries removed from SNAP for noncompliance do not stop needing food—they shift to

[46] Congressional Budget Office. (2022). *Work requirements and work supports for recipients of means-tested benefits*. https://www.cbo.gov/publication/57702

[47] Congressional Budget Office. (2023, April 26). *CBO's estimate of the budgetary effects of Medicaid work requirements under H.R. 2811, the Limit, Save, Grow Act of 2023* [Letter to Representative Frank Pallone Jr.]. https://www.cbo.gov/system/files/2023-04/59109-Pallone.pdf

other sources of support, including debt and emergency food assistance, at real financial and personal cost. When Alabama expanded its TANF work requirement to parents of infants ages 6 to 11 months, employment among that group rose by about 11 percentage points; but the requirement achieved this by removing families who were unable to comply from the program, not by helping families find work. A reduced caseload, in other words, is not evidence of self-sufficiency. It may just as easily be evidence that people who needed help stopped receiving it.

In addition to the sources identified in other subsections of this section, research on work requirements in SNAP and TANF includes:

- **The Disenrollment and Labor Supply Effects of SNAP Work Requirements:**[48] Using linked SNAP and unemployment insurance records, and exploiting variation in when parents become subject to work requirements after their youngest child turns six, this study finds that mandatory employment-and-training referrals reduced the household head's SNAP receipt by 57 percent and total household benefits by 23 percent over six months. This effect was felt especially strong among families with the lowest prior earnings, while the policies produced no significant increase in employment or earnings. The authors conclude that administrative burden, not increased work, was the principal driver of disenrollment.
- **Financial Repercussions of SNAP Work Requirements:**[49] Using a nationally representative sample of credit records and county-level variation in the timing of SNAP work requirement implementation, this study finds that the imposition of work requirements led affected individuals to seek out more credit. Total credit accounts rose 18 percent, total card balances rose 29 percent (about $500), and past-due balances rose 5 percent.
- **Supplemental Nutrition Assistance Program Work Requirements and Emergency Food Assistance Usage:**[50] Using an event-study design across a cohort of food pantries in Alabama, Florida, and Mississippi following the 2016 implementation of SNAP work requirements, this study finds that urban food pantries in areas exposed to the requirement served 34 percent more households within eight months than pantries with no exposure.

[48] Cook, J. B., & East, C. N. (2025). *The disenrollment and labor supply effects of SNAP work requirements* (NBER Working Paper No. 32441). National Bureau of Economic Research. http://www.nber.org/papers/w32441

[49] Dodini, S., Larrimore, J., & Tranfaglia, A. (2022). *Financial repercussions of SNAP work requirements* (Finance and Economics Discussion Series 2022-030). Board of Governors of the Federal Reserve System. https://doi.org/10.17016/FEDS.2022.030

[50] Cuffey, J. M., Katare, B., & Fulford, L. M. (2023). Supplemental Nutrition Assistance Program work requirements and emergency food assistance usage. *American Journal of Preventive Medicine, 65*(2), 270–277. https://doi.org/10.1016/j.amepre.2023.01.029

- **Consequences of Welfare Reform:**[51] Synthesizing 34 randomized studies and 33 econometric studies of the 1990s welfare reforms, this report finds that reforms substantially reduced welfare caseloads and generally increased employment and earnings, but that effects on income and poverty depended heavily on program design. Generous financial work incentives produced the clearest income gains. Mandatory work activities alone reduced welfare and SNAP use, but had little overall effect on income. Their effects on children were mixed.
- **The Effects of Work Requirements on the Employment and Income of TANF Participants:**[52] Using administrative data from Alabama's 2018 expansion of TANF work requirements to parents of infants ages 6 to 11 months, this study finds that the policy increased employment in this group of TANF participants by about 11 percentage points and raised their average earnings and income. It also shortened the length of TANF spells overall.

Across three different programs and more than two decades of policy variation, the pattern is consistent—work requirements shift costs onto the people subject to them more reliably than they lead to self-sufficiency. We ask that CMS incorporate these studies, and the other relevant studies identified elsewhere in this section,[53] as direct evidence of the likely outcomes of this rule, drawing on SNAP and TANF's experience with reporting, verification, exemption, and sanction systems. Aligning Medicaid with SNAP and TANF may reduce some administrative duplication, but it may just as easily duplicate their well-documented failures. CMS should identify which specific parts of this rule are designed to prevent the harmful outcomes SNAP and TANF have already demonstrated. If no such features exist, CMS should revise the rule to include them, including by accounting for the financial costs this evidence shows fall directly on members, discussed further in subsection G, below.

D. Administrative burden is a central policy effect of work requirements, not a secondary implementation problem.

Research consistently shows that otherwise eligible people lose access to public benefits because of paperwork, missed notices, reporting difficulties, technological barriers, unstable work hours, difficulty obtaining documentation, or failure to establish an exemption, not because they failed to meet the underlying requirement. In Colorado, this problem is compounded by the state's approach to administering public benefit programs. Colorado's Medicaid program is state-supervised but administered by its 64 counties, meaning applicants and members must often navigate both state- and county-level rules, processes, and systems to maintain coverage. This burden falls on two overlapping groups: people who

[51] Grogger, J., Karoly, L. A., & Klerman, J. A. (2002). *Consequences of welfare reform: A research synthesis* (DRU-2676-DHHS). RAND. https://www.rand.org/content/dam/rand/pubs/drafts/2006/DRU2676part1.pdf
[52] Falk, J. (2023). *The effects of work requirements on the employment and income of TANF participants* (Working Paper 2023-03). Congressional Budget Office. https://www.cbo.gov/system/files/2023-03/58867-TANF.pdf
[53] See also Gray et al. (2023); Wheaton et al. (2021); CBO (2022).

are actually working or otherwise meeting community engagement requirements, and people who should not be subject to the requirement in the first place.

CMS's own impact analysis appears to acknowledge this dynamic, even where the preamble does not directly address it. The agency assumes that some procedural disenrollments will involve documentation errors or nonresponse by people who actually meet program requirements, and it projects combined disenrollment of approximately 15 percent of adult group enrollment under its preferred Scenario 2. Yet the IFR's broader reasoning is difficult to square with that assumption. The rule proceeds as if procedural losses can be adequately controlled through notice, outreach, and multiple reporting methods; as if a failure to document compliance was due to an member's failure to actually perform a qualifying activity; as if members who lose coverage can simply correct the problem by reapplying; and as if Arkansas and New Hampshire's experiences mainly show a need for clearer outreach and more accessible reporting. The evidence does not support any of these assumptions.

Arkansas and New Hampshire are the clearest illustrations of why. In both states, mass coverage loss occurred despite widespread actual compliance among affected Medicaid members. More than 95 percent of the affected population in Arkansas appeared to meet the community engagement requirement or qualify for an exemption. Thousands lost coverage anyway.[54] New Hampshire officials designed a system explicitly intended to avoid Arkansas's failures, including more flexible reporting options, a grace period for missed hours, automatic reinstatement. By the state's own account, its outreach effort nonetheless repeated many of the same errors: underfunded, overly reliant on mail, and not scaled up until after the damage was done. The result was extremely high apparent noncompliance regardless.

Research on behavioral economics and administrative burden explains why: simplifying an application or reporting process meaningfully improves participation, but outreach alone, without reducing the burden of the process itself, is not enough to prevent otherwise eligible people from being screened out. Nothing in the IFR suggests CMS anticipated this outcome, and nothing in the rule explains how it is designed to avoid it. We ask that CMS review, at minimum, the following sources:

- **A Behavioral-Economics View of Poverty:**[55] People experiencing poverty exhibit the same behavioral biases as everyone else, but poverty makes the consequences of those biases more severe. This article finds that seemingly minor barriers such as complex applications, unclear rules, stigma, and inconvenient procedures, procrastination can substantially reduce benefit take-up, while simpler forms, better

[54] Sommers et al. (2019), discussed in subsection B above.
[55] Bertrand, M., Mullainathan, S., & Shafir, E. (2004). A behavioral-economics view of poverty. *American Economic Review, 94*(2), 419–423.

defaults, clearer information, and reduced administrative hassle meaningfully improve both participation and outcomes.

- **Who is Screened Out?:**[56] Using Social Security field-office closures and a difference-in-differences design, this study finds that increased application burden reduced disability applications by 10 percent and benefit awards by 16 percent. The increased burden also disproportionately screening out applicants with moderately severe conditions, low education, and low prior earnings.
- **New Hampshire's Experience with Medicaid Work Requirements:**[57] Drawing on stakeholder interviews, beneficiary focus groups, and state implementation data, this report finds that even New Hampshire's more flexible work requirement system produced widespread confusion and reporting barriers. Only 32 percent of nearly 25,000 subject enrollees were initially recorded as compliant, and as many as 17,000 were at risk of losing coverage before the state suspended the policy and a federal court halted it. The accompanying workforce program, meanwhile, served only a small fraction of its target population and did not lead to any appreciable increases in employment.
- **Withdrawal of Community Engagement Authorities for the New Hampshire Granite Advantage Health Care Program Demonstration:**[58] CMS itself withdrew approval of New Hampshire's work requirement after concluding it was unlikely to advance Medicaid's objectives. The agency's own letter cites the state's early experience that saw nearly 17,000 beneficiaries, about 40 percent of those subject to the requirement, who would lose coverage within weeks, despite evidence that most were already working or should have qualified for exemptions. CMS attributed this to confusing notices, ineffective outreach, reporting burdens, and exemption barriers, not to a lack of compliance among affected populations.

CMS should incorporate this evidence, and the other relevant sources identified elsewhere in this comment,[59] into the rule by treating procedural loss as a foreseeable and substantive harm that results directly from imposing work requirements as a condition of program eligibility. At minimum, this means allowing self-attestation in circumstances where reliable data to demonstrate compliance is unavailable, along with other strategies that reduce the

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[56] Deshpande, M., & Li, Y. (2019). Who is screened out? Application costs and the targeting of disability programs. *American Economic Journal: Economic Policy, 11*(4), 213–248. https://doi.org/10.1257/pol.20180076

[57] Hill, I., Burroughs, E., & Adams, G. (2020). *New Hampshire's experience with Medicaid work requirements: New strategies, similar results*. Urban Institute. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf

[58] Centers for Medicare & Medicaid Services. (2021, March 17). *Withdrawal of community engagement authorities for the New Hampshire Granite Advantage Health Care Program demonstration* [Letter to Lori Shibinette, Commissioner, New Hampshire Department of Health and Human Services]. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-ca2.pdf

[59] See Sommers et al. (2019); Sommers et al. 2020); Cook and East (2025).

administrative burden this rule will place on Medicaid members and on the county eligibility staff who will administer it.

Researchers examining state readiness for the community engagement requirement report that most states plan to launch only a "minimum viable product" by the January 2027 deadline, collecting compliance and exemption information manually through "auditable self-declaration" until more seamless data exchanges can be established.[60] If states themselves are planning to rely on self-attestation as a practical necessity, CMS should acknowledge this reality, and give states flexibility to make their eligibility systems work under these new requirements in the short timeframe given to them rather than leave states to build ad hoc workarounds the rule itself doesn't authorize.

E. The rule's exclusions and exceptions may not protect everyone whose health or circumstances impede work.

The community engagement requirement assumes a population that can be easily sorted between people with a disability and healthy adults who could readily work. Between these two categories sits a large group of people living with chronic illness, mental health conditions, unstable health, or experiencing homelessness, among other circumstances that affect a person's ability to work without fitting the formal disability or medical-frailty categories described in the IFR. Research suggests this group is not a small outlier. Based on other experiences, this is likely a substantial share of the population this rule will affect. This research challenges several assumptions embedded in the IFR: that the term "able-bodied" accurately describes the population remaining after statutory exclusions; that formal disability, medical frailty, and hardship categories will capture most people whose health limits employment; that people outside those categories can generally meet 80 hours or readily document why they cannot; and that noncompliance mainly reflects an unwillingness to engage rather than barriers, unstable circumstances, or reporting failures.

The evidence supporting these points falls into three groups. First, the population actually subject to the requirement is small, which limits how much of CMS's projected savings can plausibly come from that population rather than from erroneous disenrollment. Second, the people who fall outside formal exemption categories despite real barriers to work are not a unique cases, and removing them from coverage does not produce the employment gains the rule assumes. Third, where this has played out in practice, the exemption structure has failed along lines of characteristics such as age, chronic illness, low income, homelessness, and not along lines of actual eligibility. We ask that CMS review and incorporate the following sources into the final rule, along with the other relevant studies already discussed elsewhere in this section:[61]

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[60] Everhart, R. M., Gillespie, S., Maguire, M., Stella, S. A., Hanratty, R., & Johnson, T. L. (2026). Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients. *Health Affairs Scholar*, 4(7), 1–8. https://doi.org/10.1093/haschl/qxag162

[61] See Gray et al. (2023)

- **Analysis of Work Requirement Exemptions and Medicaid Spending:**[62] After accounting for people already working and common waiver exemptions, this study estimates that only about 2.1 million people, or 2.8 percent of Medicaid enrollees, accounting for 0.7 percent of Medicaid spending, would be subject to work requirements nationally. Any savings CMS projects from this rule cannot come primarily from that population.
- **Medicaid Work Requirements and Community Engagement Requirements: State Variation in Estimated Impact:**[63] This companion analysis finds the same pattern at the state level. Across 11 states with submitted waivers, 0.3 to 5.4 percent of Medicaid-eligible individuals overall, and 1.6 to 10.6 percent of nondisabled adults, were subject to but not already meeting proposed requirements. Colorado falls within that range. 4.7 percent of all Medicaid-eligible Coloradans and 8.5 percent of nondisabled working-age adults were subject to but not already meeting work requirements, even under the study's high-end scenario.
- **Understanding the Intersection of Medicaid and Work:**[64] Among Medicaid adults with a disability, only 32 percent receive SSI or SSDI, meaning 68 percent would not be captured by an exemption keyed to those programs alone. Employment falls sharply as the number of functional domains affected increases. 48 percent of Medicaid adults with one disability were working, compared with 17 percent of those with four or more—evidence that disability well short of the SSI or SSDI threshold still meaningfully limits work and suggests it will be difficult for these individuals to remain enrolled in the program under the IFR's proposed definitions for these exclusions.
- **Medicaid Work Requirements: Who's at Risk?:**[65] Of the roughly 22 million adult Medicaid enrollees who could be exposed to a broadly designed work requirement, about half were already working and 14 percent were seeking work. Among the remainder, most reported a disability, caregiving responsibilities, or school attendance, and fewer than 5 percent were voluntarily not working. The population left over after exemptions is overwhelmingly people with a barrier to work, not people choosing not to work.
- **The Impact of SNAP Work Requirements on Labor Supply:**[66] This study rules out an employment decline greater than 1.4 percentage points when SNAP work

[62] Goldman, A. L., Woolhandler, S., Himmelstein, D. U., Bor, D. H., & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. *JAMA Internal Medicine, 178*(11), 1549–1552. https://doi.org/10.1001/jamainternmed.2018.4194

[63] Silvestri, D. M., Holland, M. L., & Ross, J. S. (2018). State variation in the proportion of Medicaid enrollees subject to community engagement requirements. *JAMA Internal Medicine*, 178(11), 1552–1554.

[64] 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/

[65] Ku, L., & Brantley, E. (2017, April 12). *Medicaid work requirements: Who's at risk?* Health Affairs Blog. doi:10.1377/hblog20170412.059575.

[66] Han, J. (2020, August). *The impact of SNAP work requirements on labor supply* [Working paper]. SSRN.

requirements were suspended, though it found a modest reduction in hours among some older workers. If removing a work requirement doesn't reduce employment, imposing one on a population defined by barriers to work is unlikely to increase it. The rule's exemption gaps would fall on people work requirements cannot move into jobs.

- **Supplemental Nutrition Assistance Program Work Requirements and Safety-Net Program Participation:**[67] Using linked Connecticut SNAP and Medicaid records, this study finds that reinstating SNAP work requirements reduced SNAP enrollment by 5.9 percentage points, or about 25 percent. The largest and most persistent losses were concentrated among older adults, people with chronic illnesses such as diabetes, and Medicaid members with the lowest incomes. The study does not show whether these enrollees were actually ineligible for an exemption; it shows that the people who lost coverage were disproportionately drawn from the most vulnerable groups, regardless of whether they should have qualified for one.
- **Medicaid Demonstrations and Impacts on Health Coverage:**[68] Kentucky's own analysis of its (ultimately blocked) work requirement estimated that among beneficiaries who were projected to be neither exempt nor working, nearly three-quarters would have faced at least one significant barrier to meeting the work requirement or documenting an exemption from it. 59 percent lived with someone with a serious health limitation, 38 percent had a serious health limitation themselves, 25 percent lacked internet access, 24 percent had not completed high school, and 11 percent lacked access to a vehicle. This is the same pattern the Connecticut study shows in SNAP, documented directly in a Medicaid work-requirement population.
- **Minimizing H.R.1-Related Medicaid Coverage Disruptions for High-Risk Patients:**[69] Using linked medical, Medicaid, and housing-services data from Denver Health's Medicaid Expansion population, this 2026 case study found that three-quarters (76.0 percent) of enrollees experiencing homelessness met at least one modeled work-requirement exemption criterion—evidence that this population is disproportionately exemption-eligible while disproportionately unable to document it, consistent with findings among homeless SNAP participants subject to that program's work requirement.

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[67] Ndumele, C. D., Factor, H., Lavallee, M., Lollo, A., Jr., & Wallace, J. (2025). Supplemental Nutrition Assistance Program work requirements and safety-net program participation. *JAMA Internal Medicine, 185*(1), 92–100. https://doi.org/10.1001/jamainternmed.2024.5932

[68] Office of the Assistant Secretary for Planning and Evaluation. (2021, March 11). *Medicaid demonstrations and impacts on health coverage: A review of the evidence* (Issue Brief No. HP-2021-03). U.S. Department of Health and Human Services.

[69] Everhart, R. M., Gillespie, S., Maguire, M., Stella, S. A., Hanratty, R., & Johnson, T. L. (2026). Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients. *Health Affairs Scholar*, 4(7), 1–8. https://doi.org/10.1093/haschl/qxag162.

Taken together, these sources show that the rule's exemptions will not reliably distinguish Medicaid members who genuinely cannot meet a work requirement from those who can. The population actually subject to the requirement is small; a substantial share of that population falls outside formal disability and medical-frailty categories despite real barriers to work; and where states have implemented similar requirements, the resulting coverage losses have disproportionately impacted vulnerable populations rather than those who are actually not complying with the rules. This directly undermines the IFR's assumption that its exclusion and exception categories will adequately protect people whose health or circumstances limit their ability to work. CMS should explain how it arrived at its exemption and exclusion criteria in light of this evidence, and why those criteria are sufficient given the population-level patterns documented above. CMS should revise the rule to account for the populations shown here, and any other groups that tend to fall outside of formal exemption categories despite real barriers to work.

F. Loss of coverage may undermine employment and health rather than promote them.

Research and case studies of states that have previously implemented Medicaid work requirements, such as Arkansas, call into question the premise underlying this rule's design — that terminating coverage for noncompliance will motivate engagement without materially impairing a person's ability to work.

In Arkansas, Medicaid work requirements led to increased uninsurance without any corresponding increase in employment, and the consequences for those who lost coverage were severe and measurable. Among Arkansans who lost coverage, 50 percent reported problems paying medical debt, 56 percent delayed care because of cost, and 64 percent delayed medications because of cost; average medical debt among this group exceeded $2,200.[70] Separate research indicates that Medicaid coverage itself helps people find and maintain employment by supporting the kind of health management that makes stable work possible — the same bi-directional relationship CMS invokes elsewhere in the IFR, but does not apply here.[71] The evidence supports viewing Medicaid as a program that encourages employment, not one that discourages it.

We provide CMS with the following sources, in addition to those that have already been discussed in this section,[72] that question the agency's characterization of Medicaid and its relationship to employment:

- **Medicaid Churning and Continuity of Care:**[73] Reviewing evidence on Medicaid coverage disruptions, this brief finds that unstable coverage increased emergency

[70] Sommers et al. (2020).
[71] Chokshi and Katz (2018).
[72] See Antonisse and Garfield (2018); Chokshi and Katz (2018); Sommers et al. (2019); Hill, Burroughs, and Adams (2020); ASPE (2021); Chan (2025).
[73] Sugar, S., Peters, C., De Lew, N., & Sommers, B. D. (2021, April 12). *Medicaid churning and continuity of care: Evidence and policy considerations before and after the COVID-19 pandemic* (Issue Brief No. HP-2021-

department visits, office visits, and hospitalizations by 10 to 36 percent, and decreased use of prescription medications by 19 percent, compared with stable coverage. Churning also produces periods of uninsurance, delayed and reduced preventive care, and higher medical spending in the months following reenrollment than in the months immediately before a coverage lapse. The same brief finds that continuous eligibility, Medicaid expansion, express-lane and presumptive eligibility, and limits on premiums and cost-sharing all improve coverage stability and continuity of care — tools this rule does not require or encourage.

- **Welfare Work Requirements and Individual Well-Being:**[74] Using variation in state welfare policies and national breastfeeding data in a difference-in-differences design, this study finds that the most stringent state work requirements reduced breastfeeding rates six months after birth by 4.8 percentage points (34 percent) among WIC mothers and 2.6 percentage points (11 percent) among all mothers, and estimates that work requirements adopted under welfare reform reduced national breastfeeding at six months by 5.6 percent. The effect was concentrated specifically among full-time work requirements; the authors conclude that most of the harm would be eliminated if mothers of infants were not required to work full time — a mandate currently in place in about half of all states.

CMS offers no evidence for its assumption that terminating coverage will motivate engagement without impairing a person's capacity to work, and should either substantiate that assumption directly or revise the rule to reflect the alternative the evidence supports. At minimum, CMS should examine whether coverage terminations reduce individuals' chances of becoming or remaining employed, and should incorporate continuity of medical treatment, medication access, preventable hospital use, and the effect of Medicaid enrollment on individuals' capacity to work as relevant policy outcomes that both the agency's health rationale and the rule's operational standards must account for.

G. The regulatory impact analysis understates costs and overstates benefits or savings.

Research and evaluations of the outcomes of work requirement policies in states, such as Arkansas and Georgia, suggest that the cost/benefit analysis included in the IFR does not adequately consider all the costs and outcomes associated with conditioning program eligibility on compliance with work requirements. In addition to underestimating the costs to states for administrative and information technology upgrades, this policy will also likely lead to costs related to individuals taking on more medical debt, individuals delaying treatment or

10). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

[74] Steven J. Haider, Alison Jacknowitz, and Robert F. Schoeni, *Welfare Work Requirements and Individual Well-Being: Evidence from the Effects on Breastfeeding*, DRU-2730, Labor and Population Program Working Paper Series 02-01 (RAND, January 2002).
https://www.rand.org/content/dam/rand/pubs/drafts/2008/DRU2730.pdf

care, and hospitals and clinics paying for uncompensated care, costs already documented earlier in this section (see subsection F) but not addressed in the IFR's impact analysis.

The RIA also overstates savings on the other side of the ledger. While a community engagement requirement may lead some members to lose eligibility because increased earnings push them over the income eligibility threshold, there is no guarantee that this wage increase will exceed the value of the Medicaid coverage they forgo. CMS's own regulatory impact analysis acknowledges this dynamic, stating that foregone government assistance "can be substantial, and sometimes exceeds" the marginal value of the work performed. CBO's 2022 report on work requirements and work supports reaches the same conclusion more generally: when work requirements expand, the resulting loss in benefits typically equals or exceeds the gain in earnings, and CBO specifically notes this is more likely where employment is already common among the affected population.[75]

In the case of Georgia, the state spent $54.2 million from fiscal year 2021 through the second quarter of fiscal year 2025 on administrative costs alone. This was more than twice what it spent on medical assistance for affected members over the same period, and far more than the state's own projections anticipated given how far actual enrollment in the Georgia Pathways program fell short of expectations. Separately, CBO's 2023 estimate of a federal Medicaid work requirement modeled under H.R. 2811 found that the policy would reduce federal spending by about $109 billion from 2023 to 2033 while having a negligible effect on employment, cause roughly 1.5 million adults to lose Medicaid, leave about 600,000 of them uninsured, and shift approximately $65 billion in coverage costs to states (see subsection B). Neither Georgia's experience nor CBO's analysis was discussed by CMS in the IFR's impact analysis.

The agency should incorporate these findings into its impact analysis, along with the following source:

- **Medicaid Demonstrations: Information on Administrative Spending for Georgia Work Requirements:**[76] GAO found that CMS's demonstration approval process does not account for administrative costs at all. CMS does not require states to project these costs in their applications, nor does it include them in the budget-neutrality calculations used to approve demonstrations. Georgia's $54.2 million in actual spending was therefore never weighed against the program's expected benefits at the approval stage.

These, and other sources already shared in this comment,[77] call into question a number of statements and claims made by CMS in the IFR, including: existing systems and cross-

[75] CBO (2022).
[76] U.S. Government Accountability Office. (2025, September 3). *Medicaid demonstrations: Information on administrative spending for Georgia work requirements* (GAO-25-108160).
[77] See CBO (2022); Sugar et al. (2021); Chan (2025); Hill, Burroughs, and Adams (2020); Cuffey, Katare, and Fulford (2023); Dodini, Larrimore, and Tranfaglia (2022).

program alignment will keep implementation costs low; the rule's principal economic effects can be captured through enrollment changes, administrative hours, and government transfers; and that people losing benefits will replace the resources provided by Medicaid through work or other activities.

CMS should quantify medical debt, delayed care, and uncompensated care costs where possible, using the Arkansas and churning evidence already noted in this comment as a starting benchmark, and should identify these effects explicitly where quantification is not possible. CMS should also distinguish true resource savings from transfers of costs from the federal government to Medicaid members, states, counties, providers, and communities, rather than counting reduced enrollment or reduced administrative hours as a savings without accounting for where those costs land instead. Failure to do so would mean that CMS is not accounting for the true costs and benefits of its proposed rule.

H. State flexibility and outreach cannot substitute for enforceable federal protections.

The experiences of Arkansas, Georgia, and New Hampshire demonstrate common, consistent failures that appear to have plagued states implementing Medicaid work requirements, despite each state pursuing a different strategy to avoid them. CMS's response to these failures is to rely on better outreach and use of technology to prevent the same problems from recurring under this policy. Outreach and more accessible reporting options may reduce some harms, assuming they are effectively implemented. But experience from these three states shows they are not sufficient to prevent large-scale procedural loss.

Arkansas's experience, discussed at length in subsections B and F above, shows procedural loss occurring with minimal outreach efforts at all: more than 95 percent of the population targeted by the work requirement was already meeting it or should have qualified for an exemption, yet 18,000 people lost coverage within the policy's first six months.

New Hampshire's failure, discussed in subsection D above, is particularly instructive because it occurred despite the state's explicit attempt to avoid Arkansas's mistakes. In New Hampshire, more flexible reporting options, a grace period for missed hours, and automatic reinstatement were strategies used by the state to inform impacted members of these new changes. New Hampshire still saw an estimated 17,000 beneficiaries, roughly 40 percent of those subject to the requirement, put at risk of losing coverage within weeks. CMS's own letter withdrawing approval of New Hampshire's demonstration attributes this outcome not to noncompliance, but to confusing notices, ineffective outreach, reporting burdens, and exemption barriers.

Georgia's experience tells a similar story. As discussed in subsection B above, only about 8,077 Georgians were actively enrolled in the state's work requirement program after two years—around 7 percent of the uninsured, low-income working households the program was meant to reach. Failure to meet the qualifying-hours reporting requirement alone prevented

an estimated 54 percent of interested Georgians from ever applying, and accounted for about 11 percent of the applications that were denied. About 22 percent of all application denials, and about 30 percent of total disenrollments, were attributable to procedural or paperwork issues rather than any actual determination of ineligibility.

Three states employing three different strategies all saw the same outcome: substantial coverage loss among people the programs were not intended to disenroll. These experiences call into question CMS's apparent assumption that the general notice and outreach requirements in the IFR are sufficient to prevent mass erroneous termination of coverage for eligible individuals. We request that CMS review the following source and consider it in the IFR so that the rule can more effectively limit the possibility of mass disenrollments:

- **Medicaid Work Requirements Can't Be Fixed:**[78] This brief argues that Medicaid work requirements inevitably cause eligible people, including workers with volatile hours and people who should qualify for exemptions, to lose coverage through reporting and documentation burdens. At the same time, it argues such policies offer little prospects of increasing long-term employment or reducing poverty, and potentially undermine work altogether by depriving Medicaid members of the health care they need to remain employed.

CMS should incorporate this evidence, and the other relevant evidence already discussed in this section,[79] by establishing binding federal minimum standards to prevent the mass disenrollments seen in Arkansas, Georgia, and New Hampshire. At minimum, those standards should strengthen and make auditable the IFR's existing ex parte data-matching and exemption-screening requirements; require self-attestation as an acceptable form of verification when third-party data is unavailable, incomplete, or delayed; establish retroactive restoration of coverage when erroneous termination is identified; and establish audit procedures and corrective-action triggers, none of which the current rule provides. If CMS declines to adopt standards along these lines, it should state its reasons for doing so, and provide a reasoned, evidence-based explanation for why the agency believes the current rule is adequate to prevent the outcomes already documented in states that have implemented similar requirements.

I. Evidence from other Medicaid demonstration policies shows the same administrative-conditioning failures under different program designs.

CMS's discussion of Arkansas and Georgia implies that the mass disenrollment observed in those states resulted from features specific to their community engagement programs, and that clearer notices and more accessible reporting can be expected to prevent the same

[78] Solomon, J. (2019, January 10). *Medicaid work requirements can't be fixed: Unintended consequences are inevitable result*. Center on Budget and Policy Priorities.
[79] See Hill, Burroughs, and Adams (2020); Centers for Medicare & Medicaid Services. (2021); Sommers et al. (2019); Sommers et al. (2020); GAO (2025); Chan (2025).

outcome under this rule. That premise does not hold if the same outcomes were seen across Medicaid demonstrations that condition eligibility on entirely different requirements. Other section 1115 demonstrations, such as imposing premium-payment requirements, health-risk-assessment requirements, and wellness-activity requirements, have resulted in similar patterns of low beneficiary awareness and low completion of the required activity, with resulting coverage losses far too large to be explained by beneficiaries simply choosing not to comply.[80] This suggests that the failures documented in Arkansas, Georgia, and New Hampshire are not specific to community engagement or work reporting, but are a predictable consequence of conditioning Medicaid eligibility on completion of any administrative action, regardless of what that action is.

For example, in Michigan's healthy behavior incentive demonstration, only 27 percent of Medicaid expansion members completed a required health risk assessment despite financial incentives to do so.[81] Iowa's healthy-behavior program produced under 20 percent compliance in its first two years; a 2019 disenrollment survey found only 39 percent of respondents had ever heard of the program, 22 percent did not know they had been disenrolled, and 70 percent of those who did know had done nothing to prepare for it, leaving 54 percent still uninsured at the time of the survey, with many reporting delayed prescriptions as a result. Indiana's POWER account premium requirement left 46,000 people unenrolled between February 2015 and November 2016 for failure to make an initial payment, with 39 percent of enrollees reporting they had never heard of the requirement.

CMS should incorporate this evidence into the rule's design, not just its rationale for the rule. Because the same pattern—low awareness, low completion, and coverage loss far exceeding what noncompliance alone would explain—has recurred across multiple, structurally different policies, CMS should apply the enforceable protections requested throughout this comment, including the ex parte verification, self-attestation, notice, and audit standards described in subsections D and H, to the community engagement requirement as a baseline design feature, not as safeguards to be added only if problems emerge after implementation. If CMS believes a specific feature of this rule's notice and reporting design will avoid the outcomes seen in Michigan, Iowa, and Indiana, it should identify that feature and explain, with supporting evidence, why it is expected to succeed where those demonstrations failed. Absent such an explanation, CMS should treat the pattern documented here as evidence that low take-up and erroneous coverage loss are a predictable consequence of this rule as currently designed.

J. The rule's effects are not evenly distributed, but concentrated among beneficiaries with chronic illness, disability, and other identifiable characteristics.

The IFR discusses coverage loss and administrative burden as though they fall with equal probability across the entire population likely to be affected by this rule. The evidence

[80] See ASPE (2021).
[81] See ASPE (2021).

reviewed throughout this section indicates otherwise. The same characteristics associated with a higher likelihood of noncompliance with any administrative requirement are also concentrated among the people research finds are actually screened out or disenrolled when these policies are put in place. Research shows this pattern holds along two distinct dimensions: health status and disability, and race and ethnicity.

On health and disability, the evidence is direct and consistent. Reinstated SNAP work requirements in Connecticut disproportionately disenrolled beneficiaries with diabetes and other chronic conditions, and older beneficiaries with multiple comorbidities, at rates far exceeding those for younger, healthier beneficiaries.[82] In a separate context, increased application burden for federal disability benefits reduced applications by 10 percent and awards by 16 percent, with the decline concentrated among applicants with moderately severe conditions. These outcomes were seen not because these applicants were less likely to qualify, but because the added burden of applying for benefits screened them out disproportionately.[83] In Ohio, more than 32 percent of individuals subject to SNAP work requirements reported a physical or behavioral health limitation that likely should have qualified them for an exemption.[84] Nationally, an estimated 16.6 percent of Medicaid enrollees—people with serious difficulties in cognitive function, vision, hearing, or self-care—are disabled but do not receive Supplemental Security Income, meaning their disability is real but requires alternative documentation that a rule like this one does not adequately accommodate.[85] Taken together, these findings point in the same conclusion: a substantial share of Medicaid's disabled population lacks the SSA-linked documentation this rule's exemption categories are likely to rely on, and the administrative burden of establishing eligibility through alternative means tends to screen out exactly the moderately severe cases most likely to fall through the cracks. Colorado-specific data confirm the same pattern locally. Nearly half of the state's Medicaid Expansion population were modeled as having a qualifying chronic illness, serious mental health condition, or disability, and this population's Medicaid costs were substantially higher than the broader population's, meaning the Medicaid members most likely to be erroneously screened out by this rule are also the members whose coverage loss would be most damaging to their health and economic security.[86]

Disparate outcomes by race and ethnicity are a separate, independently documented pattern. A later state evaluation of Indiana's POWER account demonstration found that Black beneficiaries had a higher likelihood of disenrollment than white beneficiaries, and research on Iowa's healthy-behavior program similarly found that younger beneficiaries, male beneficiaries, and racial or ethnic minorities faced significantly higher risk of not

[82] Ndumele et al. (2025).
[83] Deshpande and Li (2019).
[84] Katch, Wagner, and Aron-Dine (2018).
[85] Goldman et al. (2018).
[86] Everhart et al. (2026).

completing required activities.[87] The same pattern appears in a different Medicaid work-requirement program: Hispanic and Latino Georgians make up about 15 percent of the state's low-income uninsured population eligible for its work requirement program, but only about 3 percent of the applicants who actually enrolled.[88] And in Missouri's SNAP program, 40 percent of participants subject to a reinstated work-hour time limit were Black, compared with 30 percent of all SNAP participants statewide.[89] Reviewing the broader literature on Medicaid work requirements, researchers have concluded that people with disabilities and people of color both face disproportionate challenges in meeting work requirements, and are disproportionately sanctioned under existing work requirement programs, independent of one another.[90]

CMS should treat disparate impact on beneficiaries with chronic illness, disability, and specific racial or ethnic groups as a foreseeable outcome of this rule, not an incidental byproduct of neutral administrative requirements. The disaggregated reporting and corrective-action standards requested elsewhere in this comment, including outcome measurement by disability, chronic condition, race, age, rurality, homelessness, and primary language, should be adopted as a condition of state implementation, not merely a monitoring aspiration to be pursued after the fact.

K. CMS's monitoring framework should measure real outcomes, not merely implementation and compliance by state.

The metrics CMS proposes for monitoring and evaluating implementation of the community engagement requirement are insufficient to evaluate this policy's actual impact on members, states, and the economy. A program can be administratively operational while simultaneously failing to increase employment and causing substantial harm to those it is intended to help. CMS states that its reporting requirements will support program integrity, accurate determinations of eligibility, transparency, and oversight. The evidence discussed throughout this section indicates that meeting those stated goals requires measuring outcomes CMS's current framework does not appear to capture.

Taken together, these sources suggest that CMS's monitoring framework should separately measure:

- Employment, hours, earnings, and job retention among those required to meet community engagement requirements;[91]

[87] ASPE (2021).
[88] Chan (2025).
[89] Wheaton et al. (2021).
[90] Antonisse and Garfield (2018).
[91] See Sommers et al. (2019); Sommers et al. (2020); Gangopadhyaya and Karpman (2025); Gray et al. (2023); Cook and East (2025); CBO (2022); Wheaton et al. (2021); Chan (2025).

- Whether those that lose Medicaid coverage as a result of noncompliance are later covered through employer-sponsored or other replacement health care coverage;[92]
- Whether coverage loss reflects actual noncompliance or procedural disenrollment, including loss of coverage among people who were working or who should have been excluded from the requirement entirely;[93]
- The number of reapplications and the duration of coverage gaps experienced by beneficiaries who lose and later regain coverage;[94]
- Changes in medical debt and uncompensated care, both for affected members and for the safety net providers who absorb the cost of their coverage loss;[95]
- Outcomes disaggregated by group including by disability, chronic condition, race, age, rural residence, homelessness, and primary language spoken;[96] and
- State and county administrative expenditures and contractor costs associated with implementation of this rule.[97]

CMS should adopt these measures as part of its monitoring framework, not as optional or supplementary data. Absent this evidence, CMS cannot determine whether the rule is achieving its stated goals of program integrity and accurate eligibility determinations, or whether it is instead producing the same coverage losses, administrative costs, and disparate outcomes seen in other states and documented throughout this section. If CMS declines to adopt these measures, it should explain why the metrics currently proposed in the IFR are sufficient to distinguish between a program that is operating as intended and one that is causing the harms this section has documented.

Requested CMS response

CMS should respond to the following issues before finalizing the rule's approach to work requirements, administrative burden, and monitoring:

1. Will CMS revise the preamble's discussion of employment and health to reflect the bidirectional relationship the agency itself acknowledges, recognize Medicaid coverage as a potential employment support consistent with that relationship, and evaluate whether implementation choices available to it under HR-1 would better preserve, rather than undermine, members' ability to obtain and maintain employment?

[92] See Sommers et al. (2019); Sugar et al. (2021).
[93] See Deshpande and Li (2019); Hill, Burroughs, and Adams (2020); Centers for Medicare & Medicaid Services (2021); Sommers et al. (2019); Goldman et al. (2018); Silvestri, Holland, and Ross (2018); Ndumele et al. (2025); Han (2020); Tolbert et al. (2025); ASPE (2021).
[94] See Sugar et al. (2021).
[95] See Sommers et al. (2020); Sugar et al. (2021); Everhart et al. (2026); Dodini, Larrimore, and Tranfaglia (2022) and Cuffey, Katare, and Fulford (2023).
[96] See ASPE (2021); Ndumele et al. (2025); Deshpande and Li (2019); Chokshi and Katz (2018); Everhart et al. (2026); Chan (2025); Wheaton et al. (2021); Antonisse and Garfield (2018).
[97] See GAO (2025); Dodini, Larrimore, and Tranfaglia (2022) and Cuffey, Katare, and Fulford (2023).

2. Does CMS have evidence supporting its assumption that this rule will increase employment, wages, or self-sufficiency? If not, will CMS remove that assumption from the RIA's projected outcomes?

3. Will CMS identify the specific features of the finalized rule, if any, designed to prevent the outcomes already documented in SNAP and TANF work requirement programs? If no such features exist, will CMS revise the rule to include them?

4. Will CMS account for the financial costs work requirements have imposed directly on affected individuals, including the increased medical debt, delayed care, and delayed medication use documented among Arkansans who lost Medicaid coverage under that state's work requirement, as well as the increased debt and reliance on emergency food assistance documented among SNAP beneficiaries subject to comparable work requirements, in its cost-benefit analysis of this rule? Or does CMS believe these financial harms, already documented in the one state where a Medicaid work requirement has actually been implemented, will not recur under this rule?

5. Will CMS treat procedural coverage loss as a foreseeable, substantive harm caused by imposing work requirements as a condition of eligibility, rather than as an incidental implementation problem?

6. Will CMS make self-attestation mandatory, not optional, whenever reliable third-party data is unavailable, incomplete, delayed, or inaccessible, both before and after January 1, 2028?

7. Section 1902(xx)(9)(A)(ii)(V) expressly delegates to the Secretary the authority to define who qualifies as medically frail or as having special medical needs, and CMS states in the preamble that this "demonstrates Congress's intent to afford the Secretary discretion to establish standards governing the scope and application of this term." CMS further states that it declined to use this discretion to add categories beyond the statutory five, and declined to extend to community engagement the added flexibility it permits for medical frailty in other contexts. Given that these were CMS's own discretionary choices rather than requirements imposed by the statute, will CMS explain why it exercised its discretion as narrowly as it did, in light of the population-level evidence in this section showing that people with real, work-limiting health conditions routinely fall outside the categories and documentation standards CMS chose to adopt?

8. Does CMS have evidence that terminating coverage will not impair a Medicaid member's ability to work? If not, will CMS revise the rule to reflect the alternative the evidence supports, and treat continuity of medical treatment, medication access, preventable hospital use, and the effect of enrollment on members' capacity to work

as relevant outcomes for both the rule's health rationale and its operational standards?

9. Will CMS quantify medical debt, delayed care, and uncompensated care costs in the regulatory impact analysis where possible, and identify these effects explicitly where quantification is not possible?

10. Will CMS distinguish true resource savings from transfers of cost onto Medicaid members, states, counties, providers, and communities, rather than counting reduced enrollment or reduced administrative hours as a savings without accounting for where those costs land instead?

11. Will CMS establish binding federal minimum standards, including auditable ex parte data-matching and exemption-screening requirements, self-attestation as an acceptable verification method when third-party data is unavailable, retroactive restoration of coverage upon erroneous termination, and audit and corrective-action triggers, rather than relying on state outreach and flexibility that the evidence shows has not prevented mass disenrollment in Arkansas, Georgia, and New Hampshire? If CMS declines, will it state its reasons?

12. Will CMS identify the specific design feature that distinguishes this rule from the failed health-risk-assessment, premium-payment, and wellness-activity conditioning mechanisms already documented in other Medicaid demonstrations, and apply the enforceable protections requested throughout this section as a baseline design feature rather than as a response to problems only after they emerge?

13. Will CMS treat disparate impact on beneficiaries with chronic illness, disability, or specific racial or ethnic groups as a foreseeable effect of this rule, rather than an incidental byproduct of neutral administrative requirements?

14. Will CMS adopt a monitoring framework that measures actual outcomes, including employment and earnings effects, replacement coverage rates, the share of coverage loss attributable to procedural versus substantive noncompliance, reapplication and coverage-gap patterns, medical debt and uncompensated care, state and county administrative and contractor costs, and outcomes disaggregated by disability, chronic condition, race, age, rurality, homelessness, and primary language, rather than implementation and compliance metrics alone?

15. Will CMS require this outcome-based and disaggregated reporting as a condition of state implementation, rather than as a monitoring aspiration to be pursued after the fact?

CMS should engage directly with the research, data, and state experience discussed in this section when finalizing the rule. Where CMS declines to adopt a change requested in this

section, it should explain why, with reference to the specific evidence discussed above, rather than proceeding as though this evidence does not exist.

V. CMS must distinguish substantive noncompliance from procedural inability to verify

CMS should revise the IFR, or issue binding implementation guidance, to clearly distinguish substantive noncompliance with section 1902(xx) from procedural inability to verify compliance. This distinction is essential to accurate implementation of HR-1. The statute requires consequences for applicable individuals who fail to demonstrate community engagement after notice and an opportunity to make a satisfactory showing. It does not require, and CMS should not permit, denial or termination of Medicaid eligibility for individuals who are actually working, enrolled in education, participating in a qualifying work program, deemed compliant, excluded, or eligible for an exception, but whose status cannot be verified because of missing data, delayed records, confusing notices, inaccessible reporting systems, or state administrative failures.

The IFR already recognizes that inability to verify is a distinct status for applicants and members. CMS defines "unable to verify" to mean that the state does not have sufficient information to determine whether the individual satisfied the community engagement requirement after reviewing information provided on the application or renewal form and reliable information available to the state.[98] That definition confirms that inability to verify is not the same as affirmative noncompliance, because it depends on the adequacy of information available to the state, not on the Medicaid member's compliance with the requirement. A failed data match, missing wage record, delayed school record, unreported program hour, unreachable employer, unavailable provider record, or inaccessible online portal does not establish that an individual failed to satisfy section 1902(xx). It establishes only that the state has not verified compliance through the information available to it.

This distinction should be central to CMS's approach to implementing section 1902(xx). Prior Medicaid work requirement experiences in other states show that many coverage losses were driven by reporting and documentation barriers, not by evidence that beneficiaries were refusing to work or engage in qualifying activities. In Arkansas, beneficiaries not automatically exempted through data matching initially had to report compliance or exemptions through an online portal, and 99 percent of noncompliance among non-exempt beneficiaries occurred because nothing was reported through the portal.[99] A more recent analysis of Arkansas's experience found that the work requirement reduced Medicaid

[98] 42 CFR §435.558(b)

[99] Medicaid and CHIP Payment and Access Commission (MACPAC). (2018, October 25). *Update on Implementation of Work and Community Engagement Requirements in Arkansas* [Presentation]. October 2018 MACPAC Public Meeting, Washington, DC. https://www.macpac.gov/publication/update-on-implementation-of-work-and-community-engagement-requirements-in-arkansas/

participation by approximately 28,810 adults, a decline larger than the 18,164 direct disenrollments reported for noncompliance, while finding no discernible changes in labor supply.[100] Because labor supply did not change while total participation losses exceeded the number of people the state directly disenrolled for noncompliance, the additional loss cannot be explained by beneficiaries failing to work or engage—it reflects people leaving or failing to remain in the program through the administrative process itself. This evidence underscores that non-reporting and nonparticipation are not the same thing.

CMS should therefore require states to classify and report noncompliance outcomes in a way that distinguishes a member's actual failure to satisfy the requirement from a state's procedural inability to verify. At minimum, CMS should distinguish among: individuals affirmatively determined not to have satisfied the requirement; individuals whose compliance could not be verified because state data were unavailable or incomplete; individuals who did not respond to a notice; individuals whose third-party records were delayed or missing; individuals whose reporting failed because of technology, language, disability, mailing-address, or other access barriers; and individuals later found to have been compliant, excluded, deemed compliant, or eligible for an exception.

This distinction is also necessary for notice and cure procedures. A notice sent because the state is unable to verify compliance should not tell the member that the state has determined they failed to comply unless the state has actually made that determination. The IFR's existing cure period addresses timing, and gives the member time to respond, but it does not address the separate problem of whether the notice accurately characterizes the member's status in the first place. The notice should explain that the state lacks sufficient information, identify what information the state checked, identify which potential exemptions and pathways the state could not verify, explain all available ways to demonstrate compliance or an exclusion, and provide a meaningful opportunity to correct the record. CMS should require states to use notice language such as "we could not verify," not "you failed to comply," unless the state has evidence of actual noncompliance.

The IFR already provides that states may not limit their review to a single pathway and must check whether the person satisfies the requirement or qualifies for excluded or deemed-compliant status through another pathway before requesting additional information or initiating noncompliance procedures.[101] Section VI of this comment addresses in detail how CMS should strengthen and operationalize that ex parte framework. Here, CMS should at minimum make the single-pathway-review requirement auditable by requiring states to document which data sources were checked, which pathways were evaluated, whether exclusions or exceptions were considered, and why the state remained unable to verify compliance.

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[100] Mizushima, Y. (2026, May 21). *Do Medicaid work requirements work?* [Working paper]. Harvard Medical School and Harvard Pilgrim Health Care Institute.
[101] 2 CFR §435.557(c)(1)

CMS should also clarify that a person should not be terminated solely because a state data source is incomplete or unavailable. For example, wage records may not capture informal work, self-employment, recent employment, seasonal work, in-kind work, or hours worked but not yet reported. School records may not capture less-than-half-time education, noncredit training, adult education, ESL, high school equivalency preparation, or program-required hours. Workforce and SNAP E&T records may be maintained by agencies or providers that do not share data directly with Medicaid eligibility systems, such as the Colorado Benefit Management System (CBMS) here in Colorado. In each of these situations, the absence of an electronic match should trigger an opportunity for attestation or correction, not a presumption of noncompliance.

CMS should require states to accept self-attestation, absent contrary evidence, where third-party data are unavailable, incomplete, delayed, or not reasonably accessible. Section VI of this comment addresses in detail why self-attestation is necessary here and does not excuse actual noncompliance or shift the statutory burden to make a satisfactory showing. If CMS believes self-attestation may not be required in all such circumstances, CMS should identify the statutory text that prevents it and explain how states will avoid terminating individuals who satisfy section 1902(xx) but cannot obtain timely third-party documentation.

CMS should also require states to treat later-submitted proof of compliance, excluded status, deemed-compliant status, or exception eligibility as evidence that the prior denial or termination was procedural rather than substantive. Where a member or applicant later demonstrates that they satisfied the requirement for the relevant period, CMS should require prompt reinstatement and correction of the eligibility record. CMS should also require states to report these reinstatements separately, because a high rate of late corrections would indicate that the state's verification and notice systems are failing to identify compliance accurately before termination.

Finally, CMS should require monitoring and auditing of state's Medicaid programs to determine whether procedural inability to verify is producing coverage loss among Medicaid members who are actually eligible and meet the program requirements, including community engagement requirements. Section IX of this comment sets out the specific data elements and corrective-action triggers CMS should adopt for this purpose. Consistent with that framework, if CMS finds that a state's systems are not accurately applying section 1902(xx) and are instead causing eligible individuals to lose or be denied coverage, CMS should require the state to pause the specific verification, compliance, or noncompliance processes shown to be producing that outcome until the state resolves the underlying failure.

Requested CMS response

CMS should respond to the following issues before finalizing, revising, or relying on the IFR's noncompliance framework:

1. Will CMS require states to distinguish actual noncompliance from inability to verify compliance because of missing data, delayed records, failed data matches, or reporting-system barriers?
2. Will CMS require notices to state accurately when the state is unable to verify compliance, rather than stating or implying that the individual failed to comply?
3. Will CMS require states to document which data sources and compliance pathways were checked before issuing a noncompliance notice, as requested in more detail in Section VI?
4. Will CMS require states to accept self-attestation, absent contrary evidence, when third-party data are unavailable, incomplete, delayed, or not reasonably accessible, as requested in more detail in Section VI?
5. Will CMS prohibit states from treating a failed data match as affirmative evidence of noncompliance, as requested in more detail in Section VI?
6. Will CMS prohibit states from treating a failed data match as affirmative evidence of noncompliance?
7. Will CMS require states to reinstate coverage promptly when later-submitted information shows the individual was compliant, excluded, deemed compliant, or eligible for an exception during the relevant period?
8. Will CMS require states to report procedural terminations separately from terminations based on affirmative findings of noncompliance?
9. Will CMS require states to report failed verification by pathway, including work, income, education, work-program participation, community service, exclusions, exceptions, and deemed-compliant status?
10. Will CMS adopt the corrective-action and pause triggers described in Section IX of this comment, so that adverse actions based on community engagement verification are paused when monitoring, audits, or case reviews show that state systems are denying or disenrolling individuals who are eligible, excluded, deemed compliant, exception-eligible, or otherwise satisfying the requirement?

If CMS declines to adopt these safeguards, CMS should identify the statutory text that prevents them or explain, with record evidence, why they are unnecessary to accurate implementation of section 1902(xx).

VI. CMS should strengthen and operationalize the IFR's ex parte verification framework

CMS correctly recognizes in the IFR that states must attempt to verify compliance, deemed-compliant status, and excluded status through reliable information available to the state before requesting additional information from an applicant or member.[102] CMS also correctly interprets section 1902(xx)(5) to require states to attempt ex parte verification every time they verify compliance, not only at renewal.[103] This is an important protection because the community engagement requirement will be implemented across many different pathways, data systems, agencies, schools, employers, and work program providers.

However, the final rule should strengthen the ex parte framework so that it is enforceable, auditable, and sufficient to prevent procedural coverage loss. The IFR's general requirement to use reliable information available to the state is necessary, but not sufficient. Without more specific operational standards, states may treat a failed data match, missing wage record, unavailable school record, incomplete program file, or unconnected eligibility system as a basis for shifting the burden to the member, leading ultimately to terminated coverage.

CMS should not allow states to define "available to the State" narrowly in a way that ignores information held by agencies or contractors that the state can reasonably access for eligibility purposes. CMS should also require states to document which data sources were checked before requesting beneficiary documentation, issuing a noncompliance notice, denying eligibility, or terminating coverage. The IFR already states that states may not limit their review to a single pathway and must check whether an individual satisfies the requirement or qualifies for excluded or deemed-compliant status through another pathway before requesting additional information or initiating noncompliance procedures.[104] To make that requirement meaningful, CMS should require states to create an auditable record showing which pathways were evaluated, which data sources were checked, what information was found, what information was missing, and why the state remained unable to verify compliance. This is a distinct requirement from the verification plan states must already submit under §435.945(j). A verification plan describes a state's general policies and procedures, while an auditable record documents what was actually checked in each individual case. The plan-level submission does not tell CMS, a Medicaid member, or a reviewing court what happened in any particular applicant's file, which is what an enforceable ex parte requirement needs. We recognize this asks states to build or adapt case-level documentation systems, which carries a real administrative and IT cost. However, that cost should be weighed against the cost of erroneous terminations, reinstatement

[102] Section 1902(xx)(9)(A)(ii), as discussed in the IFR preamble
[103] IFR preamble discussion of §435.557(c)(1) and section 1902(xx)(5)
[104] 42 CFR §435.557(c)(1)

processing, and fair hearings that an unenforceable ex parte requirement will generate instead.

Where ex parte sources are unavailable, incomplete, delayed, or not reasonably accessible, CMS should require states to accept self-attestation absent contrary evidence. Self-attestation in this context is not an exception to the community engagement requirement, and it does not relieve the applicable individual of the statutory burden to make a satisfactory showing of compliance. It is a verification method necessary to prevent erroneous eligibility decisions when state systems cannot confirm information that may be true. CMS should clarify that a failed data match does not create a presumption of noncompliance and does not, by itself, justify denial or termination.

Finally, CMS should use reporting and oversight to ensure that ex parte verification works in practice. Section IX of this comment sets out the corrective-action and pause triggers CMS should adopt based on that reporting. Specific to the ex parte process itself, CMS should require states to report the number of individuals verified through ex parte data, the data sources used, and the number for whom ex parte verification failed. This ex parte-specific reporting is what allows CMS to identify, under the Section IX framework, whether verification failures are concentrated in particular pathways or data sources rather than reflecting genuine noncompliance among members required to demonstrate community engagement.

Requested CMS response

CMS should respond to the following issues before finalizing, revising, or relying on the IFR's verification framework:

1. Will CMS require states to document which data sources and pathways were checked before requesting beneficiary documentation, issuing a noncompliance notice, denying eligibility, or terminating coverage, and will CMS distinguish this case-level documentation requirement from the general verification plan already required under §435.945(j)?
2. Will CMS require states to check reasonably available education, training, work-program, SNAP, TANF, wage, income, and other relevant records before treating an individual as unable to verify?
3. Will CMS require states to accept self-attestation, absent contrary evidence, where third-party records are unavailable, incomplete, delayed, or not reasonably accessible?
4. Will CMS clarify that a failed data match does not establish noncompliance and does not create a presumption that the individual failed to satisfy section 1902(xx)?

5. Will CMS require states to seek direct agency or provider verification where feasible before requiring beneficiary-supplied paperwork?
6. Will CMS require ex parte-specific reporting — verification success, verification failure and its cause, data sources used — by pathway, consistent with the broader reporting framework requested in Section IX?

If CMS declines to adopt these safeguards, it should identify the statutory text that prevents them or explain, with record evidence, why they are unnecessary to accurate implementation of section 1902(xx).

VII. CMS must ensure education and work program pathways are clear and verifiable

HR-1 recognizes several pathways through which an applicable individual may satisfy the Medicaid community engagement requirement, including work program participation, educational enrollment, and combinations of qualifying activities. CMS's implementation of these pathways will determine whether states can accurately identify compliance or whether Medicaid members, county eligibility workers, schools, workforce agencies, and training providers are left to interpret which programs fall into which pathway on their own.

CMS should ensure that the education and work program pathways are administrable in the Medicaid context. Medicaid agencies generally do not administer WIOA programs, SNAP E&T, adult education, higher education, CTE, high school equivalency programs, apprenticeships, community college workforce programs, or community-based training programs. Without clear classification and verification rules, a member may be engaged in a qualifying activity but still be treated as noncompliant because the state cannot determine whether the program counts or cannot verify participation through available records.

A. CMS should require states to identify and classify qualifying programs in advance.

CMS should require each state to identify the programs and program categories it will treat as qualifying work programs, educational programs, CTE programs, high school programs, high school equivalency programs, and less-than-half-time education or training activities that may be combined with other qualifying activities.

CMS should require states create public, searchable, regularly updated lists or databases of all qualifying education or work training programs. States should also be required to create a transparent classification process that can be used to understand why a program was classified the way it was. The purpose of this list or database should be to help members, county eligibility workers, schools, workforce agencies, community organizations, managed care organizations, and advocates determine whether a program counts for purposes of complying with the community engagement requirement.

Being included on this list should not be the only way a program can qualify. If an individual Medicaid member reports participation in a program that is not already listed, the state should be required to screen that program under all potentially applicable definitions in statute and rule before concluding that it does not count. We recognize that building and maintaining this kind of list is a real administrative undertaking. That cost should be weighed against the cost of case-by-case, inconsistent determinations by eligibility workers untrained in workforce and education systems, in addition to the cost to members of enrolling or participating in a work or education program that they mistakenly thought would qualify for compliance with the community engagement requirements. And surely there are benefits to states if a state can build this list once and maintain it, rather than re-evaluating the same program every time a different eligibility worker encounters it. Such a database would like be a benefit to Colorado, where county workers are the ones tasked with verifying eligibility—having a consolidated state-wide list would also mean the same program does not get evaluated each time a different county eligibility work encounters it.

The list should identify the basis on which each program qualifies to be counted towards community engagement. For example, CMS should require states to specify whether a program counts as a WIOA Title I program, SNAP E&T, a state or local employment and training program, a workforce partnership, a CTE program, an institution of higher education, high school, high school equivalency, or another recognized option within these pathways. This would reduce inconsistent determinations and prevent individual eligibility workers, who may be unfamiliar with workforce and education programs, from having to make case-by-case judgments about education and workforce systems outside their expertise. This would also help avoid situations where a program may count in one county, but not in another.

B. CMS should require states to screen programs under every pathway they may satisfy.

CMS should require states to screen the programs included in a state's list or database to identify every pathway through which participation in the program for the requisite amount of time would qualify for meeting the community engagement requirement. A program may qualify under more than one category, and Medicaid members should not lose coverage because the state improperly classified a program too narrowly, when in reality, it could allow for compliance using a different pathway.

This is particularly important because Medicaid and SNAP do not treat education and training in identical ways.[105] A program may count as a Medicaid educational program but not as a SNAP qualifying work program. Another program may count as a SNAP qualifying work program and therefore also count for Medicaid through the statutory cross-reference. A third program may qualify as CTE, as a state or local employment and training program, or as less-than-half-time education that can be combined with work or other activities.

[105] SSA §1902(xx)(2)(C)-(D); §1902(xx)(9)(D) cross-referencing FNA §6(o)(1); 42 CFR §435.552(b)

C. CMS should clarify the scope of the work program definition, including WIOA Title I and ETPL-listed programs.

CMS should clarify how the incorporated work program definition applies in the Medicaid context. HR-1 incorporates the SNAP definition of "work program," which includes programs under WIOA Title I, programs under section 236 of the Trade Act of 1974, state or local employment and training programs meeting standards approved by the Governor, certain veterans' employment and training programs, and workforce partnerships.[106] CMS should interpret and operationalize these categories clearly so states do not apply them inconsistently.

In particular, CMS should clarify what qualifies as a "program under title I of WIOA." This phrase could be read to include only participation in WIOA Title I programs, such as Adult, Dislocated Worker, Youth, Job Corps, YouthBuild, Native American programs, and Migrant and Seasonal Farmworker programs. It could also be misunderstood to include participation in any training program listed on a state's Eligible Training Provider List. This distinction matters because a training program may appear on an Eligible Training Provider List if it is eligible to receive WIOA funding, but not every person enrolled in that training is necessarily participating in WIOA Title I. Two individuals could participate in the same training program, with one receiving WIOA assistance and another using scholarships, private payment, employer support, or another funding source, but only the first would be able to count their participation towards complying with the community engagement requirement. The only difference is the funding source, which is not a reflection on actual participation in a qualifying activity. CMS should explain whether both individuals may count the same training toward Medicaid community engagement, whether only the WIOA-enrolled participant may count it for the work program pathway, and whether the non-WIOA-funded participant may count the same activity through another pathway.

CMS should also clarify whether states may recognize ETPL-listed programs, programs funded or authorized under other WIOA titles, or comparable training programs as qualifying state or local employment and training programs, workforce partnerships, CTE programs, educational programs, or another pathway recognized in the IFR. If CMS believes the statutory cross-reference prevents them from counting a broader number of such programs, CMS should identify the statutory text requiring that conclusion and explain how states should communicate the distinction to both Medicaid members and state and county eligibility workers.

[106] FNA §6(o)(1)/7 CFR §273.24(a)(3), as incorporated at SSA §1902(xx)(9)(D)

D. CMS should clarify that the CTE pathway is definitional and not limited to Perkins-funded programs.

CMS should clarify that the Perkins Act CTE reference is definitional. A program should not have to receive Perkins funding to qualify as a CTE program for Medicaid community engagement purposes if it otherwise meets the statutory CTE definition.[107]

States may reasonably begin with Perkins-funded program inventories when building qualifying-program lists or databases, but limiting CTE recognition only to Perkins-funded programs would improperly narrow the pathway and risk excluding students in otherwise qualifying programs, similar to the concern noted above regarding WIOA Title I programs. CMS should require states to identify how they will evaluate non-Perkins-funded CTE programs, private CTE programs, noncredit workforce programs, and community college workforce programs to determine if they qualify for one of the pathways for demonstrating compliance with community engagement requirements.

CMS should also clarify how CTE interacts with the work program pathway. Some programs may qualify both as CTE and as a state or local employment and training program, workforce partnership, WIOA-related program, or SNAP qualifying work program. States should be required to classify such programs under all applicable pathways so that they can be used by members who are pursuing different paths towards meeting the community engagement requirement.

E. CMS should clarify if adult education, ESL, literacy, digital skills, and noncredit workforce training count.

CMS should provide additional guidance on adult education, Adult Basic Education, ESL, literacy instruction, numeracy instruction, digital literacy instruction, GED preparation and testing, high school equivalency preparation, noncredit workforce training, continuing education, community college workforce programs, apprenticeships, and pre-apprenticeships and whether they qualify as programs members could participate in to meet their community engagement requirement.

These activities may be prerequisites to employment, high school equivalency, postsecondary education, or occupational training. Some individuals may not yet be ready for high school equivalency preparation because they first need foundational reading, numeracy, English-language, or digital skills. Others may need digital skills before they can apply for jobs, complete online training, communicate with employers or workforce staff, upload documents, use Medicaid eligibility portals, or complete electronic time sheets.

CMS should clarify that these activities may count where they satisfy a statutory or regulatory pathway. CMS should also clarify that states may not exclude adult education,

[107] Perkins Act §3, 20 U.S.C. §2302(5); SSA §1902(xx)(2)(D); 42 CFR §435.552(b)-(c)

English-language instruction, literacy instruction, or digital-skills programming merely because the activity is noncredit or not part of a traditional degree program.

F. CMS should specify how hours should be counted for education and training activities.

CMS should provide operational guidance on how states should count hours for education and training activities, particularly where a person is enrolled less than half-time, enrolled in a noncredit program, participating in adult education, completing asynchronous coursework, or combining education with work, community service, or work-program participation. CMS has already established a methodology for credit-bearing programs and has directed that, for programs without credit hours, states count hours spent attending class and participating in educational activities.[108] That methodology does not resolve how to count several of the activities most relevant to noncredit and adult-education programs, including case management, career navigation, job-readiness activities, and required activities that occur outside scheduled class time. CMS should extend its existing guidance to address these gaps rather than leave states to interpret them independently.

States should be instructed to count all required program activities, not only classroom seat time. This may include labs, clinicals, practicums, required study periods, supervised online learning, program orientation, assessments, case management, career navigation, job-readiness activities, required assignments, and other activities that the program requires as part of participation.

CMS should also clarify that once the state verifies enough hours or verifies half-time enrollment sufficient to establish compliance, the state should not require additional documentation of other activities for that verification period. Members should not have to prove every possible hour if one pathway or combination of pathways already establishes compliance with community engagement requirements.

G. CMS should require verification methods that reflect how education, training, and work-program records are actually maintained.

Consistent with the ex parte verification framework discussed in Section VI of this comment, CMS should require states to verify participation through program or agency records wherever feasible before requiring member-supplied paperwork. Schools, workforce agencies, SNAP E&T providers, WIOA providers, adult education programs, community colleges, and job-training providers may be better positioned than Medicaid members to verify enrollment, attendance, participation, or program status.

At the same time, CMS should recognize that records may be incomplete, delayed, or unavailable, especially for noncredit programs, adult education, community-based training, case management, supervised job search, or career services programs. Data collection may

[108] Medicaid IFC preamble; 42 CFR §435.552(d)(2)

be strongest during enrollment and active program participation but weaker for activities that occur after formal training or outside traditional classroom settings.

For the reasons discussed in Sections V and VI of this comment, CMS should require states to treat missing or delayed program records the same way as any other verification gap—as a reason to accept self-attestation, absent contrary evidence, and provide a meaningful opportunity to submit alternative documentation, not as a basis for a noncompliance finding.

H. CMS should require states to address interoperability, privacy, and data governance in verification systems.

CMS should require states to explain how Medicaid eligibility systems will communicate with workforce, education, SNAP, TANF, and provider systems. Limited interoperability, dual data entry, inconsistent workflows, delayed records, and incompatible systems can produce erroneous findings of noncompliance even when a member is participating in qualifying activities. Consistent with the distinction described in Section V of this comment, when systems cannot communicate, the state should classify the case as unable to verify, not as noncompliance. CMS should require states to document which systems can share data, which cannot, what manual workarounds will be used, and what protections will apply when a data exchange fails or is not possible due to technical, legal, or other limitations. We recognize this asks states to document technical architecture that is otherwise a state IT design choice; we ask for documentation, not a specific federal architecture, because without it CMS has no way to distinguish a state whose interoperability gaps are producing procedural coverage loss from one whose systems are working as intended.

CMS should also require privacy-protective data sharing. Education, training, and work-program verification may require information-sharing among Medicaid agencies, SNAP agencies, workforce agencies, schools, contractors, providers, and community organizations. States should share only the minimum data necessary to verify compliance, protect personally identifiable information, and avoid requiring third-party organizations to disclose unnecessary sensitive information. Clear data-sharing agreements and consistent workflows are necessary both to protect members and to make verification reliable.

Requested CMS response

CMS should respond to the following issues before relying on education and work program pathways as compliance options for meeting community engagement requirements:

1. Will CMS require states to identify and classify the education and work program pathways they will treat as qualifying under section 1902(xx)?
2. Will CMS require public, searchable lists or databases, or an equivalent transparent process for determining whether a program qualifies?

3. Will CMS require states to screen programs under every pathway they may satisfy and count each program under all applicable Medicaid community engagement pathways?
4. Will CMS clarify the difference between participation in a WIOA Title I program and enrollment in an ETPL-listed training program, and address the consequence that identical training may count differently for two participants based solely on funding source?
5. Will CMS clarify whether states may approve ETPL-listed programs, programs funded under other WIOA titles, or comparable training programs through another qualifying work-program or education-program pathway?
6. Will CMS clarify that the Perkins CTE reference is definitional and not limited to Perkins-funded programs?
7. Will CMS clarify whether adult education, Adult Basic Education, ESL, literacy instruction, digital literacy instruction, GED preparation and testing, high school equivalency preparation, noncredit workforce training, continuing education, apprenticeships, pre-apprenticeships, and community college workforce programs may count?
8. Will CMS extend its existing hour-counting methodology to address noncredit education, less-than-half-time education, asynchronous learning, required study time, labs, clinicals, practicums, case management, career navigation, and other required program activities not resolved by the current credit-hour conversion?
9. Will CMS require states to verify participation directly through program or agency records wherever possible before requesting documentation from the member, consistent with the ex parte framework requested in Section VI?
10. Will CMS require states to accept self-attestation, absent contrary evidence, when program records are unavailable, incomplete, delayed, or not reasonably accessible, consistent with Section VI?
11. Will CMS require states to treat interoperability failures, missing data, delayed records, and failed data transfers as verification problems rather than evidence of noncompliance, consistent with the framework requested in Section V?
12. Will CMS require privacy-protective data sharing, data minimization, and clear data-sharing agreements for education and work program verification?

If CMS declines to adopt any of these safeguards, it should identify the statutory text that prevents the safeguard or explain, with record evidence, why the safeguard is unnecessary to accurate implementation of section 1902(xx).

VIII. CMS must address the practical availability, capacity, and accessibility of work, education, and training pathways before treating them as meaningful compliance options

CMS should address whether work program and training pathways are actually available and usable before treating them as meaningful compliance options. Section VII addresses which pathways count and how states should classify and verify programs that allow Medicaid members to comply with community engagement requirements. This section addresses a different problem—even where a pathway legally counts, a beneficiary may be unable to use it because it is unavailable, full, unaffordable, geographically inaccessible, digitally inaccessible, limited to another population, or unsupported by necessary services, such as child care or transportation assistance.

This comment does not ask CMS to create new work programs, require states to fund new workforce infrastructure, or require states to guarantee admission to education or training programs. It asks CMS to acknowledge and monitor the practical limits of existing pathways and to prevent states from treating unavailable, inaccessible, unaffordable, or unverifiable programs as meaningful compliance options within the work program or education pathways. If CMS relies on work program and education pathways as part of the rule's rationale, CMS must address whether affected members can actually use those pathways.

We recognize that paid work, community service, and the income pathway remain available regardless of program capacity, and CMS may point to those pathways as an answer to the concerns raised in this section. But the IFR's own rationale, and CMS's own framework for demonstrating compliance, treats education and work program pathways as real, independent options, not merely as fallbacks for people who cannot already satisfy the requirement through paid work. A rule that relies on education and training pathways as meaningful options cannot then treat their unavailability as irrelevant because other pathways exist; each pathway CMS holds out as available should actually be available.

A. CMS should require states to assess pathway availability and accessibility before implementation.

CMS should require states to assess the practical availability of work, education, and training pathways in different areas of the state before implementation. For each qualifying program a state identifies as available, the state should specify where the program exists, who may use it, whether it has capacity to accept additional participants, whether Medicaid-only members can access it, whether supportive services are available, and whether participation costs may prevent access. We recognize that this assessment is a substantial administrative undertaking, particularly layered on top of the program classification work requested in Section VII. That cost should be weighed against the alternative: a state that lists a pathway as available without knowing whether it actually is risks terminating

members' Medicaid coverage for failing to use an option that was never realistically open to them.

For the work program pathway, states should identify whether programs are available statewide or only in certain counties or regions; whether participation requires SNAP, TANF, WIOA, veterans' status, dislocated-worker status, older-worker status, recent incarceration, or another eligibility characteristic; whether the program has waitlists; and whether the program can reasonably absorb new referrals that result from this Medicaid community engagement requirement.

For the education and work program pathways, states should identify whether programs impose tuition, fees, testing costs, equipment costs, technology requirements, transportation costs, books, supplies, or other costs that may prevent participation. States should also identify whether programs have enrollment deadlines, academic calendars, minimum skill requirements, limited seats, language-access barriers, disability-access barriers, or digital-access requirements that may affect whether Medicaid members can use the pathway within the relevant verification period.

CMS should require this information to be reflected in state implementation plans, outreach materials, and monitoring reports. A pathway should not be described to members as available unless the state can explain how affected individuals can realistically access it.

B. CMS should address the interaction between limited pathway access and the IFR's requirement that states make all statutory options available.

The IFR correctly recognizes that states must make all options for demonstrating community engagement listed in section 1902(xx)(2) available and may not make only a subset of those options available.[109] CMS explains, for example, that a state may not allow individuals to demonstrate community engagement through work program participation while refusing to allow them to demonstrate compliance through community service. This principle is important, but CMS should clarify how it applies when a required pathway depends on programs or placements that are not available statewide, are limited to particular populations, have waitlists, impose participation costs, or cannot serve Medicaid-only members.

For example, if SNAP E&T is treated as a qualifying program in the work program pathway but is available only to SNAP participants and is only available in some of Colorado's counties, CMS should clarify how the state will make the work program option meaningfully available to Medicaid-only members and to members in areas without SNAP E&T access. If WIOA services are limited by funding, priority-of-service rules, training-dollar availability, or waitlists, CMS should clarify whether and how the state may describe WIOA participation as

[109] Medicaid IFC preamble discussion of §1902(xx)(2); 42 CFR §435.552

an available program for the work program pathway if members are unlikely to receive WIOA services.

The same issue arises for education programs. If a state tells beneficiaries they may comply through education or training, but the only available programs charge tuition, operate on academic calendars that do not align with verification periods, or require foundational skills the member does not yet have, CMS should require the state to explain how the pathway is practically usable.

CMS should require notices and outreach materials to disclose pathway limitations in plain language. A notice that tells a person they may comply through education or a work program is incomplete if it does not explain which programs are available, who can enroll, whether there are waitlists or costs, what supports are available, and what alternatives exist if the program or pathway cannot be accessed.

C. CMS should not treat pathway unavailability or inaccessibility as member noncompliance.

Consistent with the distinction between substantive noncompliance and procedural inability to verify described in Section V of this comment, CMS should clarify that pathway unavailability is not the same as member noncompliance. A person should not be treated as failing to satisfy section 1902(xx) merely because a work program is full, a training program has a waitlist, a class is unaffordable, a program is not available in the person's county, financial aid is unavailable, transportation is unavailable, digital access is limited, or the relevant provider cannot accept or document participation for compliance with these requirements.

CMS should clarify whether the existing short-term hardship exception under §435.555 already extends to individuals who attempt to use a qualifying pathway but cannot do so because the pathway is unavailable, full, waitlisted, unaffordable, geographically inaccessible, digitally inaccessible, limited to another population, unable to provide needed accommodations, or unable to provide necessary support services. If CMS concludes that §435.555 does not reach these circumstances and that no other statutory basis permits deemed-compliant treatment or an exception, CMS should say so explicitly and explain how it has accounted for that limitation in the rule's burden analysis, outreach standards, monitoring requirements, and assessment of whether the pathways are meaningful.

At minimum, CMS should require states to track and report cases where individuals could not use a pathway because no qualifying option was available, the person was ineligible for the available option, the program was full or waitlisted, participation costs were unaffordable, supportive services were unavailable, or access barriers prevented participation.

D. CMS should account for workforce, adult education, and training-system strain.

CMS should consider the capacity of existing workforce and education systems before treating work, education, and training pathways as realistic compliance options. Existing systems may already be constrained. Workforce centers may be at capacity. Training funds may be limited. Support-service dollars may be insufficient. Adult education programs may be underfunded. Community-based providers may face unstable grants. Schools and training providers may lack staff to absorb new referrals or support participants with Medicaid-related documentation.

Federal and state funding uncertainty compounds this problem. The House Appropriations Committee's fiscal year 2027 Labor-HHS-Education bill, approved along party lines in June 2026, proposes to eliminate WIOA Youth, Reentry Employment Opportunities, the Migrant and Seasonal Farmworker Program, and Senior Community Service Employment Programs entirely; to effectively eliminate WIOA Adult through an advance-appropriations rescission; to cut Job Corps funding in half; and to eliminate Adult Education State Grants entirely, a program currently funded at $715 million.[110] This bill has not been enacted, so CMS should not treat these cuts as certain. But CMS also should not assume, without evidence, that the workforce and adult education systems this rule relies on will have stable or growing capacity to absorb new demand, when the trajectory of current federal appropriations proposals indicates a desire to move in the opposite direction.

CMS should account for this risk in the RIA and monitoring framework. If CMS assumes that work program or education pathways will help members comply or move toward employment, CMS should identify what evidence supports that assumption when programs may be capacity-limited, geographically uneven, underfunded, unaffordable, or unavailable to Medicaid-only beneficiaries.

E. CMS should account for support-service needs that affect practical access.

Participation in a work, education, or training program often requires more than a referral. Medicaid members may need transportation, childcare, internet access, a device, digital-literacy support, work clothing, tools, testing fees, tuition assistance, books, supplies, help completing financial-aid forms, language access, disability accommodations, or case management. HR-1 does not itself fund those supports for Medicaid beneficiaries. Where those supports are unavailable, the pathway may be inaccessible even if it technically exists.

CMS should require states to identify which supportive services are available for each pathway and whether Medicaid-only beneficiaries can access them. States should also report when lack of transportation, childcare, digital access, tuition assistance, testing fees,

[110] National Skills Coalition, "Partisan Funding Bill Proposes Deep Cuts to Workforce and Education Programs in FY27," June 16, 2026

required equipment, books, supplies, or other supports prevents individuals from enrolling in or completing a qualifying activity.

CMS should use this information to determine whether state implementation is accurately identifying noncompliance or instead penalizing people for barriers outside their control.

F. CMS should address older adults and people with significant labor-market or education-access barriers.

CMS should specifically address whether available pathways are realistic for adults ages 55 to 64 who are subject to the community engagement requirement. We recognize that Congress itself set this age range in HR-1, and CMS may take the position that the age range reflects a considered legislative judgment that doesn't call for additional accommodation beyond the exceptions the statute already provides. But identifying whether the existing pathways are practically usable by this population is a narrower question than whether the age range itself is appropriate; it goes to whether CMS's own implementation choices are producing accurate compliance determinations, which is squarely within CMS's implementation authority regardless of the age range Congress chose. Older adults may face longer job searches, obsolete skills, limited digital literacy, chronic health limitations that do not meet disability standards, caregiving histories, age discrimination, and difficulty navigating online employment, training, education, or Medicaid reporting systems.

Many employment and training systems are oriented toward people entering careers, recently displaced workers, or specific priority populations, and may not be designed to serve older Medicaid members who need intensive support to be ready to re-enter the labor force. Adult education and digital-skills programs may be necessary precursors to employment or training, but those programs may be underfunded, unavailable, or unable to absorb increased demand.

CMS should require states to monitor access and outcomes by age band, including adults ages 55 to 64. States should report whether older adults are referred to qualifying pathways, accepted, waitlisted, denied, unable to afford participation, terminated after failed verification, or able to demonstrate compliance through work, education, training, or combined activities. CMS should also require states to explain what non-digital, in-person, and supportive-service options are available to older adults who cannot realistically navigate self-directed job search, online education, or online reporting systems without assistance.

G. CMS should address the burden shifted to third-party organizations.

CMS should address the administrative burden that implementation may shift to third-party organizations. This burden is the direct consequence of the records-based verification approach requested in Section VII.G of this comment, which asks states to verify participation through program and agency records rather than beneficiary-supplied paperwork wherever feasible. Schools, adult education providers, job-training organizations, workforce centers, volunteer organizations, community-service sites, and community-based

organizations may be asked to accept referrals, supervise activities, track hours, verify participation, troubleshoot notices, help beneficiaries upload documents, respond to state verification requests, or explain how Medicaid and SNAP requirements interact. Many of these entities are not Medicaid contractors, may not receive funding for this role, and may lack staff, technology, data-sharing agreements, or legal capacity to take on Medicaid compliance functions.

This matters for pathway access. If organizations cannot absorb referrals, beneficiaries may be waitlisted or sent to activities that do not count. If organizations cannot provide help navigating compliance, beneficiaries may lose coverage despite attempting to comply. If organizations decline to participate because the administrative burden is too great, practical access to the pathway may shrink.

CMS should require states to account for third-party burden in their implementation plans, RIA submissions, and monitoring. States should identify which entities will be asked to support implementation, whether they will receive funding or technical assistance, and what alternatives are available if those entities cannot participate.

H. CMS should require reporting that tests whether pathways are actually usable.

CMS should require states to report whether work program and education pathways are actually being used by affected Medicaid members. Reporting should include the number of individuals referred to qualifying programs, the number accepted, the number waitlisted, the number denied or found ineligible, the number unable to participate because of unaffordable costs or lack of supportive services, the number whose participation could not be verified, and the number terminated after attempted use of a pathway.

These data should be reported by pathway, program type, county or service area, Medicaid-only versus SNAP/TANF/other-benefit status, age, disability status, language, race, ethnicity, rurality, and other relevant demographic characteristics. CMS should also require states to report whether people who lose coverage after being referred to a pathway later reapply, are reinstated, or demonstrate that they were compliant, excluded, excepted, or unable to access the pathway.

Without this reporting, CMS and states cannot determine whether work, education, and training pathways are meaningful compliance options or merely nominal options that are unavailable to many beneficiaries in practice.

Requested CMS response

CMS should respond to the following issues before relying on work, education, or training pathways as meaningful compliance options:

1. Will CMS require states to assess, by county or service area, whether qualifying pathways are practically available to individuals subject to section 1902(xx)?

2. Will CMS require states to distinguish pathways available to Medicaid-only beneficiaries from pathways limited to SNAP, TANF, WIOA, veterans, dislocated workers, older workers, recently incarcerated individuals, migrant or seasonal farmworkers, students in particular institutions, or other specific populations?

3. Will CMS clarify what it means for states to make a pathway available when programs are not available statewide, have waitlists, lack supportive services, impose participation costs, or are limited to priority populations?

4. Will CMS require states to disclose pathway availability, eligibility limits, waitlists, participation costs, supportive-service availability, financial-aid requirements, and practical access barriers in notices and outreach materials?

5. Will CMS clarify that program unavailability, waitlists, lack of supportive services, geographic inaccessibility, digital inaccessibility, unaffordable participation costs, or provider capacity limits are not evidence of beneficiary noncompliance?

6. Does CMS believe the existing short-term hardship exception under §435.555, or any other statutory basis, permits states to protect individuals who attempt to use a qualifying pathway but cannot do so because the pathway is unavailable, full, waitlisted, inaccessible, unaffordable, limited to another population, or unable to provide needed supports?

7. If CMS believes no such protection is available, how has CMS accounted for that limitation in its RIA, burden estimates, outreach standards, and monitoring framework?

8. Will CMS require states to account for increased demand on workforce, education, SNAP E&T, WIOA, adult education, community-based, and volunteer-placement systems resulting from Medicaid community engagement implementation, including the risk of reduced federal funding for these systems?

9. Will CMS require states to monitor whether adults ages 55 to 64 can access work, education, and training pathways and whether they face disproportionate terminations after attempted but unsuccessful pathway use?

10. Will CMS clarify when job search, job-search training, unemployment-insurance-related job search, and self-directed job search count toward the requirement, consistent with the work-program definitional clarity requested in Section VII?

11. Will CMS require states to account for the administrative burden placed on schools, adult education providers, job-training providers, workforce centers, volunteer organizations, community-service sites, community-based organizations, and other third-party entities, including the burden created by the records-based verification approach requested in Section VII?

12. Will CMS require state reporting sufficient to determine whether work, education, and training pathways are actually being used by affected beneficiaries or are unavailable in practice?

If CMS declines to adopt these safeguards, it should identify the statutory text that prevents the safeguard or explain, with record evidence, why the safeguard is unnecessary to accurate implementation of section 1902(xx).

IX. CMS should establish corrective-action and pause triggers when monitoring data show procedural loss or implementation failure

CMS should establish clear oversight triggers for corrective action, additional outreach, additional data collection, suspension of adverse actions, or other mitigation when state data show that community engagement implementation is not accurately identifying compliance. The IFR requires states to submit data to support CMS monitoring and recognizes that reported data may lead to corrective action, additional data collection, or additional outreach.[111] That existing framework authorizes corrective action, additional data collection, and additional outreach, but it does not itself provide for pausing denials or terminations. CMS should build on that framework by specifying what types of data will trigger intervention and what remedies will be required, including, where the defect is serious enough, a pause of adverse actions until it is corrected.

We recognize that a pause requirement goes beyond what HR-1 expressly provides. But section 1902(xx) itself assigns the Secretary responsibility to establish the criteria, procedures, and standards governing how compliance is verified and how noncompliance is determined. A requirement that states pause adverse actions when those criteria and procedures are demonstrably failing to produce accurate determinations is a procedural standard governing how the requirement is administered, not a suspension of the requirement itself. If CMS disagrees that this authority exists, CMS should identify the statutory basis for that conclusion and explain what alternative mechanism will prevent large-scale erroneous coverage loss while an issue in a state's eligibility system or processes remains uncorrected.

Monitoring is not sufficient if CMS collects data only after eligible individuals have already lost coverage. Because section 1902(xx) will be implemented quickly and across complex eligibility, workforce, education, and reporting systems, CMS should identify early warning indicators that a state's process is producing procedural loss rather than accurately identifying noncompliance. These indicators should be drawn from the earliest points in the process, such as failed ex parte verification rates and nonresponse rates, rather than only

[111] 42 CFR §435.561(b); §435.562(e)

from termination counts, so that a defect can be caught before it produces large numbers of terminations rather than after.

CMS should establish triggers based on procedural denials and terminations. A high rate of nonresponse, failed verification, returned mail, electronic-notice failure, late correction, reinstatement, fair-hearing reversal, or termination among people later found compliant should trigger enhanced oversight. CMS should also monitor whether denials or terminations are concentrated among particular groups, including older adults, people with disabilities or chronic conditions, people with limited English proficiency, rural residents, people experiencing homelessness, people without reliable internet access, and racial or ethnic groups.

CMS should also establish triggers based on pathway-specific failures. If few individuals are able to demonstrate compliance through education, work program participation, or other pathways, CMS should require the state to explain whether the pathway is unavailable, misclassified, unaffordable, inaccessible, or difficult to verify—consistent with the classification framework requested in Section VII and the availability framework requested in Section VIII of this comment. If a state reports large numbers of individuals unable to verify a particular pathway, CMS should require the state to identify the source of the verification failure before permitting additional denials or terminations based on that pathway, because a failure rate concentrated in a single pathway is more likely to reflect a systemic classification or verification problem than a pattern of individual noncompliance.

CMS should establish triggers based on state data quality and system readiness. If a state cannot submit timely, complete, and accurate data, cannot distinguish actual noncompliance from inability to verify, cannot report by pathway, cannot identify reinstatements or fair-hearing outcomes, or cannot produce auditable records showing which data sources were checked, consistent with the documentation framework requested in Section VI of this comment, CMS should require corrective action before allowing the state to continue adverse actions based on community engagement.

CMS should also establish corrective-action triggers based on program availability and partner capacity, drawing on the reporting requested in Section VIII of this comment. If state data show that work, education, or training pathways are unavailable in certain counties, have long waitlists, exclude Medicaid-only members, lack supportive services, or cannot transmit verification, CMS should require the state to address the barrier, revise outreach materials, identify alternative programs that qualify for the pathway, and report whether beneficiaries were harmed by the barrier.

Where monitoring data show serious implementation problems, CMS should require more than additional outreach. Outreach may be appropriate when beneficiaries lack awareness. But if the problem is failed data matching, unavailable programs, inaccessible portals, inadequate notices, insufficient call-center capacity, county-level inconsistency, provider

verification burden, or inability to distinguish noncompliance from inability to verify, additional outreach will not resolve the underlying defect. CMS should require states to correct the operational problem and, where necessary, pause denials or terminations until the defect is resolved.

CMS should also require retroactive correction and reinstatement when monitoring identifies systemic errors. If data show that a state terminated people who were later found compliant, excluded, deemed compliant, or eligible for an exception, CMS should require the state to identify similarly situated individuals, reinstate coverage promptly, correct eligibility records, and report the duration of coverage gaps. CMS should also require states to track medical debt, delayed care, medication interruptions, and other harms associated with erroneous or procedural terminations where feasible.

CMS should make these oversight standards public. States, Medicaid members, providers, schools, workforce agencies, and community organizations should know what data CMS will monitor, what thresholds will trigger concern, what corrective actions may be required, and when CMS will require a state to pause or modify implementation. Public standards will also improve state planning by making clear that CMS will evaluate not only whether states implemented a process, but whether that process accurately identifies compliance and protects eligible individuals from wrongful coverage loss.

Requested CMS response

CMS should respond to the following issues before relying on state monitoring and reporting as adequate safeguards:

1. Will CMS establish predefined triggers for corrective action, additional data collection, additional outreach, suspension of adverse actions, or other mitigation?
2. Will CMS require corrective action when data show high rates of nonresponse, failed verification, procedural denial, procedural termination, returned mail, electronic-notice failure, late correction, reinstatement, or fair-hearing reversal?
3. Will CMS require corrective action when data show disproportionate denials or terminations by race, ethnicity, age, disability status, language, geography, rurality, homelessness, chronic condition, or digital-access status?
4. Will CMS require pathway-specific corrective action when individuals are unable to demonstrate compliance through education, training, work-program participation, community service, SNAP E&T, WIOA, adult education, high school equivalency, or other pathways because of classification, access, or verification failures?
5. Will CMS prohibit or pause adverse actions when a state cannot distinguish actual noncompliance from inability to verify compliance?

6. Will CMS prohibit or pause adverse actions when a state cannot submit timely, complete, and accurate monitoring data or cannot produce auditable records showing which data sources and pathways were checked?
7. Will CMS require states to identify and correct systemic errors, reinstate affected individuals, and report the duration and consequences of coverage gaps?
8. Will CMS require more than additional outreach when monitoring data show that the underlying problem is system failure, program unavailability, notice defects, data-matching failure, inadequate assistance, or provider verification burden?
9. Will CMS make corrective-action standards, triggers, and state monitoring data publicly available?
10. Does CMS have statutory authority under section 1902(xx) to require states to pause adverse actions when monitoring shows systemic implementation failure, independent of the funding-deferral mechanism in section 1904 of the Act? If CMS declines to adopt pause or corrective-action triggers, how will CMS ensure that implementation failures are identified and corrected before large numbers of eligible, compliant, excluded, or deemed-compliant individuals lose coverage?

If CMS declines to adopt these safeguards, it should identify the statutory text that prevents them or explain, with record evidence, why they are unnecessary to accurate implementation of section 1902(xx).

X. Conclusion

Skills2Compete Colorado submits this comment to build an administrative record that CMS must address in finalizing CMS–2454–IFC. As detailed throughout this comment, the IFR's stated rationale relies on mischaracterized or unsupported sources (Section III) and omits directly relevant evidence from the academic literature, state implementation experience, and CMS's own program data (Section IV). These evidentiary gaps bear directly on whether the rule's implementation choices, many of which remain within CMS's discretion, will accurately identify noncompliance or will instead produce erroneous coverage loss among eligible, compliant, excluded, or deemed-compliant Medicaid members.

Sections V through IX identify specific implementation choices CMS should adopt to prevent that outcome: distinguishing substantive noncompliance from procedural inability to verify (Section V); strengthening and operationalizing the ex parte verification framework (Section VI); ensuring education and work program pathways are clearly defined and administrable (Section VII); accounting for the practical availability, capacity, and accessibility of those pathways (Section VIII); and establishing corrective-action and pause triggers when monitoring data show systemic implementation failure (Section IX). Each section identifies where CMS has discretion under section 1902(xx) to establish criteria, procedures,

standards, verification rules, and reporting requirements, and each asks CMS to exercise that discretion in a manner supported by evidence and reasoned analysis.

Skills2Compete Colorado does not ask CMS to disregard section 71119 of HR-1 or to prohibit states from implementing the community engagement requirement Congress has directed. We ask CMS to implement section 1902(xx) in a way that reflects the evidentiary record, including the evidence CMS has itself partially assembled, and that is designed to prevent the specific failures documented in Arkansas, Georgia, New Hampshire, and other Medicaid demonstrations from recurring under this rule.

For each request identified in this comment, we ask that CMS do one of three things: adopt the requested change or clarification; identify the specific statutory text that prevents CMS from doing so; or explain, with evidence and reasoned analysis, why the requested change or clarification is unnecessary to accurate implementation of section 1902(xx).

Skills2Compete Colorado appreciates the opportunity to comment on this interim final rule and is available to provide additional information, data, or analysis as CMS considers these comments.

Sincerely,

Charles Brennan
Coalition Coordinator
Skills2Compete Colorado

Appendix A: Analysis of CMS Sources and Requested CMS Response

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
"Isolation and loneliness have become an epidemic in the United States, affecting even able-bodied adults who can engage with their communities through work and other activities."	6	Cigna Corporation press release, "The Loneliness Epidemic Persists" (May 26, 2022), reporting a Morning Consult survey commissioned by Cigna	No, beyond the general "epidemic" framing. The source establishes that loneliness is widespread and unevenly distributed across populations, but every group-level finding it reports cuts against, rather than toward, the specific inference the IFR draws. The source measures loneliness only among people already employed for its "workers" data point; it does not measure or compare loneliness rates between working and non-working adults, and states nothing about work or community engagement reducing isolation.	CMS should (1) identify any evidence that work or community engagement directly/causally reduces loneliness among adults who are not currently working; (2) explain how the source's finding that parents have a higher rate than non-parents is consistent with a rule that does not exempt parents of kids under 14 from the requirement; (3) explain how the added stress of demonstrating compliance or facing disenrollment was weighed against the source's own finding that lonely adults are disproportionately likely to have a mental health condition; and (4) clarify whether footnotes 6 and 7 are being presented as independent supports given their shared authorship and funding source.
	7	Bruce LD, Wu JS, Lustig SL, Russell DW, Nemecek DA. "Loneliness in the United States: A 2018 National Panel Survey of Demographic, Structural, Cognitive, and Behavioral Characteristics." *Am J*	No, on the specific claim in the IFR. On the general "epidemic" framing, the source does not address prevalence trends or growth at all; it is a single point-in-time survey identifying correlations, not documenting an increase in loneliness. On the specific mechanism implied by the IFR sentence, the unadjusted data show unemployed and student respondents as more lonely than employed	CMS should (1) identify what in this cross-sectional, single-timepoint study supports a claim about loneliness having "become an epidemic," since the study does not measure change over time; (2) explain why it relies on this when employment status was excluded from the study's own adjusted model in favor of behavioral and relational variables; and (3) address the study's finding that

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
		Health Promot. 2019;33(8):1123–1133.	respondents, but this comparison was not retained in the authors' own adjusted model, and the authors attribute loneliness primarily to individual behavioral and cognitive factors (social support, social anxiety, daily interaction quality) rather than employment or community engagement.	students show higher unadjusted loneliness than employed adults, given that school enrollment is a qualifying CER activity.
	8	Shovestul B, Han J, Germine L, Dodell-Feder D. "Risk factors for loneliness: The high relative importance of age versus other factors." *PLOS ONE.* 2020;15(2):e0229087.	No. The source does not measure work, employment status, or community engagement in any form, so it cannot support the IFR statement at all. The source also does not document loneliness as increasing or having "become" an epidemic; it is a single-timepoint study of risk factors, and its own authors question the "epidemic" framing specifically for older adults. The dominant finding (age) is not a factor the community engagement requirement addresses.	CMS should (1) explain why a study containing no work or community-engagement variable is cited to support a claim specifically about able-bodied adults who could engage through work; (2) address the study's own finding that age is the dominant predictor of loneliness in this sample; (3) disclose the non-representative nature of the underlying sample and explain why it is treated as generalizable to the Medicaid population; and (4) reconcile the source's caution about "epidemic" framing with the rule's use of that same term.
	9	Buecker S, Mund M, Chwastek S, Sostmann M, Luhmann M. "Is loneliness in emerging adults increasing over time? A preregistered cross-temporal meta-	No, and this source directly contradicts the specific term used in the IFR. The authors explicitly reject the "epidemic" framing of this issue as exaggerated. The finding is also only inclusive of emerging adults (18–29), not to able-bodied adults generally, and the source draws no connection to employment, work, or community	CMS should (1) explain why a term the cited study's authors explicitly characterize as exaggerated is used without qualification in the rule; (2) clarify why a study limited to ages 18–29 is cited to support a claim about able-bodied adults generally, given the broader age range subject to the community engagement requirement;

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
		analysis and systematic review." *Psychological Bulletin.* 2021;147(8):787–805.	engagement status at any point. The one contextual reference to occupational instability in the introduction describes emerging adults' frequent job changes as a structural feature of this life stage, not as a cause of loneliness that a work requirement would address.	(3) address the study's finding of no significant increase in loneliness after 2012, the period closest to the present; and (4) identify what in this source, which contains no employment or community-engagement variable, supports the inference that work or activity participation affects loneliness.
"One study found that lacking social connection is as harmful as smoking 15 cigarettes per day."	10	Holt-Lunstad J, Robles TF, Sbarra DA. "Advancing social connection as a public health priority in the United States." *Am Psychol.* 2017;72(6):517–530. doi:10.1037/amp0000103. PMID: 28880099; PMCID: PMC5598785.	No. The comparison the IFR attributes to "one study" is not a finding stated in the source's text; it is inferred from relative bar heights in a figure in the study that draws its smoking-mortality data point from a different, uncited study rather than from the Holt-Lunstad et al. authors' own work. The IFR statement also drops the qualifier "less than" from the figure's label, converting a claim about mortality risk in people who smoke *fewer than* 15 cigarettes daily into a claim about smoking 15 cigarettes per day, the reverse of what the label states. Independently of the misattribution and the dropped qualifier, nothing in the source connects social connection, or addressing it, to employment or community engagement specifically.	CMS should (1) correct footnote 10 to remove the "as harmful as smoking 15 cigarettes per day" or restate it accurately as "less than 15 cigarettes daily," consistent with the source figure; (2) identify and cite the actual source of the smoking-mortality data point (Shavelle, Paculdo, Strauss, & Kush, 2003) rather than attributing it to Holt-Lunstad, Robles, & Sbarra; (3) clarify that Figure 1A is a benchmarking illustration compiled from meta-analyses rather than a peer-reviewed, quantitatively validated equivalence finding; and (4) explain what in this source, which states that effective strategies for addressing lack of social connection remain "mixed and less compelling" and does not examine employment or community engagement as a mechanism, supports using it as grounding for a rule that conditions Medicaid eligibility on a work/community-engagement requirement.

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
"Moreover, employment has been shown to be an important factor leading to long-term beneficiary health and well-being. Obtaining stable employment provides individuals with reliable income and financial stability, which in turn supports access to safe housing, nutritious food, and other resources necessary for maintaining health."	11	Zafar, Khan, Warsi, & Iqbal (2024). "Economic Strain and Recovery Trajectories in Mental Health." *Review of Applied Management and Social Sciences* 7(4):345–358.	No. The source does not test or support the specific relationship in the IFR sentence: employment → income/financial stability → access to housing, food, and other health-maintaining resources. It tests financial stability, employment status, and debt level as correlates of a mental-health recovery score, with financial stability (not employment) as the dominant predictor. It says nothing about housing, nutrition, or broader "long-term beneficiary health and well-being," and its outcome measure is narrower (recovery from a discrete period of economic strain) than the general population-health claim in the IFR. The cross-sectional design cannot establish that employment causes financial stability or that financial stability causes improved health, a limitation the authors themselves acknowledge.	CMS should (1) explain why employment is presented as the driving factor in the IFR sentence when the cited source's own regression analysis finds financial stability, not employment status, to be the stronger predictor of recovery; (2) identify a source that actually tests the claimed causal pathway from employment to housing, nutrition, and other health-maintaining resources, since this study does not address those outcomes; (3) address the cross-sectional design's limits on causal inference, which the source's own authors acknowledge; and (4) clarify whether a rule that risks reducing beneficiaries' income security (through Medicaid disenrollment for noncompliance) is consistent with this source's finding that financial stability, not employment status alone, is the dominant driver of the recovery outcomes it measures.
	12	Gerdes R, Jackson TD, Roberts R, et al. "Associations Between Employment and Health Outcomes: A Systematic Review of Reviews." *J Occup Rehabil.* 2026. DOI: 10.1007/s10926-025-10357-5.	Partially, and only based on the abstract's framing that employment is broadly associated with favorable health outcomes. The abstract does not mention income, financial stability, housing, or nutrition as pathways or outcomes at all, so nothing in the retrieved content directly supports the specific causal chain in the IFR statement (employment → income/financial stability →	CMS should (1) provide public access to, or quote the specific findings from, the full text of this review supporting the claim that employment leads to reliable income, financial stability, and access to housing and nutritious food, since the abstract does not address these intermediate outcomes; (2) reconcile the IFR's causal framing with the source's own stated conclusion that causality between employment

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
			housing/nutrition/health-maintaining resources). The abstract's own qualifying language (explicit reference to survivorship bias, heterogeneous operationalization of "employment" across studies, and an unresolved causality question) is a caveat the IFR sentence's declarative framing ("has been shown to be… leading to… long-term… health and well-being") does not reflect. This assessment is limited to what the abstract states.	and health has not yet been established, given survivorship bias and heterogeneity across included reviews; (3) address the abstract's finding that insecure or low-quality work can override the health benefits of employment, and explain how the rule's work requirement accounts for job security or quality; and (4) clarify whether the source's finding that socioeconomic status independently affects health outcomes for both employed and unemployed people is consistent with using employment status, rather than income or financial stability directly, as the rule's conditioning mechanism.
"Financial stability can lead to improved living conditions, purchasing healthier foods, and the ability to engage in healthy behaviors."	13	Chetty, Stepner, Abraham, Lin, Scuderi, Turner, Bergeron, & Cutler (2016). "The Association Between Income and Life Expectancy in the United States, 2001–2014." *JAMA* 315(16):1750–1766.	No. The study establishes a correlational link between income level and life expectancy; it does not test, and its authors explicitly disclaim, causal inference from income to health outcomes generally, let alone the specific causal chain in the IFR sentence (financial stability → improved living conditions → healthier food purchasing → healthy behaviors). The study does not measure living conditions or food purchasing as variables at all, and its one theory most relevant to "healthier food" access (environmental/residential segregation) was not supported in the hypothesized direction. The paper also uses income level, not financial	CMS should (1) reconcile the IFR's causal claim ("financial stability can lead to…") with the source authors' own explicit statement that their findings should not be interpreted causally; (2) identify what in this source specifically supports claims about improved living conditions, food purchasing, or engagement in healthy behaviors, since none of these are measured or tested as outcomes in the study; (3) clarify why an income-level study is cited for a claim specifically about "financial stability," a related but distinct topic not analyzed in this paper; (4) address the study's explicit finding that local labor market conditions, including unemployment,

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
			stability, as its exposure variable throughout.	were not significantly associated with life expectancy among low-income individuals, given the rule's broader reliance on employment as a health-improving mechanism; and (5) address the study's finding that the environmental/food-access theory was not supported in the hypothesized direction, since this is the theory most relevant to the IFR's specific claim about "purchasing healthier foods."
	14	Schoufour, de Jonge, Kiefte-de Jong, van Lenthe, Hofman, Nunn, & Franco (2018). "Socio-economic indicators and diet quality in an older population." *Maturitas* 107:71–77.	No. On the specific claim that financial stability leads to purchasing healthier foods, this source finds the reverse association for income (higher income → lower diet quality at follow-up) and finds education, not income or occupation, as the dominant variable predicting diet quality. Nothing in the abstract or highlights supports "improved living conditions" or "the ability to engage in healthy behaviors" as outcomes; diet quality (via a single dietary index) is the only outcome tested. The study also does not measure financial stability as distinct from income level, and its population (older Dutch adults) differs substantially from the U.S. Medicaid population to which the IFR sentence is applied.	CMS should (1) reconcile the IFR's claim that financial stability leads to healthier food purchasing with this source's own finding that higher income was associated with *lower* diet quality at follow-up; (2) explain why a source identifying education, not income, as the dominant driver of diet quality is cited in support of an income/financial-stability-based claim; (3) address the source's finding that occupational status was not associated with diet quality at all, given the rule's broader employment-based rationale; (4) clarify the relevance of a Dutch elderly cohort to a U.S. Medicaid population of working-age adults; and (5) provide the full text or specific findings beyond the abstract and highlights.
"Financial stability has also been linked to	15	Kim, Lee, Park, Oh, Chin, & Koo (2016). "Prevalence of	Partially. The source does support an association between lower income and higher prevalence/poorer control of	CMS should (1) clarify that this source's own explanation for the income-chronic disease relationship

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
reduced chronic conditions, such as cardiovascular risk."		chronic disease and its controlled status according to income level." *Medicine* 95(44):e5286.	chronic diseases (including hypertension, a cardiovascular risk factor), consistent with the general framing that lower income is linked to worse chronic disease outcomes. However, the source's own explanation for this association is not "financial stability" broadly, but specifically financial barriers to *healthcare access and utilization*. The low-income group could not afford necessary medical services. The source does not test or use "financial stability", and its authors explicitly note that the cross-sectional design cannot establish the direction of causality between income and chronic disease. The country context (South Korea, with a different health system and dietary patterns) is not addressed by the IFR, raising a generalizability question for a U.S. Medicaid population.	centers on financial barriers to healthcare access and utilization, not on "financial stability" as a general construct, and revise the citation or framing accordingly; (2) acknowledge the cross-sectional design's inherent limits on causal inference, which the study's own authors state explicitly; (3) address the cross-national generalizability question given the study's Korean population, diet, and health insurance system, none of which the IFR discusses; and (4) directly address the concern that conditioning Medicaid coverage on a work/community-engagement requirement could reduce healthcare access for the very population this study identifies as least able to afford necessary medical services, thereby working against the outcome the rule cites this source to support.
	16	Brownell, Ziaeian, Jackson, & Richards (2024). "Trends in Income Inequities in Cardiovascular Health Among US Adults, 1988–2018." *Circ Cardiovasc Qual Outcomes* 17(5):e010111.	No. The study shows that CVD risk correlates with static income categories. It does not test or support "financial stability" specifically, and it does not identify a mechanism (income, employment, or otherwise) by which improved income leads to improved cardiovascular outcomes at the individual level. More importantly, the study's own framing and conclusion is not "higher income causes better cardiovascular health," but rather that the U.S. has failed to	CMS should (1) reconcile the IFR's use of this source to support a claim that financial stability reduces cardiovascular risk with the study's own conclusion, which frames its findings as evidence of a persistent and worsening health equity failure rather than a demonstration that income improves individual health outcomes; (2) address the cross-sectional design's inability to support individual-level or causal claims about income change and CVD risk, a

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
			distribute population-level CVD risk reduction equitably across income groups—a health equity critique, not an endorsement of income (let alone employment-driven income) as a health-improving mechanism. Using this source to support a claim that financial stability reduces cardiovascular risk inverts the paper's own framing, which treats the persistence of poor outcomes among the lowest-income group as a policy failure to be remedied, not as evidence that income mobility is the health lever needed.	limitation the study's own authors state; (3) clarify what in this source supports "financial stability" specifically, since the study measures static income category, not financial stability, employment, or income change; and (4) address whether the type and pay level of work expected to satisfy the community engagement requirement would plausibly move affected beneficiaries into the income categories this study associates with improved cardiovascular outcomes, given that the study found no improvement for the lowest income group over 30 years.
"Beyond its role in income generation, employment itself has been shown to be an important factor in long- term beneficiary health and well-being. Evidence indicates that obtaining and maintaining stable employment is associated with improved physical and	17	Han, W.-J. (2024). "How longitudinal employment patterns shape health as individuals approach middle adulthood—US NLSY79 cohort." *PLOS ONE*, 19(4), e0300245.	Partially, and with a significant mismatch. The source supports a narrower claim than the one attributed to it: that among people who are already employed, a *stable, standard-hours schedule* is associated with better health than a *volatile schedule*. It does not support "obtaining and maintaining stable employment" (i.e., working versus not working) as the operative variable, since the "mostly NW" group was not consistently the worst-performing group. On several outcomes, employed people with volatile schedules fared as poorly or worse. The IFR sentence conflates employment status with schedule stability, two variables the study treats and reports separately.	CMS should (1) clarify that Han (2024) studies work-schedule volatility among people already employed, not employment status versus non-employment, and revise the citation or framing so it is not used as general support for "obtaining… employment" improving health; (2) explain how a community engagement requirement will ensure beneficiaries obtain stable, standard-hours work rather than the volatile-schedule work associated with the worst outcomes in this study, given the types of jobs most accessible to this population; (3) address the study's own disclaimer that its findings are associational, not causal; and (4) either identify a source that tests employment status (working versus

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
mental health outcomes and greater overall well-being, while unemployment and unstable work are linked to poorer health outcomes."				not working) directly, net of schedule type and income, or withdraw this citation as support for that specific proposition.
	18	Virtanen M, Kivimäki M, Joensuu M, Virtanen P, Elovainio M, Vahtera J. "Temporary employment and health: a review." *Int J Epidemiol*. 2005;34(3):610–622.	Partially, and only for one narrow outcome (psychological morbidity), with substantial qualification. The source does not test employment versus unemployment at all, so it cannot support the "unemployment… linked to poorer health outcomes" half of the IFR sentence. It supports a narrower claim about temporary (versus permanent) employment being associated with higher psychological morbidity, but the same review found no significant association with physical/global health or musculoskeletal disorders, and found *lower* sickness absence among temporary workers (a finding in the opposite direction from what the IFR sentence implies, which the authors attribute to job-insecurity-driven presenteeism rather than better health). The authors' own conclusion and key messages state that no consensus exists on whether temporary employment is a health risk at all.	CMS should (1) clarify that this source compares temporary to permanent employment, not employment to unemployment, and revise the citation or framing so it is not presented as general support for the unemployment-related half of the IFR sentence; (2) reconcile the IFR's declarative claim with the source's own stated conclusion that no agreement exists on whether temporary employment is a health risk; (3) address the review's finding of *lower* sickness absence among temporary workers and its own explanation (presenteeism driven by job insecurity) rather than adopt this as evidence of better health; (4) address the finding that the temporary-employment/morbidity association was weaker in high-unemployment, high-temporary-employment contexts, and explain how this bears on a rule intended to move Medicaid beneficiaries into work, including temporary or unstable work,

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
				in the U.S. labor market; and (5) address the cross-national generalizability question, given that all 27 underlying studies were conducted in countries with labor and social protections not directly comparable to the U.S. Medicaid population's likely employment context.
	19	Kim TJ, von dem Knesebeck O. "Perceived job insecurity, unemployment and depressive symptoms: a systematic review and meta-analysis of prospective observational studies." *Int Arch Occup Environ Health*. 2016;89(4):561–573.	Partially, and only for one outcome (depressive symptoms), with the U.S.-specific effect size the smallest and weakest reported in the paper. The source does support "unemployment… linked to poorer health outcomes" as a general directional finding, but the outcome measured is depressive symptoms specifically, not the "physical and mental health outcomes and greater overall well-being" the IFR sentence claims broadly. It does not support "obtaining and maintaining stable employment" as protective, because the review does not test stable employment as an exposure at all — it tests unemployment and *perceived job insecurity* as two separate, comparably harmful exposures, and its own conclusion explicitly warns that moving people from unemployment into insecure employment does not reliably reduce depression risk.	CMS should (1) clarify that this source measures depressive symptoms specifically, not the broader "physical and mental health outcomes and greater overall well-being" claimed in the IFR sentence, and narrow the citation's use accordingly; (2) report the U.S.-specific pooled effect size (OR 1.13) rather than relying on the overall pooled estimate, given that this is the subgroup most relevant to a U.S. Medicaid rule and is the weakest finding in the paper; (3) disclose that a significant publication bias was detected and corrected for in the unemployment studies, and use the bias-adjusted estimate; (4) directly address the authors' own conclusion that reintegrating people into *insecure* employment does not reliably reduce depression risk relative to unemployment, and explain how the community engagement requirement ensures beneficiaries move into secure rather than insecure work; and (5) acknowledge the source's own framing that challenges, rather than

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
				supports, the assumption that "having any job is better for one's health than having no job at all."
	20	Gerdes R, Jackson TD, Roberts R, et al. "Associations Between Employment and Health Outcomes: A Systematic Review of Reviews." *J Occup Rehabil*. 2026.	Partially, the abstract does support a general relationship between employment status and favorable health outcomes across multiple domains, which aligns with the broad thrust of the IFR sentence. However, the abstract's own conclusion attaches two qualifications the IFR sentence omits: that socioeconomic status independently affects health outcomes for both employed and unemployed people, and that insecure or low-quality work can override the benefits of employment altogether. The IFR's causal, declarative framing ("has been shown to be… associated with improved… outcomes") also overstates the authors' own stated position that establishing causality "remains a task for future research," given survivorship bias and inconsistent definitions of "employment" across the 49 underlying reviews.	CMS should (1) provide public access to, or quote the specific findings from, the full text of this review supporting the claim that employment leads to improved health outcomes, since the abstract alone cannot substantiate the specific causal chain and dose-response relationships the IFR sentence implies; (2) reconcile the IFR's causal framing with the source's own stated conclusion that causality between employment and health has not yet been established, given survivorship bias and heterogeneity across included reviews; (3) address the abstract's finding that insecure or low-quality work can override the health benefits of employment, and explain how the rule's work requirement accounts for job security, wage level, or job quality; (4) clarify whether the source's finding that socioeconomic status independently affects health outcomes for both employed and unemployed people is consistent with using employment status, rather than income or financial stability directly, as the rule's conditioning mechanism; and (5) disclose whether any of the 49 underlying reviews specifically examined low-wage, entry-level, or

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
				precarious work of the kind most likely to satisfy a Medicaid community engagement requirement.
"This early implementation experience provides insight into operational considerations, indicating that beneficiary awareness, clarity of requirements, and the accessibility of reporting mechanisms, as well as overall administrative complexity, can influence participation and compliance."	22	Centers for Medicare & Medicaid Services (CMS). (2025, December 8). "Requirements for states to establish Medicaid community engagement requirements for certain individuals" (CMCS Informational Bulletin).	No. The cited source does not contain the "early implementation experience" the IFR sentence attributes to it. It does not discuss Arkansas or Georgia, does not analyze what happened during their community engagement programs, and does not address any of the four specific operational factors the sentence claims are supported by that experience (beneficiary awareness, clarity of requirements, reporting-mechanism accessibility, administrative complexity). This is a complete mismatch between the citation and the proposition it is offered to support, not merely a matter of degree or emphasis.	CMS should either remove footnote 22 from this citation cluster as unsupportive of the specific claim, or explain what content in this document CMS believes supports the sentence.
	23	MACPAC. (2026, April 9). "Implementing Community Engagement Requirements in Medicaid: Draft chapter and recommendation" (slide deck), presented by Janice Llanos-Velazquez and	Partially. The source directly supports "beneficiary awareness" and "administrative complexity" (via "administrative challenges" and "administrative costs") as factors associated with noncompliance and coverage loss in the prior demonstrations. It does not, however, specifically use or support "clarity of requirements" or "accessibility of reporting mechanisms" as the IFR	CMS should (1) add "barriers to employment" to its summary of factors influencing participation and compliance, consistent with the source's own framing of the prior demonstrations' noncompliance drivers; (2) either substantiate "clarity of requirements" and "accessibility of reporting mechanisms" with specific findings from this source or another source that documents them, since

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
		Melinda Becker Roach.	sentence frames them. The deck's closest analogues are recommendations that CMS provide guidance on ambiguous areas (good-faith exemptions, medical frailty, self-attestation) and that states minimize beneficiary reporting through ex parte processes, which are prescriptive recommendations for the future rather than documented findings about what happened during the Arkansas/Georgia experience. More importantly, the deck identifies "barriers to employment" as a common reason beneficiaries did not report compliance (a factor entirely absent from the IFR's four-factor list), meaning the IFR's summary of "early implementation experience" omits a documented cause of noncompliance that does not fit neatly into an operational/administrative framing.	this source's support for those two specific terms is indirect at best; (3) confirm whether the version of this MACPAC document relied upon was the draft cited (dated April 9, 2026, pending a May 2026 Commissioner vote) or a subsequently finalized version, and update the citation accordingly; and (4) address the source's own call for CMS to establish a monitoring and evaluation plan, given the source's statement that no such plan or federal evaluation currently exists to assess whether community engagement requirements are achieving their intended health and employment goals.
	24	CMS. (2021, March 17). Letter to Arkansas regarding Arkansas Works demonstration (signed by Elizabeth Richter, Acting Administrator). A formal agency action withdrawing the community engagement authority approved in	Partially. The source does support that beneficiary awareness, clarity of requirements, reporting-mechanism accessibility, and administrative complexity were documented factors affecting participation and compliance in Arkansas (and, secondarily, New Hampshire and Michigan). But the IFR's framing of this as generating "insight into operational considerations" understates what the source itself concludes: that these factors combined with the design of a	CMS should (1) explain why a document whose own operative conclusion is that the Arkansas community engagement requirement should be withdrawn as inconsistent with the objectives of the Medicaid program is cited only for the narrower proposition that implementation experience yields general "operational considerations"; (2) disclose that the specific statistics attributed to footnote 24 (beneficiary awareness rates, coverage-loss figures, and the

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
		the March 5, 2018 amendment to the Arkansas Works section 1115 demonstration, issued under 42 C.F.R. § 431.420(d) after a preliminary notice letter dated February 12, 2021 and Arkansas's response of March 12, 2021.	mandatory work requirement to produce substantial, rapid coverage losses, leading CMS to withdraw the underlying authority as inconsistent with the Medicaid program's objectives. The source is also not a primary research document; its awareness, confusion, and outcome findings are drawn entirely from external peer-reviewed studies and advocacy-organization reports cited within the letter, meaning footnote 24 functions as a compilation of secondary evidence rather than independent CMS analysis.	"no increase in employment" finding) originate in external peer-reviewed and advocacy-organization sources cited within the letter, principally the Sommers et al. 2019 and 2020 studies, rather than from independent CMS data collection or analysis, and explain what independent verification CMS performed before relying on them; (3) address the extent to which footnotes 22–25, taken together, may overstate the independence of the evidentiary base given that much of footnote 24's substantive content derives from a single research program; (4) address the letter's finding that no increase in employment or community engagement resulted from the Arkansas requirement, since this bears directly on whether the "operational considerations" framing in the IFR sentence, versus a broader question of program effectiveness, is the appropriate lens for this evidence; and (5) address the letter's finding that individuals who were working or had qualifying health conditions nonetheless lost or risked losing coverage due to administrative and paperwork requirements, and explain how the current rule's administrative design addresses this documented failure mode from the Arkansas experience.

IFR statement	IFR footnote	Cited source	Does it support the IFR claim?	Requested CMS response
	25	Georgia Department of Community Health. (2025, April 28). Georgia Section 1115 Demonstration Waiver Extension Request. A state-authored request to CMS to extend the Georgia Pathways to Coverage® demonstration (operating since July 1, 2023) for a minimum of five years, including a proposed change from monthly to annual qualifying-activity reporting.	Yes, more directly than footnotes 22 or 24. This source substantively supports all four named factors: beneficiary awareness (large applicant drop-off; a State-acknowledged need for a major outreach and marketing campaign), clarity of requirements (the State's own characterization of monthly reporting as "a new policy… with which members are unfamiliar"), accessibility of reporting mechanisms (the same monthly-reporting unfamiliarity, addressed by the State's proposal to move to annual reporting), and administrative complexity (the eligibility-system burden created by the concurrent PHE unwinding). T	CMS should (1) disclose that footnote 25 is a program operator's own extension request rather than an independent evaluation, and explain what weight was given to that institutional interest in relying on it for a general proposition about operational considerations; (2) address the document's own stated primary explanation for lower-than-projected enrollment (economic improvement and eligible-population overestimation) rather than only the awareness/outreach narrative; (3) clarify that Georgia had not implemented suspensions or disenrollments for monthly reporting noncompliance as of this document's date, and explain how that limits its relevance to a rule that requires disenrollment for noncompliance; and (4) acknowledge the document's overall self-characterization as a program success supporting continuation, alongside the challenges it cites, so the IFR does not present a selectively negative reading of a source whose author intends it as an affirmative case for extension.

Appendix B: Research and Case Studies CMS Should Incorporate into the IFR

Cited source	How is it relevant to the IFR?	Requested CMS response
Larisa Antonisse and Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review* (Kaiser Family Foundation, August 2018). https://www.kff.org/medicaid/the-relationship-between-work-and-health-findings-from-a-literature-review/	This review of more than 50 academic studies, systematic reviews, and program evaluations finds that the evidence does not support treating employment as a reliable driver of better health, and that the relationship instead depends heavily on job quality, stability, and pay. This directly contradicts the causal chain the IFR relies on — that conditioning Medicaid eligibility on work will improve members' health.	CMS should (1) incorporate this review's finding that employment's health effect is conditional on job quality, stability, and pay, not a function of employment status alone; and (2) explain how the IFR's causal framing accounts for the job characteristics — low wages, instability, unpredictable schedules — likely to characterize the work available to Medicaid members subject to this requirement.
Dave A. Chokshi and Mitchell H. Katz, "Medicaid Work Requirements—English Poor Law Revisited," *JAMA Internal Medicine* 178, no. 11 (2018): 1555. https://doi.org/10.1001/jamainternmed.2018.4195	This commentary makes the same bi-directional point CMS's own preamble makes about the employment-health relationship, but draws the opposite conclusion: because Medicaid coverage itself helps beneficiaries obtain and keep employment, conditioning coverage on work risks withdrawing the very support that enables it.	CMS should (1) engage directly with this source's reverse-direction analysis in the preamble, since CMS invokes the bi-directional relationship without developing this half of it; and (2) explain how the rule's design avoids withdrawing an employment support (Medicaid coverage) from members whose ability to work depends on maintaining it.
Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes* (Center on Budget and Policy Priorities, August 13, 2018). https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce	This brief concludes that Medicaid coverage functions as a support for employment rather than a reward for it, and that removing it — particularly for people managing a chronic health condition — is more likely to undermine work than encourage it.	CMS should incorporate this source's framing of Medicaid as an employment support into the RIA, and address specifically how termination for noncompliance is expected to affect the employment capacity of members managing chronic conditions.
Sommers, B. D., Goldman, A. L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2019). Medicaid work requirements—Results from the first year in Arkansas. *The New England*	Using telephone survey data and comparison groups, this study finds that Arkansas's first six months of Medicaid work requirements were associated with a	CMS should reconcile the RIA's implicit assumption that this rule will increase employment with this finding of no significant employment change in the only

Cited source	How is it relevant to the IFR?	Requested CMS response
Journal of Medicine, 381(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772	significant loss of coverage but no significant change in employment — direct, program-specific contrary evidence to the IFR's assumption that this rule will increase employment.	state where a Medicaid work requirement of this kind has actually been evaluated at this stage.
Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Consequences of work requirements in Arkansas: Two-year impacts on coverage, employment, and affordability of care. *Health Affairs*, 39(9), 1522–1530. https://doi.org/10.1377/hlthaff.2020.00538	This follow-up study confirms the null employment result held over the full 18 months the requirement was in effect, and documents substantial financial and health-access harm among those who lost coverage.	CMS should incorporate the confirmed two-year null employment finding into the RIA, and should not treat the six-month result as an artifact of an early implementation period that later resolved.
Anuj Gangopadhyaya and Michael Karpman. (2025). The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data. *Health Services Research* 60, no. 5. https://doi.org/10.1111/1475-6773.14624	Using a difference-in-differences design with randomization inference, this study finds a 4.4 percentage-point increase in uninsurance among the targeted age group (7.4 points among those below the federal poverty level), with a negative, small, and statistically insignificant employment effect.	CMS should incorporate these specific uninsurance and employment-effect estimates into the RIA's projected outcomes for this rule.
Chan, L. (2025, October). *Pathways to Coverage: Looking back two years and into the future*. Georgia Budget and Policy Institute.	Reviewing Georgia's first two years of its work-requirement program, this brief finds no meaningful increase in employment or employer-sponsored coverage relative to comparison states over the same period.	CMS should incorporate this finding into the RIA and explain why Georgia's experience — the other state-level example CMS itself cites in the IFR — does not undermine the assumption that this rule will increase employment.
Gray, C., Leive, A., Prager, E., Pukelis, K., & Zaki, M. (2023). Employed in a SNAP? The impact of work requirements on program participation and labor supply. *American Economic Journal: Economic Policy*, 15(1), 306–341. https://doi.org/10.1257/pol.20200561	Using a regression-discontinuity design on Virginia SNAP records, this study finds large reductions in participation from work requirements, concentrated among homeless adults, with no measurable increase in employment.	CMS should incorporate this cross-program evidence — a different benefit program, a different research design, the same result — into its assessment of whether work requirements generally increase employment.

Cited source	How is it relevant to the IFR?	Requested CMS response
Wheaton, L., Vericker, T., Schwabish, J., Anderson, T., Baier, K., Gasper, J., Sick, N., & Werner, K. (2021). The impact of SNAP able-bodied adults without dependents (ABAWD) time limit reinstatement in nine states: Final report. Urban Institute.	This nine-state study finds that reinstating SNAP's ABAWD time limit substantially reduced participation without substantially increasing employment or earnings.	CMS should incorporate this multi-state finding into the RIA as further cross-program evidence against the employment-increase assumption.
Congressional Budget Office. (2022). Work requirements and work supports for recipients of means-tested benefits. https://www.cbo.gov/publication/57702	This report finds diminishing employment gains from work requirements in TANF, smaller gains in SNAP, and little apparent effect in Medicaid, with benefit reductions matching or exceeding earnings increases. It also finds that supports such as subsidized child care, job-search assistance, and subsidized employment — not the work requirement alone — reliably increase employment and income.	CMS should incorporate CBO's cross-program synthesis and specifically address the absence, under HR-1, of the supports CBO identifies as the actual drivers of employment gains in successful programs.
Congressional Budget Office. (2023, April 26). CBO's estimate of the budgetary effects of Medicaid work requirements under H.R. 2811, the Limit, Save, Grow Act of 2023 [Letter to Representative Frank Pallone Jr.]. https://www.cbo.gov/system/files/2023-04/59109-Pallone.pdf	This letter estimates that a comparable federal Medicaid work requirement would reduce federal spending by about $109 billion over 2023–2033 while having a negligible effect on employment or hours worked, cause roughly 1.5 million adults to lose federal Medicaid funding (about 600,000 becoming uninsured), and shift approximately $65 billion in coverage costs to states.	CMS should incorporate these quantitative estimates into the RIA's cost-benefit analysis and employment-effect assumptions, or explain why this rule is expected to produce materially different outcomes than the nearly identical policy CBO scored.
Cook, J. B., & East, C. N. (2025). The disenrollment and labor supply effects of SNAP work requirements (NBER Working Paper No. 32441). National Bureau of Economic Research. http://www.nber.org/papers/w32441	Using linked SNAP and unemployment-insurance records, this study finds that mandatory employment-and-training referrals reduced household SNAP receipt by 57 percent and total benefits by 23 percent over six months, with no significant increase in employment or earnings. The authors conclude administrative burden,	CMS should incorporate this finding to address whether reduced Medicaid enrollment under this rule reflects administrative burden rather than increased self-sufficiency, consistent with the distinction requested in Section V of this comment.

Cited source	How is it relevant to the IFR?	Requested CMS response
	not increased work, was the principal driver of disenrollment.	
Dodini, S., Larrimore, J., & Tranfaglia, A. (2022). Financial repercussions of SNAP work requirements (Finance and Economics Discussion Series 2022-030). Board of Governors of the Federal Reserve System. https://doi.org/10.17016/FEDS.2022.030	This study finds that SNAP work requirements led affected individuals to increase credit-seeking behavior — total credit accounts rose 18 percent, card balances rose 29 percent (about $500), and past-due balances rose 5 percent — evidence that people borrowed to replace lost benefits rather than becoming self-sufficient.	CMS should incorporate these findings into the RIA's cost analysis as a documented financial cost of work-requirement policies that falls directly on affected individuals.
Cuffey, J. M., Katare, B., & Fulford, L. M. (2023). Supplemental Nutrition Assistance Program work requirements and emergency food assistance usage. *American Journal of Preventive Medicine*, 65(2), 270–277. https://doi.org/10.1016/j.amepre.2023.01.029	This study finds that SNAP work requirements led to a 34 percent increase in food-pantry usage among affected areas within eight months — evidence that people losing benefits remained food insecure and shifted their need elsewhere rather than becoming self-sufficient.	CMS should incorporate this finding as evidence against the self-sufficiency framing CMS uses to justify SNAP/TANF alignment, and address whether a comparable shift in unmet need (e.g., to uncompensated care) is likely under this rule.
Grogger, J., Karoly, L. A., & Klerman, J. A. (2002). Consequences of welfare reform: A research synthesis (DRU-2676-DHHS). RAND. https://www.rand.org/content/dam/rand/pubs/drafts/2006/DRU2676part1.pdf	Synthesizing 67 studies of 1990s welfare reform, this report finds that income and poverty effects depended heavily on program design: generous financial work incentives produced the clearest income gains, while mandatory work activities alone reduced program use with little effect on income and mixed effects on children.	CMS should incorporate this finding to address whether self-sufficiency gains from work requirements require paired financial incentives or supports that HR-1 does not provide, given that this rule relies on mandatory activities alone.
Falk, J. (2023). The effects of work requirements on the employment and income of TANF participants (Working Paper 2023-03). Congressional Budget Office. https://www.cbo.gov/system/files/2023-03/58867-TANF.pdf	This study of Alabama's TANF expansion finds that the policy increased employment and earnings among participants, but did so partly by removing families unable to comply from the program and by shortening TANF spells overall — meaning the same policy that increased measured employment among survivors also removed	CMS should incorporate this finding to caution against reading reduced Medicaid enrollment or caseload as evidence of self-sufficiency without also accounting for the population removed through noncompliance rather than through documented work.

Cited source	How is it relevant to the IFR?	Requested CMS response
	people from the caseload without regard to work outcomes.	
Bertrand, M., Mullainathan, S., & Shafir, E. (2004). A behavioral-economics view of poverty. *American Economic Review*, 94(2), 419–423.	This article finds that seemingly minor administrative barriers — complex applications, unclear rules, stigma, inconvenient procedures — substantially reduce benefit take-up regardless of underlying eligibility, while simpler forms, better defaults, and reduced administrative hassle meaningfully improve both participation and outcomes.	CMS should incorporate these behavioral-economics findings into the design of the rule's reporting, verification, and notice systems, consistent with the specific requests made in Sections VI and VII of this comment.
Deshpande, M., & Li, Y. (2019). Who is screened out? Application costs and the targeting of disability programs. *American Economic Journal: Economic Policy*, 11(4), 213–248. https://doi.org/10.1257/pol.20180076	Using Social Security field-office closures in a difference-in-differences design, this study finds that increased application burden reduced disability applications by 10 percent and awards by 16 percent, disproportionately screening out applicants with moderately severe conditions, low education, and low prior earnings.	CMS should incorporate this cross-program evidence that documentation burden screens out eligible people, not merely noncompliant ones, and apply it to the documentation burden this rule places on Medicaid members.
Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's experience with Medicaid work requirements: New strategies, similar results. Urban Institute. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf	This report finds that New Hampshire's more flexible reporting system — designed specifically to avoid Arkansas's failures — still produced only 32 percent initial recorded compliance among nearly 25,000 subject enrollees, with as many as 17,000 at risk of losing coverage, and that the accompanying workforce program did not appreciably increase employment.	CMS should incorporate this finding as direct evidence that outreach and reporting flexibility alone are insufficient to prevent mass procedural loss.
Centers for Medicare & Medicaid Services. (2021, March 17). Withdrawal of community engagement authorities for the New Hampshire Granite Advantage Health Care Program demonstration [Letter to Lori Shibinette, Commissioner, New Hampshire Department of Health and Human	CMS's own letter attributes New Hampshire's near-loss of coverage for roughly 17,000 beneficiaries (about 40 percent of those subject to the requirement) to confusing notices, ineffective outreach, reporting burdens, and exemption barriers — not to noncompliance — and concludes	CMS should incorporate its own prior findings and conclusions from this letter into the current rule's design, and explain specifically what has changed in this rule's notice, outreach, and reporting design to prevent the same outcome from recurring.

Cited source	How is it relevant to the IFR?	Requested CMS response
Services]. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-ca2.pdf	the program was unlikely to advance Medicaid's objectives.	
Everhart, R. M., Gillespie, S., Maguire, M., Stella, S. A., Hanratty, R., & Johnson, T. L. (2026). Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients. *Health Affairs Scholar*, 4(7), 1–8. https://doi.org/10.1093/haschl/qxag162	This 2026 analysis reports that most states plan to launch only a "minimum viable product" by the January 2027 deadline, relying on "auditable self-declaration" (i.e., self-attestation) until more seamless data exchanges can be built. Using linked medical, Medicaid, and housing-services data from Denver Health's Medicaid Expansion population, the same study also finds that 76.0 percent of enrollees experiencing homelessness met at least one modeled work-requirement exemption criterion — Colorado-specific evidence that this population is disproportionately exemption-eligible while disproportionately unable to document it.	CMS should (1) acknowledge that states themselves are planning to rely on self-attestation as a practical necessity and build corresponding flexibility into the rule; and (2) address specifically how the rule's documentation requirements will accommodate individuals experiencing homelessness who are likely exemption-eligible but unable to produce standard verification.
Goldman, A. L., Woolhandler, S., Himmelstein, D. U., Bor, D. H., & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. *JAMA Internal Medicine*, 178(11), 1549–1552. https://doi.org/10.1001/jamainternmed.2018.4194	After accounting for people already working and common waiver exemptions, this study estimates only about 2.1 million people — 2.8 percent of Medicaid enrollees, 0.7 percent of spending — are actually subject to work requirements nationally.	CMS should incorporate this estimate into the RIA to correct any assumption that projected savings come primarily from this small population, and should identify where else the agency believes savings will originate.
Silvestri, D. M., Holland, M. L., & Ross, J. S. (2018). State variation in the proportion of Medicaid enrollees subject to community engagement requirements. *JAMA Internal Medicine*, 178(11), 1552–1554.	This companion state-level analysis finds that 0.3 to 5.4 percent of Medicaid-eligible individuals (1.6 to 10.6 percent of nondisabled adults) across 11 states were subject to but not already meeting proposed requirements. Colorado-specific figures	CMS should incorporate this state-level variation data, including the Colorado-specific figures, into the RIA's state-by-state impact estimates.

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	within this range are 4.7 percent of all Medicaid-eligible Coloradans and 8.5 percent of nondisabled working-age adults, even under the study's high-end scenario.	
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/	This brief finds that only 32 percent of Medicaid adults with a disability receive SSI or SSDI, meaning 68 percent would not be captured by an exemption keyed to those programs alone, and that employment falls sharply as functional limitations increase (48 percent employed among those with one disability, versus 17 percent among those with four or more).	CMS should incorporate this finding into the design of the rule's exemption categories, and address the gap between disability that meaningfully limits work capacity and the narrower set of disabilities documented through SSI/SSDI-linked exemptions.
Ku, L., & Brantley, E. (2017, April 12). Medicaid work requirements: Who's at risk? Health Affairs Blog. doi:10.1377/hblog20170412.059575	Of roughly 22 million adult Medicaid enrollees potentially exposed to a broadly designed work requirement, about half were already working and 14 percent were seeking work; among the remainder, most reported disability, caregiving, or school attendance, and fewer than 5 percent were voluntarily not working.	CMS should incorporate this finding as evidence that the population remaining after exemptions is overwhelmingly people with a barrier to work rather than people choosing not to work, and should explain how the rule's exemption design is calibrated to that population.
Han, J. (2020, August). The impact of SNAP work requirements on labor supply [Working paper]. SSRN.	This study rules out an employment decline greater than 1.4 percentage points when SNAP work requirements were suspended, finding only a modest reduction in hours among some older workers.	CMS should incorporate this finding as further evidence that removing a work requirement does not meaningfully reduce employment, which correspondingly undermines the assumption that imposing one on a population defined by barriers to work will increase it.
Ndumele, C. D., Factor, H., Lavallee, M., Lollo, A., Jr., & Wallace, J. (2025). Supplemental Nutrition Assistance Program work requirements and safety-net program participation. *JAMA Internal Medicine*, 185(1), 92–100.	Using linked Connecticut SNAP and Medicaid records, this study finds that reinstating SNAP work requirements reduced SNAP enrollment by 5.9 percentage points (about 25 percent), with the largest and most persistent losses concentrated among older adults, people	CMS should incorporate this finding as evidence that exemption structures fail along lines of vulnerability rather than actual eligibility, and should adopt disaggregated monitoring by these characteristics.

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https://doi.org/10.1001/jamainternmed.2024.5932	with chronic illnesses such as diabetes, and the lowest-income beneficiaries.	
Office of the Assistant Secretary for Planning and Evaluation. (2021, March 11). Medicaid demonstrations and impacts on health coverage: A review of the evidence (Issue Brief No. HP-2021-03). U.S. Department of Health and Human Services.	Kentucky's own analysis, reviewed in this ASPE brief, found that among beneficiaries projected to be neither exempt nor working, nearly three-quarters faced at least one significant barrier to meeting or documenting compliance with the work requirement: 59 percent lived with someone with a serious health limitation, 38 percent had one themselves, 25 percent lacked internet access, 24 percent had not completed high school, and 11 percent lacked access to a vehicle.	CMS should incorporate this state-generated data illustrating specific, common documentation barriers, and explain how the current exemption and verification structure addresses each of these barrier types.
Sugar, S., Peters, C., De Lew, N., & Sommers, B. D. (2021, April 12). Medicaid churning and continuity of care: Evidence and policy considerations before and after the COVID-19 pandemic (Issue Brief No. HP-2021-10). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.	This brief finds that unstable coverage increased emergency department visits, office visits, and hospitalizations by 10 to 36 percent, and decreased prescription medication use by 19 percent, compared with stable coverage; it also finds that continuous eligibility, expansion, express-lane eligibility, and limits on premiums and cost-sharing all improve coverage stability — tools this rule does not require or encourage.	CMS should incorporate these churning-related harms into the rule's health rationale and operational standards, and address whether continuity-of-coverage protections comparable to those identified in this brief will be adopted.
Steven J. Haider, Alison Jacknowitz, and Robert F. Schoeni, *Welfare Work Requirements and Individual Well-Being: Evidence from the Effects on Breastfeeding*, DRU-2730, Labor and Population Program Working Paper Series 02-01 (RAND, January 2002). https://www.rand.org/content/dam/rand/pubs/drafts/2008/DRU2730.pdf	This study finds that the most stringent state welfare work requirements reduced six-month breastfeeding rates by 4.8 percentage points (34 percent) among WIC mothers and 2.6 percentage points (11 percent) among all mothers, with the effect concentrated specifically in full-time work requirements, currently in place in about half of all states.	CMS should incorporate this finding as evidence that work requirements can produce adverse health outcomes for specific subpopulations — here, mothers of infants — and should explain whether and how full-time work expectations under this rule apply to that population.

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U.S. Government Accountability Office. (2025, September 3). Medicaid demonstrations: Information on administrative spending for Georgia work requirements (GAO-25-108160).	GAO found that CMS's demonstration approval process does not account for administrative costs at all — states are not required to project these costs in their applications, and they are not included in budget-neutrality calculations. Georgia's $54.2 million in actual administrative spending was therefore never weighed against the program's expected benefits at approval.	CMS should incorporate GAO's finding by requiring administrative-cost projections as part of the demonstration and rule-implementation approval process going forward, and should explain how the current RIA accounts for administrative costs given GAO's finding that this has not previously occurred.
Solomon, J. (2019, January 10). Medicaid work requirements can't be fixed: Unintended consequences are inevitable result. Center on Budget and Policy Priorities.	This brief argues that Medicaid work requirements inevitably cause eligible people — including workers with volatile hours and people who should qualify for exemptions — to lose coverage through reporting and documentation burdens, regardless of the specific system design used to implement them, while offering little prospect of increasing long-term employment.	CMS should incorporate this analysis into its rationale for adopting binding federal minimum standards rather than relying on state-level design choices.