UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al., Plaintiffs, v. MEHMET OZ, M.D., et al, Defendants.	Case No. 26-12962

PLAINTIFF STATES' MOTION FOR PARTIAL SUMMARY JUDGMENT

Plaintiffs Massachusetts, California, New Jersey, Arizona, Colorado, Connecticut, Delaware, the District of Columbia, Hawai'i, Illinois, Office of the Governor *ex rel.* Andy Beshear, in his official capacity as Governor of the Commonwealth of Kentucky, Maine, Maryland, Michigan, Minnesota, New Mexico, New York, Nevada, North Carolina, Oregon, Josh Shapiro in his official capacity as Governor of the Commonwealth of Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin (together, "Plaintiff States"), respectfully move, pursuant to Fed. R. Civ. P. 56, D. Mass. L. R. 56.1, and the Court's August 6, 2026 Electronic Order, ECF No. 100, for summary judgment on their claims in Counts I and II of their Complaint, ECF No. 1, that Defendants violated the Administrative Procedure Act through their promulgation of certain provisions of the Interim Final Rule ("IFR"), "Community Engagement Requirement for Certain Individuals," 91 Fed. Reg. 33348 (June 3, 2026).

The IFR, which purports to implement work requirements for the Medicaid program that were set out by Congress in H.R. 1, Pub. L. No. 119-21, 139 Stat. 172 (2025), contains three

provisions[1] that are contrary to statute or otherwise unlawful under the Administrative Procedure Act ("APA") and that will cause irreparable injury to Plaintiff States and their residents in the absence of relief. First, the IFR's partial abrogation of a Congressionally mandated exclusion from the work requirements for "medically frail" individuals is both contrary to law and arbitrary and capricious. In direct contravention of the language of H.R. 1, which enumerates five categories of individuals who must qualify for the exclusion, and without the reasoned explanation the APA requires, Defendants have denied the exclusion to individuals in those categories who cannot show that their medical condition "significantly impairs" their ability to comply with the H.R. 1's work requirement. And Defendants have forced the Plaintiff States to bear the costs and burdens of operationalizing this unlawful limitation.

Second, further compounding the burden on the Plaintiff States, Defendants have indicated their intention to limit States' ability to use a Medicaid member's healthcare utilization data to determine whether that individual is medically frail. And third, Defendants have restricted the Plaintiff States' ability to use self-attestation to verify exclusion from the Work Requirement. As with the significant-impairment provision, Defendants have failed to provide a reasoned explanation of their decision to implement these provisions, and they have failed to consider the adverse effects on Medicaid members and state Medicaid agencies. Under well-settled law, those failures in agency decisionmaking render these provisions arbitrary and capricious, and therefore unlawful under the APA.

[1] Counts I and II of Plaintiffs' Complaint also challenged provisions of the IFR regarding short-term hardship exceptions to the work requirements, see ECF 1, ¶¶ 213, 220(e), but Plaintiff States have elected to narrow their claims under Counts I and II to the Challenged Provisions addressed in this Motion.

For the reasons described above and detailed in Plaintiff States' accompanying Memorandum of Law, Statement of Material Facts, and supporting exhibits, Plaintiff States respectfully request that the Court grant this motion and order the relief described in the Proposed Order attached hereto, including vacatur of the challenged provisions and declaratory and injunctive relief.

The Court has already scheduled a hearing on the parties' cross-motions for summary judgment for October 20, 2026, at 2:00 pm. ECF No. 101.

Dated: September 1, 2026

Respectfully submitted,

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LOCAL RULE 7.1 CERTIFICATE

I, Nita K. Klunder, certify that between July 30, 2026 and August 5, 2026, Plaintiffs' counsel conferred with counsel for defendants regarding this motion, as set forth in the parties' Joint Motion for a Scheduling Order (ECF No. 99).

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CERTIFICATE OF SERVICE

I hereby certify that this document was filed through the ECF system and will be sent electronically to the registered participants as identified in the Notice of Electronic filing (NEF).

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al. Plaintiffs, v. MEHMET OZ, M.D., et al. Defendants.	Case No. 26-12962 Proposed Order

[PROPOSED] ORDER GRANTING SUMMARY JUDGMENT ON COUNTS I AND II

Pursuant to 6 U.S.C. § 706 and Rule 56 of the Federal Rules of Civil Procedure, and upon consideration of the parties' Motions for Summary Judgment, and the parties' briefing thereon, it is hereby ORDERED that Plaintiffs' motion is GRANTED; and it is further ORDERED that:

a. The following Challenged Provisions of the Interim Final Rule ("IFR") entitled "Community Engagement Requirement for Certain Individuals," 91 Fed. Reg. 33348 (June 3, 2026), are DECLARED unlawful, and additionally VACATED and SET ASIDE pursuant to 5 U.S.C. § 706(2):

   i. With respect to the Interim Final Rule's definition of "medically frail" or "special medical needs," the portion of 42 C.F.R. § 435.554(c)(5)(i) that reads "whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement in this subpart and is an individual";

   ii. With respect to the Interim Final Rule's 12-month limitation on the review period for adjudicated claims and encounter data, the portion of 42 C.F.R. §§

435.557 (a)(vii) that reads "that have been adjudicated in the preceding 12 months," the portion of 42 C.F.R. § 435.557(a)(viii) that reads, "for the preceding 12 months," and the portion of 42 C.F.R. § 435.557(f) that reads "that have been adjudicated in the preceding 12 months";

iii. With respect to the Interim Final Rule's limitation on States' use of self-attestation to verify eligibility for the medical frailty exclusion, the portion of 42 C.F.R. § 435.557(f)(1)(i) that reads "Before January 1, 2028" and all of 42 C.F.R. § 435.557(f)(1)(ii); and

iv. The Interim Final Rule's apparent limitation on States' ability to make an *ex parte* determination on whether an individual's "physical, mental, or other behavioral health condition significantly impairs" ability to comply with work requirements, as set forth in 91 Fed. Reg. 33373, indicating that States "cannot automatically classif[y] as medically frail or otherwise having special medical needs based solely on diagnosis or condition."

b. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants (collectively, "Defendants") are hereby ENJOINED from implementing, enforcing, retroactively enforcing, or otherwise applying the Challenged Provisions to Plaintiff States.

c. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants (collectively, "Defendants") are hereby

d. ENJOINED from penalizing Plaintiff States for any errors or delays in implementing the IFR for a period of six months following the date of this order.

SO ORDERED this __ day of _____, 2026

_____
By: Judge Richard Stearns
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al., Plaintiffs, v. MEHMET OZ, M.D., et al., Defendants.	Case No. 26-12962

PLAINTIFF STATES' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

In 2025, Congress enacted for the first time in Medicaid's 60-year history a new nationwide requirement for certain adult Medicaid enrollees, mandating that they engage in work or other kinds of community engagement to maintain eligibility for healthcare coverage. But Congress placed important limits on the work requirement. Recognizing that a loss of health insurance could have dire consequences for those with significant health care needs, Congress explicitly excluded from the work requirement anyone who was "medically frail" or had a "serious medical condition." And it defined that term to include, at a minimum, five groups of medically vulnerable individuals.

Three months ago, however, the Center for Medicare and Medicaid Services ("CMS") issued an implementing regulation (the "IFR") that partially abrogated the "medically frail" exemption enacted by Congress. In what appears to have been a last-minute regulatory decision, CMS directly contravened the statute's direction that the "medically frail" exclusion extend to individuals falling within one of the five enumerated categories. Instead, the IFR denies the exclusion to anyone falling within these statutory categories unless they can also show that their medical condition "significantly impairs" their ability to work—an extra-statutory requirement that CMS conjured out of thin air.

Not only is this significant impairment provision at odds with the statute, it has wreaked havoc on the States' ability to implement the new work requirement. For months, CMS had provided the States with implementation guidance suggesting that its forthcoming definition of "medically frail" would capture the five categories set forth in the statute—no more and no less. In reversing course and imposing the significant-impairment requirement, CMS has saddled the States with the exceptionally complex and difficult task of somehow determining the extent to which a Medicaid member's health condition impairs their individual ability to work. Worse, the IFR compounded this administrative problem in two ways: by limiting States' ability to consider

claims data that could be relevant to assessing medical frailty and by restricting the use of self-attestation as a means of verifying exclusion from the work requirement.

These three provisions of CMS's implementing regulations are unlawful under the Administrative Procedure Act (APA). First and foremost, the significant impairment provision is contrary to law. Whatever its policy preferences, an executive agency does not have the authority to supplant the will of Congress. Yet CMS has upended Congress' judgment by subjecting untold numbers of medically vulnerable individuals to the very work requirements Congress excluded them from. Second, all three provisions are arbitrary and capricious. While this Court may not substitute its policy judgment for an agency's, the APA requires the Court to ensure that CMS's regulatory decisions are reasonably explained and that the agency has at least considered important policy considerations derived from the statute. Here, CMS has failed these basic requirements for agency rulemaking. It has not offered a cogent affirmative reason to have adopted any of the challenged provisions. And it failed to consider, much less weigh, several ways in which the provisions undermine the statutory purpose and operation of the Medicaid program—including by denying healthcare coverage to potentially millions of medically vulnerable Medicaid members and by imposing unworkable administrative burdens on State agencies.

To be clear, Plaintiffs do not challenge Congress's decision to impose work requirements on non-medically frail individuals. Whatever the wisdom of that policy decision, it was Congress's to make, and Plaintiffs are working diligently to implement it. Instead, Plaintiffs challenge CMS's decision to impose work requirements on people Congress chose to exempt. Further, Plaintiffs do not seek to block the entirety of the IFR. Rather, as the attached Proposed Order shows, Plaintiffs ask that the Court narrowly vacate and enjoin the three offending provisions, and otherwise protect

States from being penalized for delays caused by the IFR. This will enable both CMS and the States to move forward with implementing the statutory work requirement as Congress intended.

BACKGROUND

Established in 1965, Medicaid is a federally-created, state-administered public health insurance program for vulnerable populations. It furnishes medical assistance to individuals of limited means, helping them "attain or retain capability for independence or self-care." 42 U.S.C. § 1396; *see also* Statement of Material Facts ("SMF") ¶3. In 2010, the Affordable Care Act enabled States to expand Medicaid eligibility to low-income individuals aged 19 to 64 (the "Expansion Population"). 42 U.S.C. §1396a(a)(10)(A)(i)(VIII); *see also* SMF ¶¶2, 13. Each of the Plaintiff States has expanded Medicaid to include all or some of the Expansion Population. SMF ¶14.

I. H.R. 1'S WORK REQUIREMENT

For the first sixty years of the Medicaid program, eligibility—and with it, access to medical care for low-income, disabled, and other vulnerable populations—did not depend on whether an individual was engaged in any particular activity. That changed on July 4, 2025, when H.R. 1 was enacted into law. SMF ¶¶20, 21. It directed all States to impose new requirements for work or community engagement for "applicable individuals" who are members of the Expansion Population. One Big Beautiful Bill Act, Pub. L. No. 119–21, tit. VII, §71119, 139 Stat. 72, 306-315 (2025) (codified at 42 U.S.C. §1396a(xx)) (the "Work Requirement"); *see* SMF ¶21. The statute identifies seven ways in which an "applicable individual" can comply with the monthly Work Requirement, including by working or performing community service for at least 80 hours, being enrolled in an education program at least half-time, or earning equivalent monthly or seasonal minimum wages. 42 U.S.C. §1396a(xx)(2)(A)–(G).

Congress placed important limitations on the Work Requirement. Among these, H.R. 1 identified nine groups of "specified excluded individual[s]" as exempt from the Work

Requirement. *Id.* at §1396a(xx)(9)(A)(ii). One of the groups Congress excluded was individuals "who [are] medically frail or otherwise ha[ve] special medical needs"—which, the statute directs, must "includ[e] an individual" who is: (i) "blind or disabled," (ii) has a "substance use disorder," (iii) has a "disabling mental disorder," (iv) has a "physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living"; or (v) has a "serious or complex medical condition." *Id.* at §1396a(xx)(9)(A)(ii)(V); SMF ¶22. While the statute includes an "impairment" requirement for certain of these groups, it does not include a general "impairment" requirement applicable to all of the groups.

H.R. 1 set key deadlines for implementation of these new provisions. First, it gave States 18 months to implement the new Work Requirement, *i.e.*, by January 1, 2027. *Id.* §1396a(xx)(1). Second, Congress directed the HHS Secretary to promulgate an interim final rule, "for purposes of implementing" the Work Requirement, no later than June 1, 2026. Pub. L. No. 119–21, tit. VII, §71119(d), 139 Stat. 72, 314 (2025) (note); SMF ¶29.

Recognizing the breadth of the changes necessary to implement the Work Requirement, and the States' need to begin planning for them well before June 1, 2026, CMS began providing subregulatory guidance to the States in November 2025. SMF ¶30. This guidance included a slide deck first presented to the States on November 19, 2025 (and later shared by email on December 4, 2025), SMF ¶¶31-33, 35-42, a bulletin released on December 8, 2025, SMF ¶¶43-47, and verbal guidance during a series of workgroup calls beginning in December 2025, SMF ¶¶48-49. CMS's guidance informed the States that, for the medically frail exclusion, it intended to "use a definition . . . similar to that described in regulations at 42 C.F.R. §440.315(f)"—a longstanding Medicaid regulation that likewise exempts "medically frail" individuals from certain program requirements. SMF ¶¶33-34. That regulation defines "medically frail" as generally including the five categories

of individuals whom H.R. 1 directed CMS to exclude from the Work Requirement as "medically frail," without any further condition or qualification—in particular, without any requirement that the individual be unable to perform work or other activities. *Compare* 42 C.F.R. §440.315(f) *with* 42 U.S.C. §1396a(xx)(9)(A)(ii)(V). CMS also informed the States that it expected to allow them to verify whether an individual qualified for the medical frailty exclusion through "medical claims data review or provider documentation, or completion of a screening tool," absent any indication that claims data review would be temporally limited. SMF ¶36. CMS also indicated that self-attestation would be a permissible means of verifying exclusions and unlike attestations used for compliance, did not indicate exclusion attestations would be limited in 2028. SMF ¶40. The States relied on CMS's guidance to plan operational, system, and process changes. SMF ¶¶67-68. In light of the magnitude of H.R. 1's changes, State Medicaid agencies necessarily started making substantial investments in systems upgrades well before June 1. SMF ¶¶67-83.

II. THE IFR AND THE CHALLENGED PROVISIONS

On June 1, 2026, CMS released the IFR, which departed significantly from both the language of H.R. 1 and CMS's prior guidance. SMF ¶¶181, 185. The IFR includes certain unanticipated provisions that impermissibly narrow the medically-frail exclusion that Congress enacted and impose burdensome restrictions that undermine States' ability to verify exclusion from the Work Requirement. *See* SMF ¶¶185-93.

First, the IFR narrows the statutory exclusion of those "who [are] medically frail or otherwise ha[ve] special medical needs" to cover only those individuals whose "physical, mental, or other behavioral health condition significantly impairs [their] ability to comply with the [Work Requirement]" ("Significant Impairment Provision"), SMF ¶¶186-87—a broad impairment requirement not in the statute.6 Moreover, the IFR preamble states that in no case can States base their medical frailty determinations solely on records showing that an individual has a "particular

diagnosis or condition," SMF ¶213; *see* SMF ¶215. Second, the IFR limits States' use of medical records to verify an individual's exclusion from the Work Requirement to only records from the preceding 12 months ("Claims Period Limitation"). *See* SMF ¶¶188-90. Third, when Medicaid agencies cannot otherwise determine an individual's status as medically frail, CMS limits individuals to one self-attestation concerning medical frailty per period of enrollment beginning in 2028—meaning States will need to expend additional resources to conduct member outreach and somehow obtain and review independent evidence of an individual's status as medically frail. *See* SMF ¶¶191-94. Together, these are the "Challenged Provisions."[1]

The Challenged Provisions will impose massive administrative burdens and costs on Plaintiff States. They will make the process of determining each individual's compliance with or exclusion from the Work Requirement extraordinarily difficult—for example, by requiring States to make individualized "impairment" assessments. SMF ¶¶10-11, 93, 104, 126-27, 172, 233-45, 256, 262-63. Moreover, Plaintiff States must make substantial changes to the implementation plans they developed over the past year, expending new funds and resources to develop new eligibility verification systems and communicate to members how to navigate this system. SMF ¶¶228, 230-31, 237-40. And, because the Challenged Provisions will cause significant disenrollment, they will impose new burdens on Plaintiff States' uncompensated care funds, publicly-run hospitals, and other programs for the uninsured. SMF ¶¶250-59, 261-63; *see* SMF ¶107.

ARGUMENT

Summary judgment is appropriate when there is no genuine dispute of material fact. Fed. R. Civ. P. 56(a). "A genuine issue of fact exists where the evidence is such that a reasonable

[1] Counts I and II of Plaintiffs' Complaint also challenged CMS's rules regarding short-term hardship exceptions, see Complaint ¶¶ 213, 220(e), but Plaintiffs have elected to narrow their claims under Counts I and II to the Challenged Provisions addressed in this motion.

[factfinder] could return a verdict for the nonmoving party." *Taylor v. Am. Chemistry Council*, 576 F.3d 16, 24 (1st Cir. 2009). The non-moving party must "present affirmative evidence" to support any alleged dispute of fact. *Bennett v. Murphy*, 166 F. Supp. 3d 128, 143 (D. Mass. 2016).

For APA claims, "the traditional Rule 56 standard does not apply; rather, a motion for summary judgment is simply a vehicle to tee up a case for judicial review." *Littlefield v. Dep't of Interior*, 656 F. Supp. 3d 280, 290 (D. Mass. 2023). Under the APA, a court must set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C).[2]

I. THE COURT SHOULD VACATE AND ENJOIN THE SIGNIFICANT IMPAIRMENT PROVISION.

The Court should vacate and enjoin the IFR's Significant Impairment Provision for two independent reasons. First, it is contrary to law: Congress directed CMS to exclude as "medically frail" five medically vulnerable groups. The IFR runs afoul of this statutory directive by denying the medically-frail exclusion to members of these groups. Second, the Significant Impairment Provision is arbitrary and capricious: CMS did not reasonably explain why it adopted this provision; failed to consider its harmful effects on the health and well-being of Medicaid members; and failed to consider the immense operational burdens it imposed on States.

A. The Significant Impairment Provision is contrary to law.

Under the APA, this Court can, and should, "hold unlawful and set aside" the Significant Impairment Provision because it is "in excess of statutory jurisdiction, authority, or limitations" and "not in accordance with the law." 5 U.S.C. § 706(2)(A), (C). Agencies violate the APA when they re-define rights conferred by statute or promulgate regulations that are inconsistent with

[2] At this time, Plaintiffs seek judgment only as to Counts I and II of their Complaint. Plaintiffs reserve the right to pursue Count III.

statutory directives. 5 U.S.C. § 706(2)(C); *see New Jersey v. Bessent*, 149 F.4th 127, 144 (2d Cir. 2025) ("An administrative agency does not have authority to pass regulations that are inconsistent with the meaning of a statute."); *POM Wonderful LLC v. Coca-Cola Co.*, 573 U.S. 102, 120 (2014) (holding that agencies generally may not "reorder federal statutory rights without congressional authorization."). After all, "[s]tatutory rights and obligations are established by Congress," not agencies. *DeCambre v. Brookline Hous. Auth'y*, 826 F.3d 1, 9 (1st Cir. 2016). Consistent with this bedrock principle of administrative law, courts routinely exercise their authority to vacate agency regulations, or sub-sections thereof, that contravene statutory directives. *See, e.g.*, *California v. Mullin*, 183 F.4th 42, 48–49 (1st Cir. 2026) (upholding the district court's vacatur of an administrative action because a successful "excess-of-statutory-authority APA claim" under § 706(2)(C) "in and of itself fully supports" vacatur of the unlawful rule); *Ryan v. ICE*, 974 F.3d 9, 19 (1st Cir. 2020) ("When an agency acts in a manner not authorized by statute, its action is ultra vires and a violation of the APA.").[3]

The Significant Impairment Provision is contrary to statute because it excludes from the definition of medical frailty many individuals whom Congress expressly directed CMS to include. The plain text of the statute, judicial precedent, and legislative history all confirm this. And while Congress gave CMS authority to define the term "medically frail," it placed a clear limit on that authority: CMS must include individuals belonging to certain medically vulnerable groups. As the Supreme Court has made clear, this Court must police the statutory boundaries of CMS's delegated authority to ensure that they have stayed within it. Because the Significant Impairment Provision

[3] *See also Nat'l Council of Nonprofits v. McMahon*, No. 25-13242-MJJ, 2026 WL 1876366, at *33 (D. Mass. June 30, 2026) ("[T]he Final Rule is contrary to law[,]… [and is thus] VACATED."); *Washington v. FEMA*, 818 F. Supp. 3d 195, 204–05 (D. Mass. 2025) (vacating agency actions which contradicted FEMA's statutory obligations); *Ass'n of Am. Univs. v. NSF*, 788 F. Supp. 3d 106, 144 (D. Mass. 2025) ("The [administrative rules] are vacated and declared … contrary to law."); *Dorcas Int'l Inst. of R.I. v. CIS*, No. 26-cv-132-JJM-PAS 2026 WL 1622708 *54 (D.R.I. June 5, 2026) ("Because each of the Challenged Policies … are "contrary to law" … the Court VACATES the Challenged Policies.").

goes beyond those boundaries, the Court must vacate and enjoin it.

1. The Significant Impairment Provision excludes from the medical frailty definition individuals whom Congress directed CMS to include.

"Where Congress has established a clear line, the agency cannot go beyond it." *City of Arlington v. FCC*, 569 U.S. 290, 307 (2013). Here, Congress established a "clear line" by categorically excluding from the Work Requirement individuals:

> who [are] medically frail or otherwise ha[ve] special medical needs (as defined by the Secretary), ***including*** an individual—(aa) who is blind or disabled (as defined in section 1382c of this title); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition.

42 U.S.C. §1396a(xx)(9)(A)(ii)(V) (emphasis added).

By specifying that these five particular categories of individuals are *per se* exempt from the Work Requirement, Congress "set[] a floor" for the definition of "medically frail." *Project Vote/Voting for America, Inc. v. Long*, 682 F.3d 331, 337 (4th Cir. 2012). But CMS' definition of medically frail falls below this floor: it covers individuals who fall within the statutory categories only *if* their condition "significantly impairs [their] ability to comply with the" Work Requirement. 42 C.F.R. 435.554(c)(5)(i). That additional criterion leaves out a significant subset of the enumerated groups Congress directed CMS to "includ[e]": not just those who are not significantly impaired but also those who cannot jump through the bureaucratic hoops to prove their condition significantly impairs their ability to work.

This is the only way logical way to interpret Congress's use of the word "including"—as the plain text of the statute, judicial precedent, and multiple canons of interpretation all confirm. When "determining the meaning of a statutory provision," courts "look first to its language, giving the words used their ordinary meaning." *Artis v. District of Columbia*, 583 U.S. 71, 83 (2018). As

one appellate court put it, "include" means the "whole" "contain[s] [the listed examples] as a part or member." *Hincapie-Zapata v. Attorney General*, 977 F.3d 1197, 1201-02 (11th Cir. 2020) (quoting Antonin Scalia & Bryan Garner, *Reading Law: The Interpretation of Legal Texts* § 15, at 132 n.1 (2012)); *see also Public Int. Legal Found. v. Bellows*, 92 F.4th 36, 48 (1st Cir. 2024) (holding that "includes" is "a term of enlargement, and not of limitation"); *Include*, BLACK'S LAW DICTIONARY (12th ed. 2024) (participle "*including*" generally "indicates a partial list," though "some drafters use phrases such as *including without limitation and including but not limited to*—which mean the same thing") (emphasis in original); *Include/Including*, MERRIAM-WEBSTER DICTIONARY (2026), https://www.merriam-webster.com/dictionary/including ("[T]o take in or comprise as a part of a whole or group"). Thus, the five categories after "including" establish, at a minimum, individuals who must be "contain[ed]" within the definition of medically frail. The Secretary is free to expand the list but may not shut out individuals Congress decided to include.

A word's plain meaning can also be confirmed by its "ordinary usage." *IRS v. Murphy*, 892 F.3d 29, 35 (1st Cir. 2018). If your spouse says "get whatever we need from the grocery store, including milk and eggs," you would presume they have directed you to get milk and eggs, along with anything else that is needed. That you may have discretion to determine whatever else you need does not mean you can forget the milk and eggs.

Case law confirms what everyday usage suggests: when a general term is followed by a list introduced by the word "including," the items on that list are necessarily encompassed by the general term. *See In re Horne*, 876 F.3d 1076, 1080–81 (11th Cir. 2017) (holding that "costs and attorney's fees" counted as "actual damages" under the statute, where Congress used the phrase "including costs and attorney's fees" to elucidate the meaning of "actual damages" because "the word 'including' serv[es] as a word of enlargement"); *Hincapie-Zapata*, 977 F.3d at 1201–02

(where statute defines "material support" to terrorists as "*including* … [the] transfer of funds or other material financial benefit," "the 'including' clause … lists examples that do qualify" as "material support."); *United States v. Cline*, 986 F.3d 873, 876 (5th Cir. 2021) (where statute defines a protection order in part as "any injunction, restraining order, *or any other order … including any temporary or final order* issued by a civil or criminal court," use of "including" indicates "an illustrative application of the general principle," so all orders listed after "including" fell "within the definition of [a] protection order").

Canons of statutory construction substantiate what the plain text and precedent make clear. Consider the rule against superfluities, which directs courts to presume that Congress does not employ statutory terms which are "superfluous or void of significance." *Dep't of Agriculture Rural Dev. Rural Hous. Serv. v. Kirtz*, 601 U.S. 42, 53 (2024). Any interpretation that gives CMS free reign to decide whether, and to what extent, the medically-frail definition should leave out members of the groups the statute expressly included would render all of the words in the statute beginning with "including" a nullity. Indeed, to find that the "authority to define terms" amounts to the "power to *redefine* those terms that the statute itself defines" would constitute a "repeal" of the "originally mandated definition." *FAIC Sec., Inc. v. United States*, 768 F.2d 352, 362 (D.C. Cir. 1985) (emphasis in original). The inclusion of each sub-category in the statute, no less than the language preceding them, represents the will of Congress and constrains CMS's definitional authority.

CMS's imposition of a separate impairment-based limitation also runs afoul of the canon of *exclusio unius*, which states that "the mention of some implies the exclusion of others not mentioned." *United Dominion Indus, Inc. v. United States*, 523 U.S. 822, 836 (2001) (internal citation omitted). This canon has particular significance when "Congress includes particular

language in one section of a statute but omits it in another[.]" *Barnhart v. Sigmon Coal Co., Inc.*, 534 U.S. 438, 452 (2002) (cleaned up). Here, Congress defined one exclusion as including those whose disability "significantly impairs their ability to perform 1 or more activities of daily living." 42 U.S.C. §1396a(xx)(9)(A)(ii)(V)(dd). And, in subsection (aa), Congress specifically referenced the definitions of "blind" and "disabled" at 42 U.S.C. § 1382c, which includes a similar requirement that a disabled individual be found "unable to engage in any substantial gainful activity." 42 U.S.C. § 1382c(a)(3)(A). So "[h]ad Congress wanted to include" a functional impairment requirement over the entire section, "it certainly knew how to do so." *Polselli v. IRS*, 598 U.S. 432, 439 (2023). That is strong evidence that Congress did not intend the medical frailty definition to be qualified with a generalized "impairment" requirement. Moreover, the Supreme Court has found this presumption—that use of a particular statutory phrase in one part of a statute implies its exclusion otherwise—to be especially strong where, as here, "the provision in question" is "in the adjacent section, having been enacted in the same Public Law." *Id.*

Substantive canons point in the same direction. The Medicaid program is enshrined in "Title XIX of the Social Security Act." *Massachusetts v. Sebelius*, 638 F.3d 24, 25 (1st Cir. 2011). And the First Circuit has long held that the Social Security Act "should be broadly construed and liberally applied in favor of beneficiaries." *Paiva v. Kijakazi*, 704 F. Supp. 3d 268, 276 (D. Mass. 2023) (cleaned up) (quoting *McCuin v. Sec'y of Health & Hum. Servs.*, 817 F.2d 161, 174 (1st Cir. 1987)); *see also Slessinger v. Sec'y of HHS*, 835 F.2d 937, 943 (1st Cir. 1987) ("The principle of liberal construction governs interpretations of the Social Security Act."). As this Court has held, the intent of the Act is "inclusion rather than exclusion of coverage" and courts should "resolv[e] doubts in favor of coverage." *Paiva*, 704 F. Supp. 3d at 276.

A construction which reads the five enumerated subcategories as a definitional minimum is also "confirmed by both statutory [] and legislative history." *Franklin Cal. Tax-Free Trust v. Puerto Rico*, 805 F.3d 322, 338 (1st Cir. 2015). Begin with the history of the statutory language. In 2006, Congress gave States the ability to require their Medicaid beneficiaries to enroll in "Alternative Benefit Plans" (ABPs). 42 U.S.C. § 1396u-7(a)(2)(B)(vi). But Congress did not permit mandatory enrollment for those who were "medically frail or otherwise [have] special medical needs." *Id.* CMS promulgated regulations defining this term as encompassing five categories of medically vulnerable individuals. SMF ¶34. Importantly, CMS defined these groups as *per se* medically frail—without any separate significant impairment requirement or other qualification. SMF ¶34. Then, when drafting the "medically frail" provision of H.R. 1, Congress lifted the same five categories from the ABP regulations and imported them into the statutory text of the "medically frail" definition with only minor changes. SMF ¶35. This history is instructive because when "Congress employs a term of art obviously transplanted from another legal source, it brings the old soil with it," meaning that courts should presume that incorporation of a regulatory definition into a statute gives that regulatory phrase, and its longstanding interpretations, the force of statutory law. *Doe v. Trump*, 157 F.4th 36, 59 (1st Cir. 2025) (cleaned up). This presumption applies with particular force where, as here, the term "had a long regulatory history in this very context." *George v. McDonough*, 596 U.S. 740, 746 (2022). Congress' decision to import into H.R. 1 the same set of sub-categories set forth in the ABP regulations—which do not include any "significant impairment" limitation—therefore underscores its intent to deem those groups "medically frail" without qualification, just as the ABP regulations did.

And the legislative history indicates that lawmakers understood H.R. 1's medical frailty exclusion to offer broad protection for those in the enumerated sub-categories. *See Succar v.*

Ashcroft, 394 F.3d 8, 31 (1st Cir. 2005) (noting that consulting legislative history is appropriate where it "confirm[s] whether the plain text reading is correct"). The House committee report states categorically that medically frail "includes, but is not limited to" the five enumerated sub-categories, confirming that the "including" clause set a definitional floor. H.R. Rep. No. 119-106, at 816. Advocates for the legislation repeatedly assured the public that those with serious illness and other qualifying conditions would be excluded, as Representative Brett Guthrie confirmed that individuals were exempt if they were "medically frail"—which he stated, without qualification, "includes anyone who's blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer." SMF ¶25; *see also* SMF ¶¶24, 26-28 (Senators noting that medically frail individuals will keep their Medicaid coverage).[4]

Finally, it is no answer for CMS to argue that the Significant Impairment Provision is consistent with the underlying purpose of H.R. 1. As an initial matter, any such argument fails as a matter of law. As the First Circuit has held, when "Congress has spoken with specificity," CMS "may not promulgate regulations that are an attempted addition" to statutory conditions, even when "the attempted addition is consistent with the underlying intent behind the authorizing statute." *In re JPMorgan Chase Bank, N.A.*, 799 F.3d 36, 42 (1st Cir. 2015). Defendants have not identified any basis to conclude that Congress intended the medical frailty exclusion to apply only to individuals who are unable to comply with the Work Requirement. To the contrary, H.R. 1's exclusions demonstrate that Congress intended to balance its desire to incentivize work with concern about continuous access to healthcare for those with higher needs for healthcare services. For example, the statute also exempts from the Work Requirement all pregnant individuals, who

[4] Senator Grassley, defending the legislation on the Senate floor, also defined medically frail as including the five sub-categories, and similarly did not mention any requirement of significant impairment in order to qualify as medically frail. *See* 171 Cong. Rec. S3497 (daily ed. June 24, 2025) (statement of Sen. Chuck Grassley).

could suffer serious consequences if their care were interrupted for any reason, even though pregnancy generally does not interfere with ability to work. The same is true of the medically vulnerable sub-categories (including someone who is blind) whom Congress directed CMS to include in its medical frailty definition regardless of ability to work.

2. CMS cannot disregard statutory constraints on its definitional authority.

Though H.R. 1 gives CMS some authority to define who qualifies as medically frail, it sets an important boundary on that authority: the agency must include in its definition individuals falling within five specified groups. As the Supreme Court made clear in *Loper Bright Enterprises v. Raimondo*, even where Congress has delegated statutory authority, courts must "independently identify" and "police the outer statutory boundaries" of that delegated authority, ensuring that the agency "exercise[s] their discretion" within the statute's text. 603 U.S. 369, 404 (2024); *see also Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 485 (2001) (agencies "may not construe [a] statute in a way that completely nullifies textually applicable provisions meant to limit discretion."); *Ortiz-Santiago v. Barr*, 924 F.3d 956, 961 (7th Cir. 2019) ("If Congress has defined a term, then an implementing regulation cannot re-define that term in a conflicting way.").

Again, judicial precedent confirms that, even when an agency has definitional authority, "that discretion may only be exercised within the bounds of the statutory definition itself." *Safer Chemicals, Healthy Fams. v. EPA*, 943 F.3d 397, 425 (9th Cir. 2019). In *Safer Chemicals*, the Ninth Circuit assessed the meaning of the statutory term "conditions of use" within the Toxic Substances Control Act. *Id*. The statute defined the term to mean "the circumstances, as determined by the [EPA] Administrator, under which a chemical substance is intended, known, or reasonably foreseen to be manufactured, processed, distributed in commerce, used, or disposed of." *Id.* at 406–07. The EPA maintained that its definitional authority, included in that provision, allowed it to define "conditions of use" to exclude from consideration any chemicals no longer being actively

manufactured. The Ninth Circuit disagreed, holding that the inclusion of terms after a general term meant that the "definition" of the statutory term was "clear" such that agency lacked the discretion to depart from the "clear[] inclu[sion]" of those examples within the general phrase, even when granted definitional authority. *Id.* at 425.

CMS may argue, as it did at the preliminary injunction stage, that its definitional authority permits it to define not just "medically frail," but also the meaning of the statutory sub-categories—for example, what it means to have a "substance use disorder" or "serious or complex" medical condition. But even assuming that is true, it is irrelevant: the Significant Impairment Provision that Plaintiffs challenge is not part of CMS's definition of the statutory sub-categories. Rather, the IFR defines medically frail individuals as those who fall within the enumerated sub-categories *and* whose condition significantly impairs their ability to comply with the Work Requirement:

> An individual who is medically frail or otherwise has special medical needs is defined as an individual [1] whose … health condition significantly impairs the individual's ability to comply with the community engagement requirement … *and* [2] is an individual [who meets one of the five sub-categories].

42 C.F.R. § 435.554(c)(5)(i) (emphasis added). In other words, under the IFR, medical frailty has two separate and independent preconditions: (1) a condition which causes significant impairment, and (2) membership in one of the statutory sub-categories, as defined by CMS. Plaintiffs challenge only the former precondition—the Significant Impairment Provision—not CMS's definitions of the individual sub-categories.[5]

* * *

Congress granted those in the five statutory sub-categories an exclusion from the Work

[5] As to the individual sub-categories, the IFR did not use the exact language of the statute and instead provided more particularized definitions. For example, it elaborated on what it means to have a "substance use disorder." *Compare* 42 C.F.R. § 435.554(c)(5)(i)(B) *with* 42 U.S.C. §1396a(xx)(9)(A)(ii)(V)(bb). But it did not add a "significant impairment" element to any sub-category definition.

Requirement. CMS disagrees with that policy and is now attempting to use its delegated authority to overcome clear statutory text. But fundamental principles of administrative law prevent CMS from overriding the will of Congress. The Court must ensure the statute is enforced as written.

B. CMS's promulgation of the Significant Impairment Provision was arbitrary and capricious.

Even if CMS had statutory authority to promulgate the Significant Impairment Provision, it should still be vacated and enjoined because it separately violates the APA's bar on "arbitrary or capricious" agency actions. 5 U.S.C. §706(2)(A). An agency action is arbitrary or capricious "if it is not reasonable and reasonably explained.'" *Ohio v. EPA*, 603 U.S. 279, 292 (2024). "In reviewing an agency's action under that standard," courts ask whether the agency "has offered 'a satisfactory explanation for its action, including a rational connection between the facts found and the choice made.'" *Id.* Among other things, agency action is arbitrary and capricious if the agency "has relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, … or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise," *Motor Vehicle Mfrs. Ass'n of the U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), or failed to "consider and explain its rejection of… significant and viable and obvious alternatives," *Nat'l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 215 (D.C. Cir. 2013).

Whatever discretion Congress affords an agency in implementing a statute, the APA requires that the agency exercise that discretion in a reasonable way—and requires courts to ensure that they do. So, while Congress directed CMS to issue a rule implementing the Work Requirement, CMS was required to take a reasoned approach to implementation: providing reasoned explanations for its regulatory choices and considering the impacts of those choices on

the statutory goals of the Medicaid program—including ensuring healthcare coverage for eligible individuals and administrative simplicity.

The Significant Impairment Provision falls short of these requirements. First and most fundamentally, CMS failed to "reasonably explain" why it promulgated the Provision.[6] Its lone explanation is that "[r]eading the statute to require automatic classification as medically frail or otherwise having special medical needs based solely on diagnosis or condition would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." SMF ¶215. This circular statement is a tautology—essentially saying that reading the statue without CMS's requirement risks sweeping in individuals who do not meet CMS's requirement. This is neither reasonable nor reasonably explained. *Am. Pub. Health Ass'n v. NIH*, 791 F. Supp. 3d 119, 131, 180, 183 (finding circular definition of DEI arbitrary and capricious and noting that "conclusory statements will not do"); *Firearms Regul. Accountability Coal., Inc. v. Garland*, 112 F.4th 507, 523 (8th Cir. 2024) (rejecting as arbitrary and capricious an agency standard that relies on circular reasoning); *Amerijet Int'l, Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014) (finding agency action arbitrary and capricious where agency provided "not a statement of reasoning, but of conclusion"). Without an articulated need for this provision, its promulgation was plainly arbitrary and capricious.

Second, CMS "failed to consider an important aspect of the problem": the impact of the Significant Impairment Provision on the ability of medically vulnerable Medicaid members to obtain necessary treatment for their complex medical conditions. *State Farm*, 463 U.S. at 43. This consideration is especially important because Congress has barred CMS from promulgating

[6] Notwithstanding the length of the administrative record, over 4,800 pages, the mere existence of supporting evidence in the record is insufficient to uphold an agency action. *See, e.g., Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 20 (2020) ("It is a 'foundational principle of administrative law' that judicial review of agency action is limited to 'the grounds that the agency invoked when it took the action.'")

regulations that create "unreasonable barriers" to access to medical care. 42 U.S.C. § 18114(1). And here, CMS knew well that additional administrative hurdles would cause individuals to lose coverage: the administrative record is replete with evidence that tying the definition of medically frail to ability to work would prevent medically vulnerable people, including those with cancer and HIV, from being excluded from the Work Requirement and lead to disenrollment and gaps in coverage with potentially fatal consequences. SMF ¶¶113-16, 150-51 172, 174-77.[7] To be sure, the IFR's Regulatory Impact Analysis concedes that many Medicaid members who are eligible for Medicaid will lose their health insurance due to administrative complexities associated with the statutory work requirements generally. SMF ¶223. Yet the IFR fails to provide any analysis of the *additional* procedural disenrollments that will result from the Challenged Provisions in particular—despite clear evidence that they would increase disenrollments by imposing additional administrative burdens on Medicaid members.[8]

The administrative record is replete with evidence regarding the additional loss of health insurance that would result from the Work Requirement generally, and the Challenged Provisions specifically. SMF ¶¶93, 104, 124 (self-attestation ensures eligible individuals do not lose coverage), 126, 129-32 (using a 12 month claims look back period as opposed to a 24 month look

[7] In addition, CMS ignored evidence from states that previously rolled out Medicaid work requirements, like Georgia and Arkansas, which showed loss of coverage, including for individuals who were working or had serious medical conditions and should have been eligible for exemptions, with *no* increase in employment. SMF ¶¶92-97, 103-04. CMS concluded in the IFR preamble that "[the] early implementation experience [in Arkansas and Georgia] provides insight into operational considerations," SMF ¶221, but later dismissed the early experiences in the Regulatory Impact Analysis as "involv[ing] different implementation patterns" that are not "directly applicable," stating "[w]e have not relied on these previous demonstrations for data or assumptions used in this analysis." SMF ¶222.

[8] One estimate projects disenrollments resulting from the Work Requirement—after accounting for the effects of the IFR—at 8.2 million by 2034. SMF ¶251. That is approximately 3 million more than reliable estimates of the number of disenrollments resulting from the statute alone, and nearly 5 million more than CMS's estimated disenrollment. SMF ¶¶224, 248. This underscores CMS's glaring failure to analyze the number of people who would lose coverage as a result of the IFR's Challenged Provisions. At the July hearing, counsel for Defendants claimed that CMS "firmly grappled with [the fact that its choice created millions of additional disenrollments], and it still chose the policy path that it did in spite of acknowledging the significant number of disenrollments." SMF ¶225. But there is no evidence of this grappling, let alone engagement with unfavorable facts, and the *ipse dixit* of litigation counsel is irrelevant to this Court's arbitrary and capricious analysis. *Kisor v. Wilkie*, 588 U.S. 558, 579 (2019).

back period reduces the number of individuals who qualify as medically frail by at least 2 million), 175-76 (Significant Impairment Provision would limit ability to get coverage or delay coverage which "[f]or a cancer patient… can be deadly"), 178-79. Faced with this evidence, CMS was required to explain how the choice to promulgate the Challenged Provisions, which would exacerbate these massive societal costs, carried a countervailing benefit. *President & Fellows of Harvard Coll. v. U.S. Dep't of Health & Hum. Servs.*, 798 F. Supp. 3d 77, 131 (D. Mass. 2025) (defendants must "consider the potential societal costs"); *Washington v. HUD*, No. 25-cv-626-MSM-AEM 2026 WL 1863886 (D.R.I. June 29, 2026), at *4 (finding agency explanation arbitrary and capricious where it gave "little to no thought or analysis of the negative externalities created" by the agency action"). But the agency provided no explanation at all.

Third, CMS "failed to consider [another] important aspect of the problem": the significantly heightened burden that States face in administering the non-statutory Significant Impairment Provision. The burdens of implementation and compliance on regulated entities are a core factor that agencies must consider when issuing regulations. *See Michigan v. EPA*, 576 U.S. 743, 759 (2015) ("The Agency must consider cost—including, most importantly, cost of compliance—before deciding whether regulation is appropriate and necessary."). That is especially true here, where Congress has expressly directed CMS to prioritize "simplicity of administration" in the administration of Medicaid. 42 U.S.C. §1396a(a)(19).

The administrative record shows that CMS was presented with extensive evidence that (i) administrative efficiency is critical to state Medicaid agencies' ability to make eligibility determinations, and (ii) that the more cumbersome the process for verifying compliance with or exclusion from the Work Requirement, the more administrative strain it would impose on States. SMF ¶¶93, 124, 140-44 ("determination of functional limitations should include an individual,

face-to-face assessment"). Indeed, it will be exceptionally difficult for States to conduct individualized assessments of the ability to work for potentially millions of Medicaid recipients. SMF ¶¶10-11, 172 (Significant Impairment Provision will "set up an enormous administrative process for states to go through to determine eligibility and determine work ability on top of that"), 238, 242, 244-45, 256 (engaging directly with members is "costly and time-intensive"), 262-63. That is especially true given CMS's indication in the preamble to the IFR that States cannot rely solely on records of "the presence of a particular diagnosis and condition" to verify an individual's compliance with the significant-impairment requirement. SMF ¶213. Yet CMS plowed ahead with the Significant Impairment Provision without addressing or even acknowledging these concerns.

CMS's failure to consider the administrative burdens on the States is especially egregious in light of the contrary guidance that CMS had earlier provided to the States. Plaintiff States necessarily began time-consuming and costly efforts to implement H.R. 1's Work Requirement immediately after enactment. SMF ¶¶67-88. Both Plaintiffs and CMS were faced with the staggering challenge of implementing the Work Requirement by January 2027. As such, CMS provided detailed guidance, frequent meetings, and an approved exemplar in Nebraska's early roll out. SMF ¶39. And just as CMS intended, the States relied on its guidance.[9] SMF ¶¶67-88, 157, 161 (California "relied extensively on CMS's preliminary guidance over the last several months to design, build, and operationalize major programmatic, systems, and staffing changes needed to comply with H.R. 1 by January 1, 2027"), 167. Having engaged in this crucial partnership for at least seven months, CMS was not free to ignore the burden placed on Plaintiffs by changing key system and policy requirements a few months before a major implementation deadline. This is

[9] "CMS was aware…that California and other states were making time-sensitive, largely irreversible implementation decisions, including vendor contracts, IT builds, and staffing commitments, in direct reliance on its guidance, and continued providing that guidance without any indication that a material policy shift was under consideration. The reliance is embedded in systems that are already in final development and testing." SMF ¶161.

more than an "important aspect of the problem": it is *the* key gating factor for launching the Work Requirement on time. *State Farm*, 463 U.S. at 43.

Notably, CMS itself acknowledged that "[c]ommunity engagement is an entirely new factor of eligibility, and as such, States must consider criteria that were not previously applicable to Medicaid eligibility and establish new policies and procedures for verif[ication]." SMF ¶212. Against this backdrop, CMS had to consider how its late-stage departure from its own guidance and the "entirely new factor" would impact State Medicaid agencies. The administrative record and the IFR demonstrate zero consideration of these important factors, and evidence in the administrative record underscores the problem. For example, in March, months ahead of the IFR release, CMS received an urgent request for "examples of acceptable formats/models for screeners" noting "[t]he state needs to update applications, code into eligibility systems and logic, do user testing, etc. – and **rule release in June is likely too late to stay on track for timely implementation.**" SMF ¶87. All States, including those not party to this litigation, were faced with the herculean task of designing, testing, and implementing new systems on an already tight timeline, and CMS knew this. For example, Louisiana, which in February 2026 provided CMS its "Medically Frail Definition & Diagnosis Framework" (which permitted *ex parte* verification), indicated that having completed this first step in the process, significant work remained to be done in the then 11 months leading up to the implementation deadline. SMF ¶¶76-78, 80-81.

Knowing that the medically frail definition was the linchpin from which every other step flowed, CMS was required to consider that changing the definition in June 2026 would cause States to redo systems requirements and workflow to which they had already committed significant personnel time and financial resources based on CMS' original guidance and to make those changes within an incredibly challenging timeline. Missing from the administrative record—and

thus unconsidered by CMS—are the multiple submissions provided to CMS by Plaintiff States and their Medicaid agencies once rumors of CMS's change in direction had circulated. SMF ¶¶154-71. For example, California's Medicaid agency noted, "[i]mplementing new processes on this significantly shortened timeline would heighten the risk of systems errors, improper terminations, and administrative failures affecting eligible individuals. DHCS anticipates that any major shift in direction at this stage could delay implementation by 18-24 months." SMF ¶161. CMS was required to consider the constraints imposed on States by the January 1, 2027, implementation deadline, and its failure to do that was arbitrary and capricious. *Washington*, 2026 WL 1863886, at *3 (agency action was arbitrary and capricious where it failed to "consider the impact that a rapid, untimely overhaul would have on the organizations that administer these programs and the individuals that rely upon them").

Fourth, CMS also failed to consider the administrative burdens resulting from the Significant Impairment Provision in light of its assertion in the IFR's preamble that States cannot rely solely on records of "the presence of a particular diagnosis and condition" to verify an individual's compliance with the "significantly impaired" requirement, SMF ¶¶ 213, 215. That statement contradicts, without explanation, Congress's direction that States, when verifying exclusions, should not "requir[e], where possible, the applicable individual to submit additional information." 42 U.S.C. §1396a(xx)(5). Indeed, such records are exactly the kind of "reliable information available to the state" that would enable States to verify eligibility without additional information from an enrollee in accordance with other terms of the IFR, 42 C.F.R. §§ 435.557, 435.558(b), and with established Medicaid regulations on eligibility redeterminations, *id.* § 435.916(a)(2) and (b). And CMS was presented with a clear alternative to limiting *ex parte* verification: several public health scholars provided CMS with a "structured, validated, and

auditable approach that states may use to automatically exempt medically frail individuals using ICD-10… codes." SMF ¶¶119-21. So, to the extent the IFR suggests States cannot rely solely on existing information, such as claims data, to verify the medical frailty exclusion, that is arbitrary and capricious in itself and also underscores the unreasonableness of the agency's failure to consider the Provision's burden on States.

CMS's failure to consider these important factors is unsurprising given their late-breaking decision to add the Significant Impairment Provision. *See* SMF ¶152 (noting rumors in May 2026 that "the White House [was] pushing CMS to tighten the exemption definitions"); *see also* SMF ¶55. Indeed, portions of the IFR still read as if there were no significant-impairment requirement, as originally envisioned and communicated to States for the preceding six months. SMF ¶214.[10]

II. CMS'S PROMULGATION OF THE CLAIMS PERIOD LIMITATION WAS ARBITRARY AND CAPRICIOUS AND SHOULD BE VACATED AND ENJOINED.

The Claims Period Limitation is also arbitrary and capricious for several reasons. First, it is neither reasonable nor reasonably explained. CMS attempts to justify the 12-month limit by asserting that "older information may not reflect the individual's current condition." SMF ¶218. But that is necessarily true of all categories of data used to verify eligibility and any time period selected. *See* 42 C.F.R. § 435.557(a)(i)-(viii). As to claims data, data from just one month, *may* not reflect an individual's current status—but it also may. An individual with a chronic or permanent condition, like an intellectual or developmental disability, may not receive care evidencing the underlying condition in a shorter time period, but may see a provider for other reasons where that condition would not be obvious in 12-months of claims data. SMF ¶136; *see also* ¶¶137, 139. CMS does not explain why States should be categorically barred from considering potentially probative

[10] Plaintiffs have repeated their request, pursuant to Executive Order 12866, for the original IFR submitted to OIRA a month after their original request, on August 16, 2026 but have received no response. SMF ¶209.

claims data simply because, like any other source of data, it may not be determinative. And CMS's position is especially incoherent given that it chose not to place temporal limits on other categories of potentially relevant data, such as "[p]ayroll data." 42 C.F.R § 435.557(a)(vi).

Second, CMS failed to consider an incredibly "important aspect of the problem": uncontroverted data in the administrative record indicating that a one-year claims period—as opposed to a two-year claims period—would result in denying the medical frailty exclusion to at least two million people with serious conditions. SMF ¶¶131-32; *State Farm*, 463 U.S. at 43. This is in part because claims data in months 13-24 sometimes identifies people who would qualify as medically frail, such as a person with a chronic or permanent condition who may not receive treatment for that condition in months 1-12. SMF ¶136. In fact, conditions like intellectual or developmental disabilities often do not show up on every claim. SMF ¶136. Nothing in the administrative record indicates that allowing State Medicaid agencies to review additional historic claims data would cause them to make arbitrary medically frail determinations.[11] Accordingly, CMS has prescribed a limitation with no benefit, but clear detriment. *Michigan*, 576 U.S. at 753 ("[R]easonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions."). Yet CMS failed to consider this issue. Nor did it consider the obviously "reasonable alternative[]" of a two-year lookback. *Dubois v. United States Dep't of Agric.*, 102 F.3d 1273, 1289 (1st Cir. 1996). These failures were arbitrary and capricious.

Third, the Claims Period Limitation is inconsistent with the statute's direction—and CMS's direction—that States should, to the greatest extent possible, verify compliance with and exclusion from the Work Requirement "without requiring" Medicaid members "to submit additional information." 42 U.S.C. § 1396a(xx)(5); *see* SMF ¶38; *see INS v. Yang*, 519 U.S. 26, 32 (1996)

[11] State Medicaid agencies need to maintain auditable records, and risk Payment Error Rate Measurement (PERM) penalties if they incorrectly exclude members as medically frail. SMF ¶241.

("[A]n irrational departure from [a governing] policy ... constitute[s] action that must be overturned as 'arbitrary, capricious, or an abuse of discretion'" under the APA). Artificially limiting the claims period impedes States' ability to follow the Congressional mandate to use every effort to verify medically frail exclusions based on already-available information. The 12-month limit is also inconsistent with CMS's own direction that States "must consider such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on documentation, and on program integrity in terms of the potential for ineligible individuals to be enrolled and for eligible individuals to be denied coverage." SMF ¶220. CMS' failure to consider or explain these inconsistencies is arbitrary and capricious. *Encino Motorcars, LLC v. Navarro*, 579 U.S. 222 (2016); *State Farm*, 463 U.S. at 43. The administrative costs of allowing States to use a longer claims period are net positive: the burden of adding months (or even years) of claims data to a system that already evaluates claims data is minimal, whereas seeking additional documentation from members is time-consuming and costly. SMF ¶256. Imposing these additional costs on Plaintiff was an "important aspect of the problem" and CMS's failure to consider it was arbitrary and capricious. *Michigan*, 576 U.S. at 759 ("The Agency must consider cost—including, most importantly, cost of compliance").

III. CMS'S PROMULGATION OF THE SELF-ATTESTATION LIMITATION WAS ARBITRARY AND CAPRICIOUS AND SHOULD BE VACATED AND ENJOINED.

CMS's decision to limit Medicaid members to one self-attestation of medical frailty per enrollment period starting in 2028 should also be vacated as arbitrary and capricious for several reasons: CMS failed to provide any reasoned explanation for this limitation and failed to consider evidence regarding the difficulty Medicaid members would face in obtaining provider documentation regarding medical frailty and the burdens on providers that such a documentation requirement would impose.

First, CMS's lone explanation for the self-attestation limitation was that the agency "believe[s] that requiring verification of medical frailty to confirm an individual's specified excluded status using data or documentation [after one self-attestation] will motivate individuals to access care." SMF ¶217. But CMS points to no evidence—nor is there any in the administrative record—that this extra administrative barrier to coverage will make Medicaid members more likely to access available care. Unsubstantiated "conclusory statements will not do" to satisfy the requirement of reasoned decisionmaking. *NIH*, 791 F. Supp. 3d at 178. And absent any factual support, CMS has simply offered a "solution in search of a problem," confirming that the self-attestation limit is arbitrary and capricious. *New York v. HHS*, 414 F. Supp. 3d 475, 546 (S.D.N.Y. 2019). Requiring patients to schedule provider visits for the purpose of obtaining documentation of their medical frailty will unduly burden providers and increase costs to state and federal governments to pay for such visits. SMF ¶¶262-63. The Self-Attestation Limitation will only further strain already-stretched provider networks. That CMS failed to acknowledge, let alone grapple with, any of these issues, is also arbitrary and capricious. *State Farm*, 463 U.S. at 43.

CMS's rationale is especially unreasonable because, as discussed above, *see infra* at 24, seeing a provider will not necessarily result in claims data that speaks to an individual's status as medically frail. For example, if a medically frail individual seeks necessary medical care for an ear infection, the claims data generated from that visit will not demonstrate the individual's medical frailty, but instead will show services provided for an ear infection. SMF ¶¶136-39.

Second, CMS failed to consider evidence in the administrative record that it can be quite difficult for a Medicaid beneficiary to obtain documentation from a provider confirming that they qualify for a work requirement exclusion. SMF ¶¶98-101 (past work requirement experiments showed individuals struggled to find willing providers to sign off on disability related exemptions

in a timely manner, particularly given the smaller pool of Medicaid providers). CMS was also presented with evidence that "self-attestation has been found to be a highly reliable form of verification" that is "less burdensome to states and the best method for ensuring that eligible individuals do not lose health coverage due to administrative barriers." SMF ¶124. But CMS failed to acknowledge, let alone grapple with, this evidence.

IV. PLAINTIFFS ARE ENTITLED TO THE RELIEF THEY SEEK.

A. Plaintiffs are entitled to vacatur of the Challenged Provisions.

Finally, Plaintiffs seek only "[t]he normal remedy for a successful APA challenge": "vacatur of the [challenged agency action] and its applicability to all who have been subject to it." *Woonasquatucket River Watershed Council v. U.S. Dept. of Agriculture*, No. 25-1428, 2026 WL 2279789, at *19 (1st Cir. Aug. 7, 2026); *see also Harrington v. Chao*, 280 F.3d 50, 60 (1st Cir. 2002). To be clear, Plaintiffs seek to vacate *only* those "part[s] of [the] agency rule" which constitute the "relevant discrete agency action"—here, incorporation of the Challenged Provisions—leaving the vast majority of the IFR untouched. *Ass'n of Am. Univs. v. DoD*, 806 F. Supp. 3d 79, 121 (D. Mass. 2025). The IFR itself states that CMS and HHS "inten[d] that if any provision of this final rule is held to be invalid … it shall be severable[.]" 91 Fed. Reg. 33351. Plaintiffs neither challenge the full IFR nor seek to vacate anything beyond the Challenged Provisions.

B. Plaintiffs are entitled to a permanent injunction of the Challenged Provisions.

Plaintiffs have also met the burden for permanent injunctive relief. The traditional standard requires Plaintiffs to demonstrate (1) "actual success on the merits," (2) "irreparable injur[y] in the absence of injunctive relief," (3) "that the harm suffered "from the defendant's conduct would exceed the harm to the defendant accruing from the issuance of an injunction," and (4) that "the public interest would not be adversely affected." *Doe v. R.I. Interscholastic League*, 137 F.4th 34,

40 (1st Cir. 2025). However, "once the court reach[es] the conclusion that the rule was indeed illegal … there [is] no separate need to show irreparable injury." *Illinois v. FEMA*, 801 F. Supp. 3d 75, 97 (D.R.I. 2025) (quoting *Nat'l Min. Ass'n v. US Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998).[12] That holding is congruent with the text of the APA, which permits "actions for … prohibitory or mandatory injunction[s]." 5 U.S.C. § 703. Following that precedent, and assuming Plaintiffs succeed on the merits, all that remains are the final two factors, which "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). And effectuating Congressional policy to ensure continued Medicaid access for medically frail Americans is an undoubtedly weightier interest than "the perpetuation of unlawful agency action" which serves "no public interest." *Rhode Island v. Trump*, 155 F.4th 35, 50 (1st Cir. 2025).

C. Plaintiffs are entitled to a stay of enforcement of the IFR for six months.

Finally, consistent with CMS's statutory authority to allow States additional time to comply with H.R. 1's new Medicaid provisions, 42 U.S.C. § 1396a(xx)(11), this Court should enjoin CMS from penalizing Plaintiffs for a period of six months for any delays in complying with the IFR. Plaintiffs have worked diligently towards implementing the Work Requirement. However, CMS's promulgation of unlawful regulatory constraints—particularly the Significant Impairment Provision and Claims Period Limitation—has badly disrupted the States' implementation plans. SMF ¶¶227-45. Plaintiffs have been forced to overhaul their plans for verifying compliance with, or exclusion from, the Work Requirement. As the detailed declarations from experienced State Medicaid administrators show, valuable implementation time has been irrevocably lost as Plaintiffs

[12] In any event, the record clearly establishes that Plaintiffs will suffer irreparable injury if they are required to implement the Challenged Provisions—all of which impose substantial administrative costs on State Medicaid agencies by requiring them to engage in more burdensome efforts to verify compliance with and exclusion from the Work Requirements. *See* SMF ¶¶236-38, 240-45. Indeed, the First Circuit has already held that "intensive alterations" to "eligibility verification systems for [] federal programs" constitute irreparable injury due to the necessary and unrecoverable expenditures. *Doe v. Trump*, 157 F.4th 36, 79 (1st Cir. 2025); *see also New York v. DHS*, 969 F.3d 42, 86 (2d Cir. 2020) ("undertak[ing] costly revisions to [Medicaid] eligibility systems" constitutes irreparable harm).

devoted resources to trying to comply with the Challenged Provisions. SMF ¶¶227-45. Thus, even with a ruling vacating and enjoining those provisions, Plaintiffs cannot guarantee that there will not be brief delays in implementing the remainder of the IFR by January 1, 2027.

Plaintiffs thus request that this Court exercise its "broad [equitable] powers" to ensure Plaintiffs are not penalized for having lost approximately six months of implementation time as they attempted to navigate implementation of the unlawful Challenged Provisions. *NW Env't. Def. Ctr. v. Bonneville Power Admin.*, 477 F.3d 668, 680–81 (9th Cir. 2007); *see also CREW v. DOJ*, 846 F.3d 1235, 1242 (D.C. Cir. 2017) (holding that a district court's equitable powers are especially broad "where, as here, federal law is at issue and the public interest is involved"); *see* 5 U.S.C. § 705 ("[T]he reviewing court … may issue all necessary and appropriate process … to preserve status or rights[.]"). To be sure, Plaintiffs will continue to work diligently to implement the Work Requirement as soon as possible—and in many cases, that will be by January 1, 2027. But to protect them against the risk of enforcement if they face any delays or errors resulting from the chaos caused by CMS's promulgation of the unlawful provisions, Plaintiffs ask the Court restore the pre-litigation status quo by enjoining Defendants—for a period of six months—from penalizing Plaintiffs for failure to comply with the IFR. *See SEC v. Sanchez-Diaz*, 88 F.4th 81, 88 (1st Cir. 2023) (explaining that equitable remedies necessarily involve "restoring the status quo"); *Illinois v. FEMA*, 2025 WL 2908807 (D.R.I. Oct. 14, 2025) (granting relief in an APA case beyond vacatur, including prohibiting enforcement).

CONCLUSION

For the reasons stated above, Plaintiff States respectfully request that the Court grant their motion and enter judgment in Plaintiffs' favor.

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Respectfully submitted,

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I hereby certify that this document was filed through the ECF system and will be sent electronically to the registered participants as identified in the Notice of Electronic filing (NEF).

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al. Plaintiffs, v. MEHMET OZ, M.D., et al. Defendants.	Case No. 1:26-cv-12962

PLAINTIFF STATES' STATEMENT OF MATERIAL FACTS
IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT

I. MEDICAID PROGRAM OVERVIEW

A. Medicaid Generally

1. Medicaid is a cooperative federal-state program that provides medical services to low-income individuals and individuals with disabilities, funded with both federal and state funds. *See* 42 U.S.C. § 1396-1; Ex.[1] 55, 2; Ex. 72 (AR), 002328 *see., e.g.*, Ex. 6 ¶5; Ex. 7 ¶5.

2. In 2010, Congress expanded Medicaid to cover low-income, working-age adults. Ex. 55, 2-3; AR, 002357, 002360, 003655.

3. Medicaid's purpose is to enable States to furnish medical assistance to individuals who cannot otherwise afford it and to provide services to help those individuals "attain or retain capability for independence or self-care." *See* 42 U.S.C. §1396-1; Ex. 55, 2.

4. State Medicaid agencies administer the Medicaid program pursuant to State plans, which are reviewed and approved by the Centers for Medicare and Medicaid Services (CMS).

[1] References to "Ex." herein refer to Exhibits to the Declaration of Nita K. Klunder, dated September 1, 2026.

See 42 U.S.C. § 1396-1; *see, e.g.*, Ex. 2 ¶5; Ex. 5 ¶5; Ex. 6 ¶5; Ex. 7 ¶5; Ex. 8 ¶5; Ex. 12 ¶6; Ex. 15 ¶5; Ex. 20 ¶6; Ex. 21 ¶5; Ex. 39 ¶5.

5. Federal law requires states to determine eligibility for Medicaid services in a way that both simplifies administration of the program and is in the best interests of Medicaid recipients. *See* 42 U.S.C. § 1396a(a)(19); Ex. 55, 2.

6. CMS is responsible for overseeing State compliance with federal rules and regulations relating to Medicaid and has authority to impose severe financial penalties if States are found to be out of compliance with their State Medicaid plans and federal regulations. Ex. 57, 1-2; Ex. 58, 1-2, 11.

7. The Payment Error Rate Measurement Program (PERM) measures improper state Medicaid payments. 91 Fed. Reg. 33377[2]; AR, 002310-11.

8. CMS has a long-held practice of providing guidance to States, outside of formal rulemaking, to assist States in complying with urgent and significant changes in federal Medicaid law. *See, e.g.*, Ex. 3 ¶13; Ex. 4 ¶12; Ex. 9 ¶12; Ex. 10 ¶12; Ex. 11 ¶16; Ex. 13 ¶11; Ex. 16 ¶12; Ex. 18 ¶12; Ex. 19 ¶13; Ex. 23 ¶12; Ex. 39 ¶12.

9. State Medicaid agencies have for many years relied on CMS guidance, and the associated slide decks and other written materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance. *See, e.g.*, Ex. 2 ¶12; Ex. 5 ¶12; Ex. 7 ¶17; Ex. 21 ¶12; Ex. 24 ¶12; Ex. 25 ¶13; Ex. 39 ¶12.

[2] The Interim Final Rule, 91 Fed. Reg. 33348 (June 3, 2026) is included in the administrative record at 000001-135. Citations herein are to the Federal Register page numbers.

10. While a few States have chosen to experiment with work requirements in the past, the Medicaid program as a whole has never before required Medicaid recipients to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. State Medicaid agencies therefore do not have in place systems for verification of compliance with work requirements. *See, e.g.*, Ex. 6 ¶¶9, 31; Ex. 8 ¶¶9-11, 21; Ex. 13 ¶9; Ex. 19 ¶11; Ex. 20 ¶11; Ex. 25 ¶11.

11. State Medicaid agencies also do not have systems in place for determining an individual's ability to work. State Medicaid agencies generally do not employ occupational medicine experts with the training to ascertain severity of impairment in relationship to ability to work. *See, e.g.*, Ex. 1 ¶10a; Ex. 7 ¶47; Ex. 15 ¶43; Ex. 16 ¶55; Ex. 21 ¶53; Ex. 22 ¶16; Ex. 55, 11.

12. Eligibility specialists who make decisions about eligibility for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) rely on extensive guidance from the Social Security Administration with details about what constitutes a disability and relevant factors for adjudicators to consider, including functional limitations like ability to work and residual functional abilities, relative to prior job experience. *See, e.g.*, Ex. 55, 11; Ex. 59; Ex. 60; Ex. 61.

B. Medicaid Expansion Populations

13. Individuals who are eligible for Medicaid due to the expansion of coverage authorized by the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, codified as amended at 42 U.S.C. § 18001 *et seq.* (Mar. 23, 2010), for low-income, working-aged adults ages 19-65 (the "Expansion Population") are subject to the Interim Final Rule. *See* 42 C.F.R. § 435.551; s*ee, e.g.*, Ex. 4 ¶6; Ex. 10 ¶6; Ex. 15 ¶6; Ex. 17 ¶5; Ex. 18 ¶6; Ex. 19 ¶7; Ex. 23 ¶6; Ex. 24 ¶6; Ex. 55, 2-3.

14. The Plaintiff States have each expanded Medicaid to all or some of the Expansion Population. *See, e.g.*, Ex. 2 ¶6; Ex. 3 ¶7; Ex. 11 ¶6; Ex. 14, Exh. 2 at 2-3; Ex. 17 ¶5; Ex. 25 ¶7; Ex. 39 ¶6; Ex. 55 at 2-3.

15. In the Plaintiff States, approximately 51 million residents are covered by Medicaid and CHIP, and of those, approximately 15 million residents are enrolled as part of the Expansion Population. Ex. 1 ¶10.h; Ex. 2 ¶¶4,8; Ex. 3 ¶¶5, 9; Ex. 4 ¶¶ 4, 8; Ex. 5 ¶¶ 4, 8; Ex. 6 ¶¶4, 8; Ex. 7 ¶¶4, 7; Ex. 8 ¶¶4, 8; Ex. 9 ¶¶4, 8; Ex. 10 ¶¶4, 8; Ex. 11 ¶¶4,8; Ex. 12 ¶¶5, 9; Ex. 13 ¶¶3, 7; Ex. 14, Exh. 1 at 1, Exh. 2 at 16; Ex. 15 ¶¶4, 8; Ex. 16 ¶¶4, 8; Ex. 17 ¶¶4, 6; Ex. 18 ¶8; Ex. 19 ¶¶5, 9; Ex. 20 ¶¶5, 9; Ex. 21 ¶¶4, 8; Ex. 22 ¶¶4, 7; Ex. 23 ¶8; Ex. 24 ¶¶4, 8; Ex. 25 ¶¶3, 9; Ex. 39 ¶¶4, 8.

16. Plaintiff States have enjoyed higher rates of insurance, increased healthcare affordability, improvements in health access and outcomes, and expanded economic benefits for medical providers and Medicaid members as a result of expanding access to Medicaid for the Expansion Population. Ex. 14, Exh. 2 at 1-2; Ex. 55, 2-3.

17. As part of Medicaid expansion, the Plaintiff States adopted new methods that allow for greater automation of eligibility determinations. *See* Ex. 56, 3, 15, 16.

18. State Medicaid agencies must attempt to conduct what are known as *ex parte* renewals for all Medicaid members; in other words, decisions regarding renewal that are based on reliable information available to the State Medicaid agency through electronic data sources. AR, 002312-13.

19. When possible, *ex parte* verification helps State Medicaid agencies make decisions about eligibility without demanding more information from the Medicaid member or applicant. AR, 002312-13.

II. H.R. 1

20. On July 4, 2025, the One Big Beautiful Bill Act, also known as H.R. 1, was signed into law. H.R. 1, Pub. L. No. 119-21, 139 Stat. 172 (2025); *see, e.g.*, Ex. 4 ¶39; Ex. 11 ¶10; Ex. 20 ¶17.

21. H.R. 1 included Section 71119, which newly imposed community engagement requirements for "applicable individuals," who include adults covered under the Medicaid expansion provisions of the ACA and adults enrolled in certain 1115 demonstrations. Pub. L. No. 119-21, tit. VIII, § 71119, 139 Stat. 72, 306 (2025) (codified at 42 U.S.C. § 1396a(xx)) (Work Requirement); *see, e.g.*, Ex. 2 ¶9; Ex. 11 ¶10.

22. Within Section 71119 of H.R. 1, Congress defined "Specified Excluded Individual"—individuals to whom the Work Requirement does not apply—to include "an individual, as determined by the State (in accordance with standards specified by the Secretary)— . . . (V) who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual—(aa) who is blind or disabled (as defined in section 1614); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).

23. As a result of H.R. 1, State Medicaid agencies must make substantial changes to administration of their Medicaid programs for applicants and enrollees in the Expansion Population. *See, e.g.*, Ex. 1 ¶¶ 3, 8-10; Ex. 7 ¶¶44-46; Ex. 8 ¶¶13-14; Ex. 15 ¶¶10, 39-40; Ex. 17 ¶¶13-14; Ex. 21 ¶¶10, 40-42; Ex. 22 ¶¶9, 13, 15; Ex. 25 ¶¶11, 42-44.

24. Proponents of H.R. 1 repeatedly described the medically frail exclusion without reference to an individual's ability to comply with the Work Requirement. Ex. 62, 6-7.

25. Representative Guthrie, Chairman of the House Energy and Commerce Committee, assured the public that individuals are "exempt if you're medically frail, which includes *anyone* who's blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer," and that "our bill couldn't be clearer" that it "includes a long list of exempted individuals." Ex. 62, 6 (emphasis added).

26. Senator Grassley explained that Congress provided "reasonable exemptions" for "[i]ndividuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition." Ex. 62, 6-7.

27. Senator Crapo assured colleagues that the legislation "does not take Medicaid away from . . . the medically frail." Ex. 62, 7.

28. Senator Sullivan described exemptions for "individuals who are medically frail or are dealing with a substance use disorder" as unqualified protections. Ex. 62, 7.

29. In H.R. 1, Congress directed the Secretary of Health and Human Services to "promulgate an interim final rule for purposes of implementing the provisions of" Section 71119 "[n]ot later than June 1, 2026." Pub. L. No. 119–21, tit. VII, §71119(d), 139 Stat. 72, 314 (2025) (note).

III. CMS Implementing Guidance

A. Communications from CMS to Plaintiffs

30. Between at least November 2025 and June 1, 2026, CMS provided guidance to State Medicaid agencies concerning implementation of the Work Requirement. *See, e.g.*, Ex. 2 ¶11; Ex. 3, ¶12; Ex. 11 ¶15; Ex. 13 ¶10; Ex. 22 ¶10; Ex. 25 ¶12.

31. On November 19, 2025, CMS presented a slide deck to State Medicaid agencies with the title "Implementing Section 71119 of the Working Families Tax Cut Legislation: Key

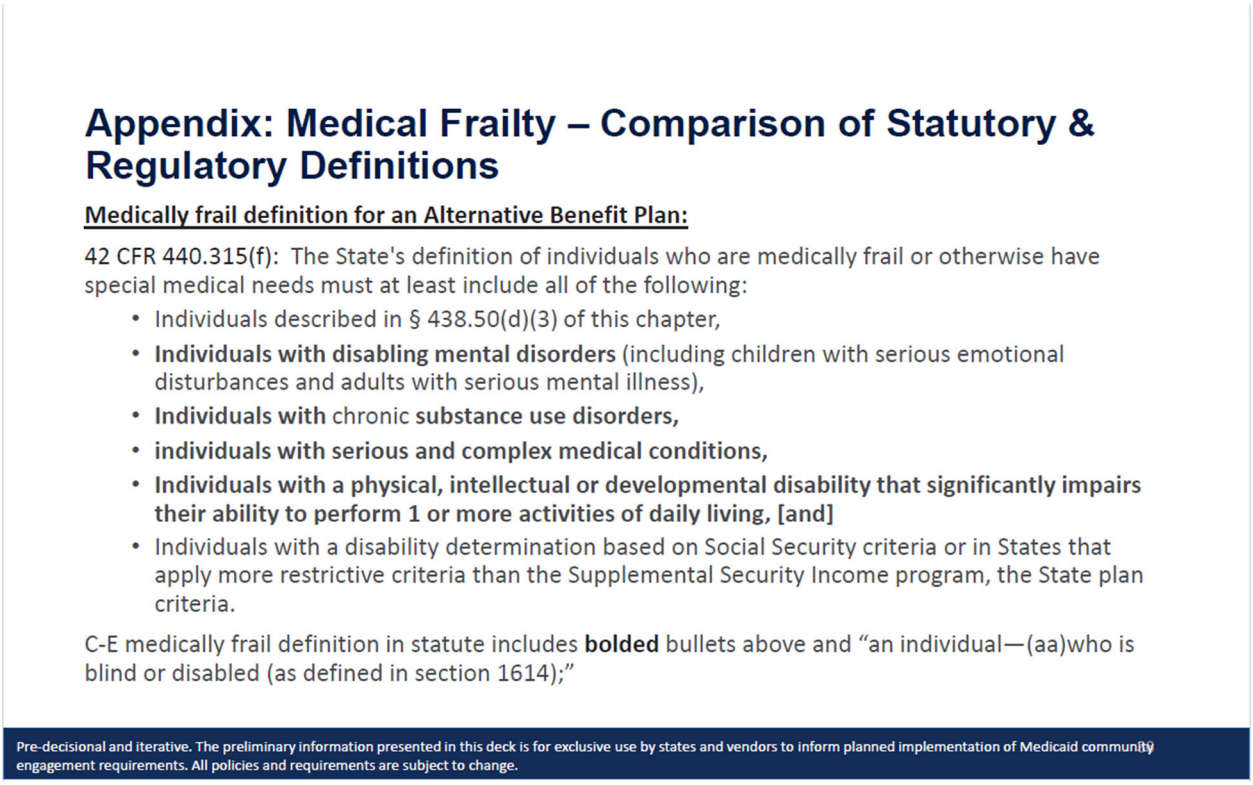
Requirements and Preliminary Direction from CMS." *See* Ex. 15, Exh. 1 (November 2025 Slide Deck), 1; *see, e.g.*, Ex. 2 ¶11; Ex. 4 ¶11; Ex. 5 ¶11; Ex. 9 ¶11; Ex. 18 ¶11; Ex. 21 ¶11.

32. The November 2025 Slide Deck was provided to State Medicaid agencies on December 4, 2025. *See, e.g.*, Ex. 2 ¶11; Ex. 4 ¶11; Ex. 5 ¶11; Ex. 9 ¶11; Ex. 18 ¶11; Ex. 21 ¶11.

33. In the November 2025 Slide Deck, CMS stated: "CMS intends to require states to use a definition of medical frailty similar to that described in regulations at 42 CFR § 440.315(f)." November 2025 Slide Deck, 11.

34. 42 CFR § 440.315(f), which CMS described as the "Medically frail definition for an Alternative Benefit Plan," states: "For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria." 42 C.F.R. § 440.315(f); *see* November 2025 Slide Deck, 36.

35. CMS included the following slide in the November 2025 Slide Deck reflecting a "Comparison of Statutory & Regulatory Definitions" of "Medical Frailty":



Appendix: Medical Frailty – Comparison of Statutory & Regulatory Definitions

Medically frail definition for an Alternative Benefit Plan:

42 CFR 440.315(f): The State's definition of individuals who are medically frail or otherwise have special medical needs must at least include all of the following:

- Individuals described in § 438.50(d)(3) of this chapter,
- **Individuals with disabling mental disorders** (including children with serious emotional disturbances and adults with serious mental illness),
- **Individuals with** chronic **substance use disorders,**
- **individuals with serious and complex medical conditions,**
- **Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, [and]**
- Individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

C-E medically frail definition in statute includes **bolded** bullets above and "an individual—(aa)who is blind or disabled (as defined in section 1614);"

Pre-decisional and iterative. The preliminary information presented in this deck is for exclusive use by states and vendors to inform planned implementation of Medicaid community engagement requirements. All policies and requirements are subject to change.

November 2025 Slide Deck, 36.

36. In the November 2025 Slide Deck, CMS also stated: "CMS will expect states to implement an auditable approach to verify medical frailty, in alignment with certain guardrails. E.g., ***medical claims data review*** or provider documentation, or completion of a screening tool. States may require new applicants without any claims history to complete a screening tool to verify medical frailty, but CMS expects to require states to confirm that determination via claims data/documentation within 6 months post enrollment." November 2025 Slide Deck, 11 (emphasis added). CMS did not indicate that it would impose a temporal limitation on claims data review. *Id.*

37. CMS then reiterated its expectation that States use available data, including claims data, to verify exceptions or exclusions from the Work Requirement, including the medically

frail exclusion. *See* November 2025 Slide Deck, 16, 17, 29. CMS did not indicate that it would impose a temporal limitation on claims data review. *Id.*

38. CMS further informed States that it expected them to use reliable information, including data, to conduct *ex parte* verification to "establish whether an individual met the community engagement requirement, without requiring, where possible, the applicable individual to submit additional information." November 2025 Slide Deck 15; *see id.* at 29.

39. In the November 2025 Slide Deck, CMS also stated "[f]ull implementation of C-E [Community Engagement] includes multiple, interdependent elements that extend beyond system updates" and "States will need to address policy, process, and operational capacity to meet compliance." November 2025 Slide Deck, 25. CMS noted further, "CMS is developing formal guidance that will be released on a rolling basis in 2025-2026" and listed as a next step, resuming weekly "Eligibility Workgroup Calls." November 2025 Slide Deck, 5, 35.

40. In a slide addressing States' "Minimum Viable Product," CMS stated that an "[a]uditable individual declaration" would be allowed in 2027—"year 1"—for "Community Service and Job Program Enrollment" and did not include any comparable "year 1" only limits for declarations regarding other community engagement criteria. *Id.* at 29. On the same slide, CMS did not mention any limits on use of auditable declarations for determining "Mandatory Exceptions & Exclusions." *Id*.

41. Though the November 2025 Slide Deck contained disclaimers stating that the information provided therein was preliminary and subject to change, it said that "states and vendors are strongly encouraged to review this deck to inform planning." November 2025 Slide Deck, 5. Several slides also include a disclaimer in small print that includes the following statement: "[t]he preliminary information presented in this deck is for exclusive use by states

and vendors to inform planned implementation of Medicaid community engagement requirements." *Id.* at 2, 4-6, 8-12, 14-18, 20-21, 25-29, 31, 33-36.

42. CMS also "encourage[d] readers to refer to the applicable statutory language for complete information." November 2025 Slide Deck, 5.

43. On December 8, 2025, CMS publicly released an Informational Bulletin with the subject "Section 71119 of the 'Working Families Tax Cut' Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals" (December 8 Bulletin). AR, 000905-17;

44. In the December 8 Bulletin, CMS stated "we recognize that planning must begin now, as States enter budget and legislative sessions and begin procurement of new systems and services to support implementation of the Medicaid provisions in the WFTC legislation." AR, 000906.

45. The December 8 Bulletin also listed among the "specified excluded individuals," "[a]n individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition." AR, 000909-10. It added no other test or qualification. *Id*.

46. It also informed the States that "[t]he state may not request additional information or documentation unless it is unable to establish that the individual met community engagement requirements (or was not required to do so) using reliable information available to it." AR, 000912.

47. The December 8 Bulletin did not include any limits on the use of auditable self-declaration. AR, 000905-17.

48. Around the same time, on December 5, 2025, CMS began participating in workgroup calls to provide guidance and conduct question-and-answer sessions with States concerning implementing the Work Requirement. *See, e.g.*, Ex. 3 ¶12; Ex. 6 ¶10; Ex. 10 ¶11; Ex. 11 ¶15; Ex. 13 ¶10; Ex. 16 ¶11; Ex. 24 ¶11.

49. These workgroup calls took place once every other week from December 2025 through April 2026, then switched to a weekly cadence beginning in May 2026, and continued through at least June 2026. *See, e.g.*, Ex. 13 ¶10; Ex. 16 ¶11; Ex. 19 ¶12; Ex. 21 ¶11; Ex. 23 ¶11; Ex. 24 ¶11.

50. CMS initially signaled to State Medicaid agencies that it intended to limit use of self-attestation. November 2025 Slide Deck, 16; *see, e.g.*, Ex. 2 ¶15; Ex. 4 ¶15; Ex. 5 ¶15; Ex. 9 ¶15; Ex. 18 ¶15.

51. But CMS later indicated to State Medicaid agencies that self-attestation would be an acceptable verification method when data was not available., *See, e.g.*, Ex. 2 ¶15; Ex. 11 ¶ 19; Ex. 18 ¶15; Ex. 19 ¶16; Ex. 21 ¶15; Ex. 23 ¶15.

52. In March 2026, CMS reiterated to State Medicaid agencies that they could use auditable self-declaration to verify applicability of the "medically frail" exclusion, specifically when confirming ongoing medical frailty and when a member newly identifies as medically frail. *See, e.g.*, Ex. 2 ¶16; Ex. 4 ¶16; Ex. 5 ¶16; Ex. 9 ¶16; Ex. 10 ¶16; Ex. 11, ¶20; Ex. 21 ¶16; Ex. 23 ¶16.

53. Also in March 2026, CMS submitted the draft Interim Final Rule to the Office of Information and Regulatory Affairs in the Office of Management and Budget for review. Ex. 63.

54. On May 1, 2026, CMS presented to the State Medicaid agencies a slide deck that included a definition of the "medically frail" exclusion and did not mention a requirement that an individual's condition impair their ability to comply with the Work Requirement. *See, e.g.*, Ex. 5 ¶17; Ex. 10 ¶17; Ex. 13 ¶16; Ex. 16 ¶17; Ex. 24 ¶17; Ex. 25 ¶18.

55. On or about May 6, 2026, CMS informed State Medicaid agencies that information conveyed by CMS on the May 1, 2026, workgroup call should not be acted upon and was subject to change. *See, e.g.*, Ex. 10 ¶18; Ex. 11 ¶22; Ex. 16 ¶18; Ex. 24 ¶18; Ex. 25 ¶19.

56. At no point before promulgation of the Interim Final Rule in June 2026 did CMS indicate to State Medicaid agencies that Medicaid members would be limited to using self-declaration only once per enrollment period. *See, e.g.*, Ex. 2 ¶16; Ex. 3 ¶18; Ex. 7 ¶22; Ex. 9 ¶16; Ex. 13 ¶15; Ex. 16 ¶16; Ex. 23 ¶16.

57. At no point between passage of H.R. 1 and promulgation of the Interim Final Rule in June 2026 did CMS indicate that the medically frail exclusion would include a requirement that a condition "significantly impair" the individual's ability to comply with the Work Requirement. *See, e.g.*, Ex. 6 ¶11; Ex. 11 ¶18; Ex. 13 ¶13.

B. Early Implementation of the Work Requirement in Nebraska

58. On December 17, 2025, Nebraska and CMS Administrator Mehmet Oz, M.D., announced that Nebraska would be the first State to implement the Work Requirement on May 1, 2026. Ex. 29, 1.

59. Administrator Oz stated that "CMS will be working together with Nebraska and its 50 counterparts to ensure every program is implemented smoothly, responsibly, and in compliance with federal law." Ex. 29, 3.

60. A press release regarding the announcement stated "Nebraska Medicaid will use available data to verify compliance during application and renewal." Ex. 29, 2.

61. A press release regarding the announcement included a list of individuals who "are excluded from this requirement," which included "[p]eople who are medically frail" with no reference to whether those people are significantly impaired from otherwise complying with the Work Requirement. Ex. 29, 2-3.

62. In later state guidance addressing the "Medically Frail and SUD Treatment Program Exemptions," Nebraska's Department of Health and Human Services referred to a list of "medical diagnosis and procedure codes" identifying "conditions that may qualify an individual as medically frail or participating in an SUD treatment program." Ex. 64, 2.

63. This guidance stated that, for existing enrollees, "[i]f qualifying medical conditions or treatment indicators are identified" based on those codes, "the individual will be treated as exempt without needing to take additional action." *Id.* at 1.

64. Nebraska's reliance on diagnosis and procedure codes allows the State to conduct *ex parte* verifications of medical frailty or serious or complex medical conditions. *See id.*

65. This guidance did not reference the significant impairment of an individual's ability to comply with the Work Requirement. *Id.* at 1-3.

66. CMS noted in the Regulatory Impact Analysis included with the Interim Final Rule that "Nebraska began implementing the community engagement requirement on May 1, 2026." 91 Fed. Reg. 33459.

C. States' Implementation Efforts Based on CMS's Preliminary Guidance

67. Consistent with CMS's direction that States begin preparing to implement the Work Requirement that they could begin providing member notices by the August 31, 2026, date, and could be operational by the January 1, 2027, implementation date, and in line with past practice, State Medicaid agencies necessarily relied on the subregulatory guidance CMS provided to make their choices and investments in advance of promulgation of the Interim Final Rule (IFR) on

June 1, 2026. *See, e.g.*, Ex. 1 ¶3; Ex. 2 ¶39; Ex. 3 ¶50; Ex. 4 ¶40; Ex. 5 ¶41; Ex. 6 ¶20; Ex. 7 ¶¶11-12, 46; Ex. 8 ¶14; Ex. 22 ¶10; Ex. 39 ¶¶12, 19.

68. Consistent with CMS's earlier acknowledgment that the States should "refer to the applicable statutory language for complete information," Plaintiff States also relied on the language of H.R. 1 itself to inform their implementation efforts. *See, e.g.*, November 2025 Slide Deck, 5; Ex. 9 ¶43; Ex. 10 ¶41; Ex. 11 ¶53; Ex. 13 ¶40; Ex. 15 ¶40; Ex. 16 ¶41.

69. The States understood that the short timeline for implementation would require taking significant, costly, and binding steps ahead of the June 1, 2026, IFR. *See, e.g.*, Ex. 12 ¶11; Ex. 18 ¶¶40-41; Ex. 19 ¶¶42-43; Ex. 20 ¶¶17-18; Ex. 21 ¶¶40-41; Ex. 23 ¶¶35-36; Ex. 24 ¶¶40-41; Ex. 25 ¶¶42-43.

70. Plaintiff States worked with their State legislatures to appropriately fund the statutory changes required by H.R. 1. *See, e.g.*, Ex. 2 ¶53; Ex. 3 ¶70; Ex. 7 ¶63; Ex. 10 ¶61; Ex. 12 ¶22; Ex. 13 ¶40; Ex. 14 ¶¶5-6.

71. Plaintiff States worked with third-party vendors to make the necessary changes to their eligibility systems and allow for use of new data sources. *See, e.g.*, Ex. 1 ¶8; Ex. 12 ¶11; Ex. 15 ¶40; Ex. 16 ¶41; Ex. 21 ¶41; Ex. 23 ¶36.

72. Plaintiff States prepared notices and other outreach materials and campaigns for members. *See, e.g.*, Ex. 2 ¶39; Ex. 3 ¶50; Ex. 4 ¶40; Ex. 5 ¶41; Ex. 6 ¶20; Ex. 7 ¶46; Ex. 8 ¶14; Ex. 9 ¶43.

73. Plaintiff States initiated processes to hire and train new staff. *See, e.g.*, Ex. 11 ¶53; Ex. 15 ¶40; Ex. 16 ¶41; Ex. 21 ¶41; Ex. 22 ¶13; Ex. 23 ¶36.

74. Plaintiff States developed plans and entered into new contracts and expanded existing contracts to account for increased call volume and new processes. *See, e.g.*, Ex. 8 ¶14; Ex. 9 ¶43; Ex. 11 ¶53; Ex. 19 ¶63; Ex. 25 ¶43.

75. Plaintiff States worked extensively with clinical and systems personnel to build processes to identify individuals who are "medically frail" or have a "serious or complex medical condition," including by identifying specific diagnostic and procedure codes to confirm eligibility for the exclusion on an *ex parte* basis. *See, e.g.*, Ex. 1 ¶8; Ex. 2 ¶40; Ex. 3 ¶51; Ex. 4 ¶41; Ex. 5 ¶42; Ex. 6 ¶21; Ex. 7 ¶47.

76. Louisiana submitted to CMS a "Medically Frail Definition and Diagnosis Framework" dated February 6, 2026. AR, 004342-86.

77. Louisiana's "Definition and Diagnosis Framework" relied on "Algorithms/Medical Codes," and Louisiana also submitted to CMS the "draft medical code list" it had created. AR, 004351-86.

78. Louisiana's reliance on medical codes would allow the State to conduct *ex parte* verifications of medical frailty or serious or complex medical conditions. *See* AR, 004354-55, 004357, 004359, 004361-64.

79. The framework does not include any reference to whether a condition identified via diagnosis code "significantly impairs" or otherwise affects an individual's ability to comply with the Work Requirement. AR, 004342-86.

80. As of February 6, 2026, Louisiana reported its "Tasks Complete" in the following order: "Medically frail definition established," then "Working draft medical code list created to identify those who meet the definition of medically frail." AR, 004385.

81. Also as of February 6, 2026, Louisiana reported the following next steps; "Continue to refine list and put into format needed by IT (excel?)"; "Work with Mitzi/others on trial data run with codes"; "Refine list"; "Build claims algorithm (IT)"; "Create verification pathways for self and clinical attestation"; "Set up notice and appeals processes"; "Meetins [*sic*] set with LDH physician focus groups to review codes"; "Engage stakeholders —goal to start next quarter"; and "Finalize policy." AR, 004385.

82. Utah also communicated to CMS its "first draft of Utah's implementation of the medical frailty exception," which included a "Comprehensive ICD-10 Code List for Medical Frailty." AR, 004759-61.

83. Utah's approach classified "conditions according to three levels of severity," and proposed that the different levels of severity would merit different lengths of "exception" based on medical frailty. AR, 004759-60.

84. Throughout this time period, in weekly calls with CMS representatives and, at CMS's direction, through direct communication with CMS staff, the State Medicaid agencies informed CMS of the States' efforts to operationalize the work requirements, asked questions, and sought additional guidance and clarification. *See* November 2025 Slide Deck, 5; AR, 004840 (row 516, column D) (noting that "States submitted 18 questions related to HR1 requirements during" a recent meeting); *see, e.g.*, Ex. 9 ¶¶11-12; Ex. 10 ¶¶11-12; Ex. 11 ¶15-16; Ex. 13 ¶¶10-11; Ex. 15 ¶¶11-12; Ex. 16 ¶¶11-12; Ex. 18 ¶¶11-12; Ex. 19 ¶¶12-13; Ex. 21 ¶¶11-12; Ex. 22 ¶10; Ex. 23 ¶¶11-12; Ex. 24 ¶¶11-12; Ex. 25 ¶¶12-13.

85. At CMS's direction, State Medicaid agencies also communicated directly with CMS staff to provide updates on their implementation efforts, ask questions, and seek additional

guidance and clarification. *See* November 2025 Slide Deck, 5; *see, e.g.*, Ex. 18 ¶¶11-12; Ex. 19 ¶¶12-13; Ex. 21 ¶¶11-12.

86. A spreadsheet labeled by CMS in the administrative record Index as "State Requests for Technical Assistance re: 71119-Community engagement data" reflects that States submitted approximately 690 requests and questions to CMS between July 16, 2025 and May 29, 2026. AR, 004840, (column K).

87. In one such submission dated March 27, 2026, Plaintiff New Jersey asked, "Is CMS able to publicly release a few examples of acceptable formats/models for screeners as soon as possible (i.e. in the next couple of weeks), that would be incredibly helpful. The State needs to update applications, code into eligibility systems and logic, do user testing, etc. – and rule release in June is likely too late to stay on track for timely implementation." AR, 004840 (row 507, column D).

88. States also met on a regular basis with CMS IT system leads to report on their progress in building their IT systems to implement a minimum viable product workplan. *See, e.g.*, Ex. 1 ¶3; Ex. 2 ¶11, Exh. A; Ex. 3 ¶12; Ex. 4 ¶11; Ex. 7 ¶¶12-17, 46; Ex. 8 ¶¶11, 12; Ex. 9 ¶¶11-12; Ex. 10 ¶¶11-12; Ex. 12 ¶11; Ex. 15 ¶¶11-12; Ex. 20 ¶¶12-13; Ex. 21 ¶¶11-12; Ex. 22 ¶10.

IV. Information Before CMS Prior to Promulgation of the IFR

A. Information in the Administrative Record

89. Before June 1, 2026, stakeholders provided CMS with relevant data and concerns relating to the implementation of the Work Requirement. *E.g.*, AR, 003865-4013; AR, 004007-08; AR, 004723-30.

90. The administrative record reflects many communications from third parties along with other research, data, and suggestions that were available to CMS prior to promulgation of the IFR on June 1, 2026. *See* AR Certification; AR, Index 1-21; AR, 000001-4840.

1. Pre-HR 1 Implementations of Medicaid Work Requirements

91. The administrative record includes information about State implementation of work requirements prior to enactment of H.R. 1. *E.g.*, AR, 000922; AR, 004733-36.

92. A slide deck in the administrative record titled "Implementing Community Engagement Requirements in Medicaid: Draft chapter and recommendation" by the Medicaid And CHIP Payment and Access Commission (AR, 000916-36) noted that "before recent changes in federal law, some states pursued Section 1115 demonstrations to implement work and CE requirements." AR, 000922.

93. The slide deck noted that where such work and "CE" requirements were implemented, "observed and projected coverage losses were ***substantial***." AR, 000922 (emphasis added). It added that common reasons for lack of compliance included "[l]ack of beneficiary awareness, barriers to employment, and ***administrative challenges***." *Id.* (emphasis added).

94. A March 27, 2026 letter to CMS from six Members of Congress also discussed the projected and observed coverage losses from earlier State implementation of work requirements. AR, 004733-36.

95. Concerning an earlier "short-lived" implementation in Michigan, the letter stated, "80,000 individuals were at risk of losing their health care coverage within the first month of implementation, and 100,000 were expected to lose coverage in the first year of implementation." AR, 004733. It also stated that "49 percent of beneficiaries were already working, and 10 percent were students or homemakers, suggesting that many of those at risk of

losing coverage were already meeting the new requirements, but faced coverage loss as a result of the red tape associated with the policy." AR, 004733-34.

96. Addressing Georgia's Pathways to Coverage Program, which it described as "a statewide program that expanded Medicaid eligibility to adults aged 19-64 years with low incomes and simultaneously introduced work requirements for newly eligible enrollees," the Members of Congress wrote: "They experienced no gains in Medicaid coverage or in employment rates compared with their counterparts in neighboring non-expansion states during the 15 months after Pathways to Coverage." AR, 004734. They added, "Georgia's program ***reduced coverage without increasing employment***, suggesting that the red tape associated with work requirements impeded Medicaid enrollment in the state." AR, 004734 (emphasis added).

97. On the subject of implementation of work requirements in Arkansas, the letter stated "[i]n Arkansas, work requirements decreased Medicaid and Marketplace coverage by 13.2 percentage points among adults aged 30-49 years within six months, while there was no change in employment or engagement in community activities." AR, 004734. It also said, "more than 18,000 adults in Arkansas lost coverage because of Medicaid work requirements, out of an estimated 100,000 people who were subject to them." *Id*.

98. A November 19, 2025 letter to CMS from the National Health Law Program (NHeLP) (AR, 003990-4013) noted that, "when states implemented work requirements through section 1115 projects, many individuals who were required to submit evidence from a provider to verify the existence of a disability-related exemption struggled to find a willing provider or one who could timely sign off. AR, 004008; *see also* Ex. 26.

99. In support of this contention, NHeLP cited a research report by Ian Hill et. al, titled *New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results."* AR, 004008.

100. The research report reflected reports from stakeholders that "many providers were confused or did not want to participate" in completing medical frailty exemption requests. Ex. 65, 22-23.

101. NHeLP wrote, "[g]iven that Medicaid beneficiaries are limited to the smaller pool of providers that accept Medicaid and—if subject to managed care models—are also limited to in-network providers, then finding a willing provider becomes even more difficult." AR, 004008.

102. CMS itself, in a March 17, 2021 letter to the Arkansas Department of Human Services "withdrawing approval of the community engagement requirement" raised several difficulties with the implementation in Arkansas. AR, 000937-90.

103. CMS noted that "[b]efore the court halted the community engagement requirement, the State reported that from August 2018 through December 2018, a total of 18,164 individuals were disenrolled from coverage for 'noncompliance with the work requirement'" and that "there was no associated increase in employment or other community engagement activities among low-income individuals subject to the community engagement requirement whether in the first year when the policy was still in effect or nine months after the policy was blocked." AR, 000940, 000942.

104. CMS also noted that, in Arkansas, New Hampshire, and Michigan, "evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements." AR, 000943-44.

105. The administrative record also contains a "Georgia Section 1115 Demonstration Waiver Extension Request" dated April 28, 2025, which relates to its Pathways to Coverage Program. AR, 000991-1128.

106. The Georgia Extension Request included an Interim Evaluation Report providing "findings and recommendations based on the first 13 months of the Demonstration, July 1, 2023, through July 31, 2024" from a state-contracted Independent Evaluator, required by CMS. AR, 000999, 001041. The Interim Evaluation Report included the findings that "[e]nrollment into Pathways was lower than projected in the first year" and "[t]he [qualifying hours and activities] requirement limited Pathways enrollment." AR, 001041-42. Its recommendations included "[s]treamline and simplify the application and documentation processes." AR, 001042.

107. A letter from "22 public health and health policy deans, chairs, and scholars," dated December 12, 2025 (AR, 004183-96) noted that "Medicaid enrollees who lost coverage due to Arkansas's work requirement were significantly more likely to delay obtaining healthcare due to cost (56 percent) and delay obtaining medications due to cost (64 percent), compared to those who remained enrolled in coverage." AR, 004191.

108. The letter also stated that "Arkansas Medicaid enrollees also reported that the work requirement created heightened stress and fear that they might lose coverage." AR, 004191.

2. The Medically Frail Exclusion

109. The administrative record reflects communications and other information relevant to the medically frail exclusion. *E.g.*, AR, 003990-4013.

110. Regarding the medically frail exclusion, NHeLP wrote in its November 19, 2025 letter that "the history of the phrase 'medically frail or otherwise has special medical needs' reveals that it is unrelated to ability to work." AR, 004001. NHeLP explained that under the implementing regulation for amendments to the Medicaid Act addressing Alternative Benefit

Plans (42 C.F.R. § 440.315(f); *see supra* ¶34), CMS permitted States to define the phrase "medically frail or otherwise an individual with special medical needs," but required that State definitions include "at least six categories of individuals" to "ensure that individuals with significant health care needs maintain adequate health coverage." AR, 004001-02.

111. NHeLP explained that, in H.R. 1, Congress adopted each of the categories from the Alternative Benefit Plan regulation, "dropping only the category that is limited to children under age 19," who are not subject to the Work Requirement, thus expressing "its intent to exclude from the work requirements applicants and beneficiaries who have a particular need for comprehensive health care coverage." AR, 004001-02.

112. In a December 12, 2025 letter, "22 public health and health policy deans, chairs, and scholars, in their individual capacities" submitted a comment to HHS and CMS to "share relevant research findings and recommendations for implementing the new work requirements" with a "specific focus on the exemption for people who are 'medically frail or otherwise have special medical needs.'" AR, 004183.

113. In the letter, they wrote that "[m]edical frailty has been part of Medicaid for 20 years, but [...] determining whether someone can work is not part of that process." AR, 004185. They also wrote that "H.R. 1's criteria almost exactly parallel's [*sic*] the ABP definition." AR, 004186.

114. They also wrote that "[i]ndividuals who are employed and have a serious or complex medical condition, or multiple conditions, often work in low-wage jobs and report that working conditions such as unpredictable schedules make it hard to manage their conditions" and "[t]he 'serious or complex' subcategory of HR 1 is an essential guardrail to ensure these

individuals maintain their coverage, regardless of their work status in a given month." AR, 004186.

115. An October 2025 document in the administrative record from the AIDS Institute, which is titled "7 Reasons to Exempt People with HIV from Medicaid's Community Engagement Requirement," (AR, 003867-68) states that "HIV can make it more difficult to adhere to a regular work schedule because of medication side effects, periods of illness, and the need to attend many doctors' appointments." AR, 003867.

116. It also states that "Medicaid is a work support for people with HIV, because it provides consistent and continuous access to treatment that keeps people with HIV healthy. Disruption of care due to administrative reporting requirements undermine the ability of people to work and can lead to long term unemployment." AR, 003867.

117. In an October 10, 2025 letter to CMS, the Consortium for Constituents with Disabilities (CCD), the Disability and Aging Collaborative (DAC), and allied organizations (AR, 003869-73) informed CMS that "Medicaid helps people with disabilities work by providing them with health care and important employment supports [...] [M]ost people enrolled in Medicaid who are not doing paid work are caregiving, retired, and/or have chronic conditions or disabilities and are temporarily unable to work or need supportive services to find and keep a job." AR, 003869.

118. They added that "[t]he reality is that people with disabilities face substantial barriers to employment, including inadequate accommodations, inaccessible workplaces, and outright stigma" and "emphasize[d] that having a disability or health condition that qualifies for an exemption is not inconsistent with an individual's ability to work." AR, 003871. They asked that the "Administration set standards that prohibit States from using 'ability to work' or

evidence of employment (such as payroll data) to deem an individual ineligible for this exemption." *Id.*

119. On March 12, 2026, researchers from the Harvard T.H. Chan School of Public Health and Brigham & Women's Hospital submitted a memo to CMS to "provide a structured, validated, and auditable approach that states may use to automatically exempt medically frail individuals using ICD-10 (International Classification of Diseases 10th Revision) codes, which capture conditions and diseases in medical claims." AR, 004492-674.

120. The authors wrote that they drew from two sources in developing this approach: CMS's "list of Chronic Conditions and Other Chronic Health, Mental Health, and Potentially Disabling Chronic Conditions Algorithms from the Chronic Conditions Warehouse" and "Alternative Benefit Plan (ABP) determination processes from states using medical frailty definitions that had been publicly released." AR, 004492-93. They then wrote that "[t]wo physicians independently reviewed each algorithm to determine whether it should be entirely included or entirely excluded based on statutory criteria for identifying medically frail individuals." AR, 004493.

121. The memo stated that ICD codes were included if they were deemed to meet three requirements: (1) "likely to result in ongoing medical care needs OR impairment that limits likelihood of employment, number of hours worked if employed, extent of community participation, or other aspects of economic self-sufficiency"; (2) "likely to last 6 months or longer," and (3) "not easily curable with treatment." AR, 004493.

3. Use of Auditable Self-Declaration

122. An issue brief in the administrative record titled "Promoting Effective Identification of Medically Frail Individuals Under Medicaid Expansion," AR, 003806-34, which addresses the medically frail exception to mandatory enrollment in Alternative Benefit

Plans, notes that CMS suggested in that context that States employ a combination of the following methods to identify individuals qualifying as medically frail: "[e]ligibility category (for example, those in a disabled or foster child eligibility category may be automatically deemed medically frail); "[h]istorical medical encounter data (e.g., for current enrollees)"; and/or "[s]elf-identification, as on a questionnaire/screening tool." AR, 003811.

123. In an April 9, 2026 slide deck, the Medicaid and CHIP Payment and Access Commission wrote "self-attestation will be important, especially where data are limited" on a slide titled "CMS and states should ensure that eligible individuals can gain and maintain coverage." AR, 000927.

124. In their November 19, 2025 letter, NHeLP wrote, "CMS should require states to use the least burdensome verification method available, self-attestation. Notably, self-attestation has been found to be a highly reliable form of verification. Further, it is less burdensome for the state and the best method for ensuring that eligible individuals do not lose health coverage due to administrative barriers." AR, 004007-08.

125. In a March 27, 2026 letter, the National Association of Community Health Centers wrote to CMS, "[t]o prevent administrative hurdles from disenrolling eligible individuals, CMS should encourage states to streamline, simplify state-led verification forms and other documents when verify [*sic*] medical frailty standards." AR, 004740.

4. *Ex Parte* Verification

126. In a slide deck included in the administrative record, the Medicaid and CHIP Payment and Access Commission wrote "[s]takeholders emphasized that ex parte processes can minimize beneficiary reporting and reduce coverage loss" and "[s]tates may modify their use of existing data (e.g., income, Medicaid applications, or claims) and add data sources, as well as automating data checks." AR, 000927.

127. In a January 21, 2026 letter, the HIV and Hepatitis Policy Institute wrote, "[u]nder statute, states are directed to maximize *ex parte* verification of eligibility in relation to the community engagement requirements. Automatic exemption through use of data already available to the Medicaid program (such as diagnostic codes and claims data) minimizes the burden on the enrollee. It also reduces the administrative burden on the state and on the health-care workforce providing care to people with HIV." AR, 004318.

128. In a March 11, 2026, in a letter to CMS outlining its approach to defining medical frailty, the Commonwealth of Pennsylvania's Department of Human Services wrote to CMS: "[t]he law further requires that states use reliable information available to the state to determine whether an individual meets the criteria for an exemption or has met the requirement for community engagement (i.e., ex parte) to prevent individuals from having to submit additional information when possible." AR, 004469.

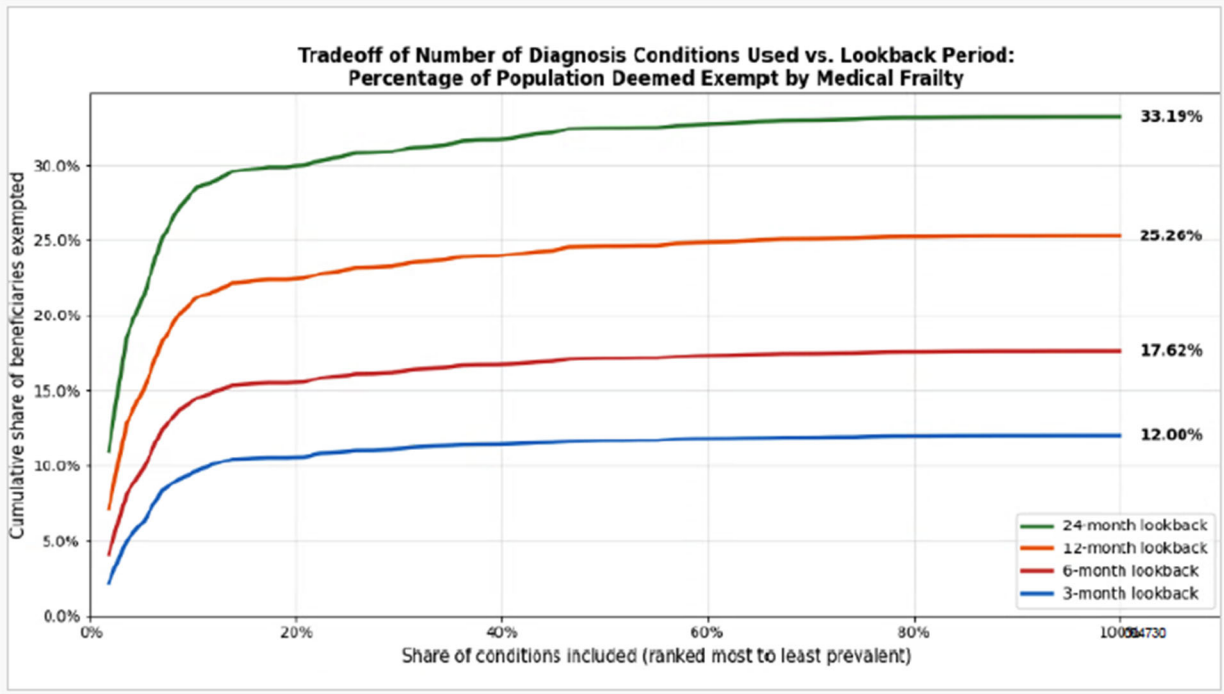
5. Use of Claims Data

129. The administrative record includes a proposal by researchers at the Harvard T.H. Chan School of Public Health titled "*Identifying Persons Qualifying for Medical Frailty Exemptions Using Medicaid Claims Data*" and dated March 20, 2026. AR, 004723-30.

130. The proposal by researchers at the Harvard T.H. Chan School of Public Health, see paragraph 129, *supra*, notes that "[c]laims-based identification requires healthcare utilization that includes a diagnosis code," which "[i]ndicates the important [*sic*] of the diagnosis timeframe ('lookback period') for identifying relevant claims." AR, 004727.

131. It contains data demonstrating that using a "lookback window" of 1 year, rather than 2 years, reduces the number of people identified as "medically frail" by at least 2 million individuals. AR, 004728-29.

132. It also contains the following graphic demonstrating that a longer lookback period for claims data increased the cumulative share of Medicaid beneficiaries excluded from the Work Requirement as medically frail:



AR, 004730.

133. The administrative record also contains a document published by CMS in 2024 and authored by researchers at Mathematica titled "*Methodology for Identifying Medicaid Long-Term Services and Support Expenditures and Users, 2022*." AR, 003835-64.

134. This document notes that CMS's own Chronic Conditions Data Warehouse algorithms "draw from either one or two years of claims." AR, 003856.

135. The authors also wrote: "we can identify only chronic conditions with observable medical treatment. Chronic conditions with infrequent treatment . . . might also be under-identified[.]" AR, 003858.

136. Another document titled "State Associations Community Engagement Feedback – December 18th, 2025," AR, 004216, notes that CMS was informed in a meeting that "medical

frailty as it relates to disability might not show up in claims data the way we expect" and that "a person with ID/DD [Intellectual Disabilities/Developmental Disabilities] might go in for a physical or other medical appointment, but the claim will likely not point specifically to the person having ID/DD. Often those 'secondary' diagnoses don't show up in claims (particularly true for individuals with ID/DD, autism, etc.)" AR, 004218.

137. A letter from Dr. Kyu Rhee, President and CEO of the National Association of Community Health Centers to CMS dated March 27, 2026 recommends that "CMS should allow a 24-month period for states to confirm medical frailty" due to "providers having 12 months to submit claims as well as shorter review periods which may miss relevant conditions that are not frequently recoded or documented but are ongoing." AR, 004740.

138. In an article titled "Implementing Medical Frailty Exemptions Under HR 1: Clinical Considerations From Medicaid Medical Directors," a "group of senior clinicians serving in more than 40 state Medicaid agencies" wrote that "[o]perational flexibility from CMS will be essential to ensure that medical frailty definitions align with state-specific contexts." AR, 004784-85.

139. They gave the following example:

> "Take, for example, a 38-year-old woman with opioid use disorder and unstable housing who seeks to engage in treatment. In a state that covers a robust continuum of behavioral health and substance use disorder services, such as residential treatment, intensive outpatient programs, and case management, her utilization history may provide clear evidence of medical frailty. In a state with more limited benefits, however, the same patient may have fewer encounters or differently encoded services unrelated to the degree of clinical severity."

AR, 004785.

6. Administrative Burden

140. In its letter to CMS, NHeLP stated that "[a]mple research demonstrates that additional administrative barriers deter and reduce coverage," and provided CMS with citations to studies and articles in a footnote. AR, 004008.

141. The cited studies and articles do not appear in the administrative record. *Compare* AR, Index 1-21, *with* AR, 004008.

142. A comment related to the medically frail exception from mandatory Alternative Benefit Plans, noted in a section labeled "Identifying the Medically Frail" that "[i]n the preamble to the final regulation, CMS acknowledges that states may not have prior experience with implementation of an ABP or with identifying individuals who meet the criteria for exemption." AR, 003797.

143. The comment also states that "[a] determination of functional limitations should include an individual, face-to-face assessment by an independent assessment entity." AR, 003804.

144. An article in the administrative record titled "Implementing Medical Frailty Exemptions Under HR1: Clinical Considerations From Medicaid Medical Directors," authored by "senior clinicians serving in more than 40 state Medicaid agencies" states:

> "Administrative efficiency is also critical. Medicaid insurers and safety-net clinicians already operate under substantial administrative strain. ***Experience from prior work requirement demonstrations suggests that administrative complexity can contribute to coverage losses unrelated to actual eligibility.*** Streamlined processes, standardized forms, and alignment with existing workflows may reduce burdens on clinicians and patients alike. Limiting the use of clinician and patient attestation to times only when other data are not sufficient will mitigate unnecessary burden."

AR, 004786 (emphasis added).

7. Population Subject to Work Requirement

145. The administrative Record includes a May 30, 2025 issue brief from KFF titled "Understanding the Intersection of Medicaid and Work: An Update." AR, 003575-615.

146. The Issue brief states that "[d]ata show the majority of Medicaid enrollees are working." AR, 003575.

147. It continues, "in 2023, nearly two-thirds of adults ages 19-64 covered by Medicaid were working and nearly three in ten were not working because of caregiving responsibilities, illness or disability, or due to school attendance, reasons that counted as qualifying exemptions from the work requirements under previous policies." AR, 003576.

148. It further states, "[m]any Medicaid adults who work are employed by small firms and are not eligible for employer-sponsored health insurance at their job," AR003585, and "Medicaid adults who work full-time are eligible for Medicaid in expansion states because they work low-wage jobs and meet income eligibility criteria," AR, 003588.

8. Consequences of Coverage Loss

149. In a letter dated December 12, 2025, "22 public health and health policy deans, chairs, and scholars" wrote to CMS that "[t]he adverse health effects of being uninsured are well established: compared to those with insurance, uninsured adults are 'more likely to forgo needed care,' 'less likely . . . to receive preventive care and services for major health conditions and chronic diseases,' and 'more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.'" AR, 004183, 004191 (citing Tolbert, J. Cervantes *et al*, (2024, December 18) *Key Facts about the Uninsured Population*. KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/).

150. On October 28, 2025, the AIDS Institute, AIDS United and the Center for Health Law & Policy Innovation sent a letter to CMS regarding implementation of the Work Requirement. Ex. 54 ¶34 & Exh. A; AR, 003912-14.

151. The letter informed CMS that, "[f]or people living with HIV, loss of Medicaid due to arbitrary denials and administrative red tape can lead to care disruptions that can pose enduring, costly, and complex health risks." Ex. 54, Exh. A at 3; AR, 003914.

B. Information Provided to CMS Due to Suspected Policy Changes

152. In May 2026, while the IFR was being reviewed by the White House Office of Management and Budget, CMS staff were aware that rumors were circulating that "CMS may limit the self-attestation option and that the White House [was] pushing CMS to tighten the exemption definitions." AR, 004793.

153. In May 2026, several State Medicaid agencies became concerned that CMS would change its policy direction related to the Work Requirement after CMS informed them that subregulatory guidance provided on May 1, 2026 should not be acted upon and was subject to change. *See, e.g.*, Ex. 3 ¶¶20-21; Ex. 9 ¶¶18-19; Ex. 11 ¶¶22-23; Ex. 23 ¶¶18-19.

154. MassHealth, Plaintiff Commonwealth of Massachusetts' Medicaid agency, sent a letter to CMS on May 29, 2026. Ex. 11 ¶23 & Exh. A.

155. MassHealth wrote to "share some concerns about the potential impact of any significant deviation from the statute and CMS guidance shared to date," noting that Massachusetts was "well into the development process and [had] very limited time remaining before the January 1, 2027 effective date." Ex. 11, Exh. A at 1-2.

156. MassHealth also stated that "any material shift in federal policy regarding Medicaid Community Engagement requirements could result in a significant increase in implementation costs and disruptions to Massachusetts." Ex. 11, Exh. A at 2.

157. With respect to the "medically frail" exclusion, MassHealth expressed its belief, "[a]fter reflecting on . . . inputs from CMS since the law's passage," that "leveraging clinical data derived from claims and encounters" and "accepting self-reported information from applicants with no available claims history" would allow Massachusetts to "achieve broad, auditable compliance with federal rules, while minimizing the burden on members and providers

impacted by Community Engagement requirements and allowing eligible Medicaid members to maintain their coverage." Ex. 11, Exh. A at 2.

158. Addressing self-attestation, MassHealth wrote that self-declaration has been historically permitted in the Medicaid program and added that "the acceptance of self-declaration in certain situations is a critical tool to facilitate enrollment of new members, keep eligible members covered, and reduce administrative churn where eligible members may experience gaps in coverage due to paperwork issues." Ex. 11, Exh. A at 2.

159. This letter from MassHealth is not in the administrative record. *Compare* Ex. 11, Exh. A, *with* AR, Index 1-21.

160. Medi-Cal, California's Medicaid agency, also contacted CMS to express California's "significant concerns should CMS materially alter its prior guidance on Medicaid work requirements in the forthcoming interim final rule." Ex. 2 ¶19 & Exh. A at 1.

161. California explained that it had "relied extensively on CMS's preliminary guidance over the last several months to design, build, and operationalize major programmatic, systems, and staffing changes needed to comply with H.R. 1 by January 1, 2027." *Id*. It wrote, "CMS was aware throughout this period that California and other states were making time-sensitive, largely irreversible implementation decisions, including vendor contracts, IT builds, and staffing commitments, in direct reliance on its guidance, and continued providing that guidance without any indication that a material policy shift was under consideration. The reliance is embedded in systems that are already in final development and testing." *Id.* at Exh. A at 2. It added, "[i]mplementing new processes on this significantly shortened timeline would heighten the risk of systems errors, improper terminations, and administrative failures affecting eligible

individuals. DHCS anticipates that any major shift in direction at this stage could delay implementation by 18-24 months." *Id.* at Exh. A at 1-2.

162. California also wrote, "[a]ny major shift in federal policy at this stage, particularly concerning medically frail identification, self-attestation, or verification requirements, would require reengineering multiple system modules already approaching finalization, jeopardizing California's ability to meet the statutory deadlines." *Id.* at Exh. A at 2.

163. California added that any "significant late-stage policy shifts will increase coverage losses among eligible individuals, particularly those with disabilities and chronic or complex medical needs, as well as introduce avoidable administrative barriers through new documentation requirements and also create operational instability during a major programmatic transition affecting millions of Californians." *Id*.

164. This letter from Medi-Cal is not in the administrative record. *Compare* Ex. 2, Exh. A, *with* AR, Index 1-21.

165. The Governors of several other Plaintiff States also wrote to CMS in advance of the release of the Interim Final Rule. Ex. 66.

166. On May 29, 2026, the Governors of Oregon, Maine, Michigan, New York, New Mexico, and Washington sent a letter to Secretary Kennedy. *Id*.

167. In the letter, the governors reiterated the challenge their states faced in implementing community engagement requirements on a compressed timeline. They noted the continued absence of official guidance and reminded CMS that their States had made "good-faith operational decisions to revise [their] state systems" consistent with "verbal assurances" and "informal policy direction from CMS." They further requested that "published, final guidance align as closely as possible with states' working assumptions based on informal policy

direction from CMS to date and that states not be required to make significant changes at this stage of implementation." *Id.* at 1.

168. The governors highlighted the administrative complexity and resource-intensive nature of their States' implementation efforts, specifically reminding CMS of the "structural reality of Medicaid administration" that the States must work with third-party vendors to update their IT systems. *Id.* at 2.

169. They wrote, "[e]very change must be specified in writing, scoped and contracted with the vendor, reviewed for compliance with federal certification standards, independently tested, and validated before deployment," and "[v]endors typically require six to twelve months or more to complete significant system modifications." *Id.*

170. The governors also wrote that their States had "built out IT systems, drafted member communications, and developed the guidance and policies necessary to implement" the requirements, and "[i]f the IFR contains policy guidance that differs in any material respect from the operational choices states have made—whether in the absence of CMS guidance or in reliance on the verbal communications CMS has provided—states may need to revise or revisit significant portions of their implementation work." *Id.* at 1-2.

171. This letter from the Governors of Oregon, Maine, Michigan, New York, New Mexico, and Washington is not in the administrative record. *Compare* Ex. 66, *with* AR, Index 1-21.

172. An article dated May 26, 2026 that was forwarded internally within CMS titled "Families USA Sounds Alarm Over Rumored IFR Work Req Restrictions" includes the following statements from Families USA: "[t]his change in the definitions here [for] medical frailty would not only exclude many, many vulnerable individuals from the exemption, but also

set up an enormous administrative process for states to go through to determine eligibility and determine work ability on top of that, and that's just one that states are not prepared for, and they haven't been preparing for over the last year"; and"[h]aving the ability to self-attest is really paramount for people who would meet the medical frailty exemption but just don't have the paperwork to document their health status." AR, 004793-94.

173. The article also says "[s]tates have already begun the hard work of building their own medical frailty definitions and systems, including states that have already implemented and started work requirements early" and "[a] last-minute federal mandate tying medical frailty to inability to work would override state-level work that is already underway, take away the flexibility of the law, which it was designed to preserve, and cause chaos and confusion for people with disabilities and chronic conditions in states that have already begun implementation or states that are just starting to figure it out." AR, 004794.

174. On May 28, 2026, the American Cancer Society (ACS) sent an email to CMS stating, "[w]e have heard rumors that the rule CMS is planning to release could make it harder for cancer patients and those recovering from cancer to maintain or enroll in Medicaid coverage." AR, 004796.

175. ACS wrote that it had "heard that the administration may only apply the definition of medical frailty to individuals who cannot work" and "[t]ying medical frailty to an inability to work will prevent many people impacted by cancer from using this exemption." AR, 004797.

176. ACS further stated, "[l]imiting the exemption to just those deemed unable to work would set up a situation where many individuals will not be able to get Medicaid coverage right away—and lack access to care while they wait for a determination that they are unfit to work.

For a cancer patient, that gap in coverage—whether it's a few weeks, months, or years—can be deadly." AR, 004797.

177. ACS also wrote "[t]his change will also prevent cancer patients or survivors who can still work—and many want to—from working whatever hours they are able. It forces people with serious illnesses to choose between losing their Medicaid, working 80 hours per month, or not working at all to prove they are unable. It prevents cancer patients from picking up work when they can—for example, when they are well enough to work shifts in between chemo rounds, but not enough shifts to guarantee 80 hours/month." AR, 004797.

178. Concerning self-attestation, ACS wrote that it had "heard reports that the interim-final rule could eliminate or severely restrict the use of self-attestation for compliance and exemptions" and "[a]llowing individuals to self-attest to medical frailty and other criteria—including exemptions and qualifying activities—is an important and practical tool, especially for the first year of implementation." AR, 004797.

179. ACS wrote further, "[t]he impact on coverage could be enormous as additional documentation adds paperwork and bureaucracy that leads eligible people to lose coverage." AR, 004797.

180. ACS also wrote, "[f]or those medically frail, there are many reasons data in a patient's chart may not show up. People may face challenges seeing specialty providers in rural and medically underserved areas and states can experience data lags between the point of care and claims data." It added, "[a]sking cancer patients—who may be uninsured—to submit medical records or go to a doctor to certify their exemption status is a recipe for these individuals to lose coverage and, with it, a lifeline to the medical care they need." AR, 004797.

V. Interim Final Rule

181. On June 1, 2026, CMS released the IFR, entitled "*Medicaid Program: Community Engagement Requirement for Certain Individuals*" (IFR), which was published in the Federal Register on June 3, 2028. AR, Certification, 000001-135.

182. In the preamble, the IFR states: "The [Work Requirement] has the potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency and independence." 91 Fed. Reg. 33349.

183. It also states, "[i]mplementing the community engagement requirement, we believe will assist in prioritizing coverage for Medicaid's most vulnerable populations such as seniors, individuals with disabilities, pregnant women, and children while empowering able-bodied individuals through community engagement." 91 Fed. Reg. 33350.

184. In Section "V. Regulatory Impact Analysis," the Interim Final Rule states, "a well-designed community engagement requirement may benefit individuals so that they are not dependent, demoralized, or stuck in situations that hinder their economic, physical, and mental state." 91 Fed. Reg. 33451.

185. The Interim Final Rule includes several provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than the language of H.R. 1. *See, e.g.*, Ex. 2 ¶20; Ex. 4 ¶19; Ex. 5 ¶19; Ex. 7¶25; Ex. 11 ¶ 24; Ex. 13 ¶18; Ex. 21¶19; Ex. 22 ¶11; Ex. 23 ¶20; Ex. 24¶19; Ex. 25 ¶21.

i. *Medically Frail or Otherwise Has Special Medical Needs*

186. The Interim Final Rule defines "[a]n individual who is medically frail or otherwise has special medical needs" as "an individual whose physical, mental, or other behavioral health

condition significantly impairs the individual's ability to comply with the community engagement requirement in this subpart and is an individual:

(A) Who is blind or disabled (as defined in section 1614 of the Social Security Act);

(B) With a substance use disorder, excluding an individual in stable recovery (which means, an individual who is in recovery for 5 or more years);

(C) With a disabling mental disorder;

(D) With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or

(E) With a serious or complex medical condition which is a medical condition that is life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments." 42 C.F.R. § 435.554(c)(5)(i).

187. The following language does not appear in H.R. 1: "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement in this subpart." *See* Pub. L. No. 119-21, 139 Stat. 172 (2025).

ii. *Use of Claims Data to Verify Medical Frailty*

188. The Interim Final Rule requires that, when verifying "medical frailty," a State Medicaid agency must "attempt to verify that an individual is a specified excluded individual on the basis that the individual is medically frail or otherwise has special medical needs . . . using reliable information available to the State, including claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended or denied, and encounter data, as relevant to the individual." 42 C.F.R. § 435.557(f)(1).

189. It defines "reliable information available to the state" as

> "including, but not limited to: (i) information from electronic data sources that the agency has determined to be effective . . . ; (ii) Information from other State or local agencies; (iii) Information related to community engagement from Federal agencies and other data sources provided through the electronic services established by the Secretary . . . ; (iv) Information in the States' eligibility system; (v) Information in the individual's case record; (vi) Payroll data; (vii) Claim(s) relevant to the individual that have been adjudicated in the preceding 12 months, including those that have been paid, pended or denied; and (viii) Encounter data, as relevant to the individual, for the preceding 12 months."

42 C.F.R. § 435.557(a).

190. Of the eight categories of data specifically included in the definition of "reliable information available to the State," claims data and encounter data are the only two that are temporally limited. *See* 42 C.F.R. § 435.557(a).

iii. *Use of Auditable Self-Declaration*

191. With respect to the "medical frailty" exclusion, under the Interim Final Rule, a State Medicaid agency must first attempt to use "reliable information available to the State" to verify that an individual is "medically frail or otherwise has special medical needs." 42 C.F.R. § 435.557(f)(1).

192. When there is no "reliable information available to the State," a State Medicaid agency may require documentation or accept a statement or other information under penalty of

perjury" to verify that an individual is medically frail or otherwise has special medical needs, only "[b]efore January 1, 2028." 42 C.F.R. § 435.557(f)(1)(i).

193. "Beginning on January 1, 2028," a State Medicaid agency "may accept a statement or other information provided under penalty of perjury that provides sufficient information . . . to verify qualification for the exclusion only once during the beneficiary's period of enrollment . . . when there is no reliable information available to the State or the reliable information available to the State is not reasonably compatible with the information provided by or on behalf of the individual." 42 C.F.R. § 435.557(f)(1)(ii).

194. The Interim Final Rule defines a "period of enrollment" as a "continuous period of enrollment in coverage under the State plan or waiver without the individual being disenrolled, regardless of the number of consecutive eligibility period, of redeterminations or renewals, or of transitions between eligibility groups." 42 C.F.R. § 435.557(a). The Social Security Act does not recognize a "period of enrollment." *E.g.*, Ex. 2 ¶¶28-29; Ex. 11, ¶ 36; Ex. 15 ¶26; Ex. 21 ¶27. The concept of a "period of enrollment" in the context of Medicaid is introduced for the first time in the IFR. *E.g.*, Ex. 11, ¶ 36; Ex. 15 ¶26; Ex. 21 ¶27.

195. The Interim Final Rule provides that, when verifying "compliance with or exception or exclusion from the community engagement requirement" *other than exclusion due to medical frailty*, 42 C.F.R. § 435.557, the State Medicaid agencies "may require documentation or accept other information . . . when there is no reliable information available to the State or the reliable information is not reasonably compatible with the information provided by or on behalf of the individual" only "[b]efore January 1, 2028." 42 C.F.R. § 435.557(b)(2)(i).

196. Under the Interim Final Rule, "[b]eginning on January 1, 2028," when there is "no reliable information available to the State or the reliable information is not reasonably

compatible with the information provided by or on behalf of the individual, the agency must require documentation whenever documentation is reasonably available" to verify compliance with or exception or exclusion from the community engagement requirement, other than exclusion due to medical frailty. 42 C.F.R. § 435.557(b)(2)(ii).

197. Only when documentation is not reasonably available may a State Medicaid agency "[a]ccept information other than documentation" to verify eligibility or exception or exclusion from the Work Requirement, other than exclusion due to medical frailty. 42 C.F.R. § 435.557(b)(2)(iii).

VI. CMS's Explanations and Considerations Concerning the Interim Final Rule

A. The Administrative Record

198. On August 14, 2026, CMS provided to Plaintiffs the administrative record for the Interim Final Rule, along with an index and a "Certification of the Rulemaking Record." AR, Certification; AR, Index; AR000001-4840.

199. Of the 220 documents included in the administrative record, eight are documents from the Federal Register, which include the IFR itself and a correction issued to the IFR on June 29, 2026, and eight are executive orders and proclamations. *See* AR, Index 1-21.

200. The remaining 204 documents are labeled in the Index for the administrative record as "Other Materials." AR, Index 2-21.

201. Though the Index includes 220 documents total, only approximately ninety-three of those documents are cited in footnotes in the Interim Final Rule. 91 Fed. Reg. 33348-482.

202. Of the 204 documents labeled as "Other Materials," only approximately eighty-seven are cited in footnotes in the IFR. AR, Index 2-21; AR, 000001-4840.

203. Of the approximately eighty-seven documents labeled "Other Materials" that are cited in footnotes in the IFR, not one is cited in connection with (a) CMS's decision to add to the

medically frail exclusion the requirement that a condition "significantly impairs" an individual's ability to comply with the Work Requirement; (b) CMS's decision to limit self-attestation for the medically frail exclusion to once per enrollment period; or (c) CMS's decision to limit the use of claims data to claims adjudicated in the previous 12 months. 91 Fed. Reg. 33348–82; AR00001-3794. Those portions of the IFR do not cite any evidence to support CMS's choices.

204. The remaining approximately 117 documents labeled as "Other Materials" that are not cited in the IFR include published research, documents provided to CMS by third parties, and submissions from certain States to CMS.

205. There is no indication in either the administrative record or the IFR of how CMS did or did not consider, grapple with, or weigh the information contained in these approximately 117 documents.

206. For example, one document in the "Other Materials" category that is not cited in the IFR is a spreadsheet identified in the Index as "204. State Requests for Technical Assistance re: 71119-Community engagement data." AR004840.

207. The spreadsheet contains questions received from States regarding technical implementation of the Work Requirement. Though the spreadsheet indicates that many of the questions were answered, the answers are not included in the spreadsheet. AR004840.

208. The administrative record does not include the version of the IFR that was submitted to the Office of Information and Regulatory Affairs within the Office of Management and Budget on March 31, 2026. *See* AR, Index 1-21; *see also* Ex. 63.

209. Plaintiffs have, on two occasions, requested the version of the Interim Final Rule that was submitted to the Office of Information and Regulatory Affairs of the Office of Management and Budget, but they have not yet received a response. Ex. 31; Ex. 67.

210. The administrative record also does not include several communications from States and stakeholders addressing implementation of the Work Requirement. *Supra* ¶¶ 154-71; *Compare* Ex. 54 ¶37 & Exh. D, *with* AR, Index 1-21.

B. CMS's Explanation of the Interim Final Rule

211. The IFR contains a preamble that spans approximately 122 pages of the Federal Register. 91 Fed. Reg. 33348-69. It is broken into five Sections: "I. Background"; "II. Provisions of the Interim Final Rule with Comment Period"; "III. Good Cause for Proceeding With an Interim Final Rule With Comment Period"; "IV. Collection of Information Requirements"; and "V. Regulatory Impact Analysis."

212. Concerning the Work Requirement generally, CMS wrote in the preamble, "Community engagement is an entirely new factor of eligibility, and as such, States must consider criteria that were not previously applicable to Medicaid eligibility and establish new policies and procedures for verifying whether an individual meets those criteria." 91 Fed. Reg. 33395.

213. In this preamble, CMS stated: "The best reading of the statutory phrase 'medically frail or otherwise has special medical needs' is one that considers not only the presence of a particular diagnosis or condition, but also the extent to which the condition impairs an individual's ability to engage in community engagement activities (including but not limited to work) or otherwise comply with the statutory requirements in section 1902(xx) of the Act." 91 Fed. Reg. 33373.

214. Yet elsewhere in the preamble, CMS wrote, "[w]e are defining medically frail individuals as individuals who meet one or more of the five categories identified at section 1902(xx)(9)(ii)(V) of the Act" with no reference to the Significant Impairment Provision. 91 Fed. Reg. 33372.

215. CMS also stated, "[r]eading the statute to require automatic classification as medically frail or otherwise having special medical needs based solely on diagnosis or condition would risk sweeping in individuals whose conditions do not significantly impair their functional capacity. . . ." 91 Fed. Reg. 33373.

216. Regarding enforcement of its implementation of the medically frail exclusion, CMS stated in the preamble, "[i]f through Payment Error Rate Measurement Program (PERM) audits and reporting, or any other CMS audits, we determine that States determined that an individual is medically frail in a manner inconsistent with § 435.554(c)(5)(i) (meaning there is frequent approval of individuals as medically frail with little to no support for the conclusion that their physical, mental, or other behavioral health condition significantly impairs their ability to comply with the community engagement requirement), States would not be in compliance with the regulation." 91 Fed. Reg. 33377.

217. CMS also wrote, "[w]e believe that requiring verification of medical frailty to confirm an individual's specified excluded status using data or other documentation after the State has verified that exclusion using a statement or other information provided under penalty of perjury (such as a screening tool) will motivate individuals to access care." 91 Fed. Reg. 33406.

218. The preamble also states, "States may not consider information older than 12 months when verifying medical frailty or other special medical needs, because older information may not reflect the individual's current condition." 91 Fed. Reg. 33405.

219. It also states, "Section 1902(xx)(5) of the Act, implemented at § 435.557(b), requires States to conduct *ex parte* verification of compliance and deemed compliance with the

community engagement requirement, and qualification as a specified excluded individual." 91 Fed. Reg. 33392.

220. Discussing the data sources States may use, CMS wrote, "the State must consider such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on documentation, and on program integrity in terms of the potential for ineligible individuals to be enrolled and for eligible individuals to be denied coverage." 91 Fed. Reg. 33394.

221. Concerning state implementation of work requirements prior to H.R. 1, CMS wrote in the preamble: "[t]his 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." 91 Fed. Reg. 33350.

222. Later in the preamble, in the "Regulatory Impact Analysis" section, CMS wrote, "[p]rior to this IFC, States could only impose [community engagement] requirements through section 1115 demonstrations. The limited section 1115 demonstration experience that exists involved different implementation patterns, including reinstatements following terminations of eligibility and self-selected enrollment populations, that are not directly applicable to estimating the impact of mandatory requirements applied to an existing State plan enrollment. We have not relied on these previous demonstrations for data or assumptions used in this analysis." 91 Fed. Reg. 33456.

223. In the Regulatory Impact Analysis, CMS also wrote, "we estimate that 7 percent of applicable individuals who may be working, enrolled in school, or otherwise performing activities in line with community engagement requirement [*sic*], or qualify for a mandatory

exception or short-term hardship exception that deems them as demonstrating community engagement, would lose coverage due to administrative or procedural reasons (or in the case of a new applicant, may have their application denied and thus not enroll).” 91 Fed. Reg. 33460.

224. Also in the Regulatory Impact Analysis (which never once mentions the IFR’s significant-impairment provision of the medically frail exclusion, let alone the limitations on the use of claims and encounter data or on use of self-attestation), CMS “project[ed] that enrollment would be reduced by 2.3 million individuals in FY 2027 . . . and by between 3.1 to 3.3 million individuals in subsequent years.” 91 Fed. Reg. 33461.

C. CMS’s Statements at the Preliminary Injunction Stage

225. During the hearing on Plaintiffs’ Motion for a Preliminary Injunction, counsel for the Defendants stated that CMS had “firmly grappled with this problem [disenrollments] and it still chose the policy path that it did in spite of acknowledging the significant number of disenrollments.” Ex. 68, 42:4-9.

226. At the same hearing, counsel for the Defendants also stated, “the regulation that dictates that agencies submit regulations to OIRA for review in coordination with the executive office, the President, and there is policy arms in coordination with other agencies before they are promulgated that is not just a process to rubber-stamp what agencies do. Sometimes those that are closer to the President and who are working in these formal policy roles have strong views about how things should be changed, and those views filter into policy.” *Id.* at 37:15-23.

VII. States’ Efforts to Implement H.R. 1’s Work Requirement

A. Efforts to Make Changes After the IFR

227. The revisions to the IFR require States to expend considerable resources on tight timelines to bring their systems in line with the IFR’s unlawful provisions.

228. For example, the IFR requires States to define "significantly impairs," identify the data they need to make assessments, acquire that data, develop systems and engage vendors with the expertise to process the data, and then implement that system at scale. Ex. 9 ¶57; Ex. 11 ¶65.

229. While State Medicaid agencies expected CMS to provide further definition of the terms "medically frail" or otherwise having "special medical needs," they did not expect that CMS would limit the category of individuals in the "medically frail or otherwise having special needs" to only those whose ability to comply with work requirements is substantially impaired because of their physical, mental, or behavioral health condition. *See, e.g.*, Ex. 39 ¶14; Ex. 44 ¶7; Ex. 45 ¶8; Ex. 46 ¶7; Ex. 48 ¶7; Ex. 49 ¶7; Ex. 50 ¶10; Ex. 51 ¶7; Ex. 52 ¶8; Ex. 53 ¶7.

230. And in light of the notice requirement, many States only had until August 31, 2026, or in some cases an even earlier date, to determine key features of the system and decide how to communicate with residents about its implementation—a fact which dramatically increases the costs as States engage vendors to work rush jobs and ask their staff to work overtime to meet deadlines. *See, e.g.*, Ex. 5 ¶40; Ex. 6 ¶9; Ex. 8 ¶15; Ex. 9 ¶42; Ex. 10 ¶40; Ex. 13 ¶39; Ex. 15 ¶39; Ex. 20 ¶¶17-18; Ex. 21 ¶¶40-41; Ex. 22 ¶¶12-14, 17; Ex. 25 ¶21; *see also* 91 Fed. Reg. 33427 (acknowledging substantial system and process updates required by States to comply with IFR).

231. These late-stage revisions also required increased spending on public outreach and administrative support for enrollees. *See, e.g.*, Ex. 2 ¶53; Ex. 3 ¶70; Ex. 5 ¶54; Ex. 6 ¶31; Ex. 9 ¶56; Ex. 10 ¶62; Ex. 11 ¶64; Ex. 12 ¶24; Ex. 13 ¶54-55.

232. Plaintiff States have struggled to figure out how to inform members of how to navigate the Work Requirement in light of the new "medically frail" provisions. *See, e.g.*, Ex. 1 ¶10; Ex. 2 ¶41; Ex. 3 ¶54; Ex. 4 ¶43; Ex. 36 ¶20.

VIII. Plaintiffs Face Harms if the IFR is Implemented as Written

A. Harms to State Medicaid Agencies

233. The IFR differs from CMS's pre-IFR guidance and the language of H.R. 1 in contradictory ways that render the States' obligations unclear. *See supra* ¶¶ 185-197, 227-32.

234. Since November 2025, the States have been preparing to comply with the notice deadline and the January 1, 2027, implementation deadline, consistent with their understanding of the statutory requirements and guidance provided by CMS. *See* 42 U.S.C. §§ 1396a(xx)(1), (8); *see, e.g.*, Ex. 1 ¶3; Ex. 2 ¶¶9, 11; Ex. 3 ¶¶10-12; Ex. 4 ¶9, 11; Ex. 7 ¶¶9, 11-12; Ex. 8 ¶¶9, 11, 13; Ex. 11 ¶¶15-16; Ex. 12 ¶11; Ex. 18 ¶¶9, 11-12; Ex. 19 ¶¶9-10, 12-13; Ex. 23 ¶¶ 9, 11-12; Ex. 24 ¶¶9, 11-12; Ex. 41 ¶¶6-11.

235. But just three months before the notice deadline, the IFR imposed new, ambiguous requirements on Medicaid enrollees that require States to make significant and new changes to their Medicaid systems. *See supra* ¶ 185.

236. Plaintiff States' Medicaid agencies communicated to CMS through the present litigation and other correspondence that they will suffer irreparable harm due to the imminent outlays of agency staff time and funding necessary to comply with CMS's regulatory about-face. *See, e.g.*, Ex. 2 ¶¶18-19; Ex. 3 ¶¶20-21; Ex. 9 ¶¶18-19; Ex. 11 ¶¶22-23; Ex. 19 ¶¶19-20; Ex. 23 ¶¶18-19.

237. Plaintiff States' Medicaid agencies have had to rapidly change their operational approach and systems development. *See, e.g.*, Ex. 2 ¶54; Ex. 15 ¶55; Ex. 39 ¶28; Ex. 41, ¶13; Ex. 44 ¶7; Ex. 45 ¶10; Ex. 46 ¶¶7, 9; Ex. 48 ¶¶7, 9; Ex. 49 ¶¶7, 9.

238. In addition to analyzing, developing, and implementing new ways to evaluate medical frailty, Plaintiff States' Medicaid agencies have needed to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which has added development

costs as well as costs for accessing new data. *See, e.g.*, Ex. 33 ¶9; Ex. 38 ¶9; Ex. 39 ¶¶26-28; Ex. 50 ¶¶12-15; Ex. 51 ¶¶7, 9; Ex. 52 ¶10; Ex. 53 ¶¶9-10.

239. Plaintiff States' Medicaid agencies have had to send incomplete or ambiguous notices to members, which have served to create confusion and erode the trust and goodwill that State Medicaid agencies have built up over time. *See, e.g.*, Ex. 2 ¶51-52; Ex. 5 ¶53; Ex. 11 ¶63.

240. Plaintiff States' Medicaid agencies have had to incur the cost of educating their members, staff, and other stakeholders both about what the new requirements mean, and how they can be met in an unsteady legal environment. *See, e.g.*, Ex. 2 ¶54; Ex. 15 ¶55; Ex. 2 ¶51-55; Ex. 5 ¶¶52-53; Ex. 16 ¶55; Ex. 17 ¶14; Ex. 24 ¶52; Ex. 25 ¶57.

241. If Plaintiff States' Medicaid agencies are not able to configure their systems quickly enough, or if they configure systems inconsistently with CMS's guidance, they could face negative audit findings and significant financial penalties under H.R. 1 § 71106. State Medicaid agencies will need to maintain auditable records, and risk penalties through the Payment Error Rate Measurement Program (PERM) if they incorrectly exclude members as medically frail who are not. 91 Fed. Reg. 33377; AR, 002310-11; s*ee, e.g.*, Ex. 1 ¶14; Ex. 3 ¶57; Ex. 7 ¶52; Ex. 9 ¶47; Ex. 16 ¶45; Ex. 18 ¶45.

242. Plaintiff States' Medicaid agencies eligibility systems are not built to support community engagement requirements and are not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. *See, e.g.*, Ex. 3 ¶69; Ex. 4 ¶53; Ex. 6 ¶31; Ex. 8 ¶21; Ex. 11 ¶64; Ex. 15 ¶55; Ex. 16 ¶54.

243. Plaintiff States' Medicaid agencies have already requested funds for the statutory requirements under H.R. 1, and these funds have been expended. Plaintiff States are unable to request additional funds as required by the IFR due to limitations on fiscal year spending. *See,*

e.g., Ex. 1 ¶7; Ex. 2 ¶53; Ex. 3 ¶50; Ex. 4 ¶53; Ex. 5 ¶41; Ex. 7 ¶63; Ex. 9 ¶56; Ex. 10 ¶61; Ex. 11 ¶64; Ex. 12 ¶11; Ex. 13 ¶40; Ex. 15 ¶40; Ex. 16 ¶54; Ex. 19 ¶43.

244. Plaintiff States' Medicaid agencies will experience new, complex, and variable limitations on self-attestation, which will require them to increase their operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. *See, e.g.*, Ex. 4 ¶55; Ex. 6 ¶33; Ex. 7 ¶67; Ex. 10 ¶65; Ex. 13 ¶54; Ex. 21 ¶54; Ex. 23 ¶52.

245. Plaintiff States' Medicaid agencies expect that the self-attestation limitation will—separate and apart from the medical frailty exclusion—lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. The change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules. *See, e.g.*, Ex. 5 ¶56; Ex. 7 ¶65; Ex. 16 ¶56; Ex. 17 ¶14; Ex. 19 ¶68; Ex. 21 ¶53; Ex. 22 ¶16.

B. Disenrollment and Resulting Effects on States

246. The purpose of the Affordable Care Act (ACA) was to "make affordable health insurance available to more people" and "[e]xpand the Medicaid program to cover all adults with income below 138% of the [Federal Poverty Line]." Ex. 69.

247. Studies conducted before the IFR was released suggest that Plaintiff States' Medicaid Expansion members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations. *See, e.g.*, Ex. 70, 6.

248. On October 28, 2025, the Congressional Budget Office (CBO) issued a "Supplemental Cost Estimate" "for the budgetary effects of title VII, Finance, subtitle B, Health, chapter 1, Medicaid, of P.L. 119-21, as enacted in July 2025." Ex. 70, 1.

249. In the Supplemental Cost Estimate, CBO and the Joint Committee on Taxation "estimate[d] that the number of people without health insurance will increase by 5.3 million in 2034" due to implementation of "Section 71119," the Work Requirements. Ex. 70, 6.

250. Separate and apart from the disenrollment effect of H.R. 1, the IFR's unlawful provisions will lead to further massive disenrollments not contemplated by H.R. 1. *See, e.g.*, Ex. 34 ¶18; Ex. 42. ¶18; Ex. 46 ¶18; Ex. 48 ¶18; Ex. 49 ¶18; Ex. 50 ¶25; Ex. 71, 1 (noting that "the IFR is likely to increase coverage loss significantly beyond what would have occurred under a plain-language reading of the statute").

251. An analysis by Manatt Health, entitled "CMS's Medicaid Work Requirements Rule: a 50-State Analysis of Additional Coverage Losses, FFY 2027–2034" states the following:

> Manatt health estimates Manatt Health estimates that the IFR implementation approach would increase average annual Medicaid coverage losses by **1.8 million people**, from **6.4 million to 8.2 million** between FFY 2027–2034—nearly **1 in 10 Medicaid enrollees** nationwide. The estimate assumes a 40% coverage-loss rate among those subject to work requirements, informed largely by New Hampshire's prior experience implementing work requirements. Coverage losses are projected to grow over time—from **2.8 million** people in FFY 2027 **to 9.2 million** people by FFY 2034, when the requirements are fully implemented.

Ex. 71, 1 (emphasis in original).

252. Hundreds of thousands of members will lose coverage not because they are statutorily ineligible, but because CMS has unlawfully narrowed the statutory exemptions and created needless procedural obstacles to demonstrating eligibility. *See* Ex. 4 ¶46; Ex. 6 ¶27; Ex. 7 ¶58; Ex. 12 ¶18; Ex. 10 ¶50; Ex. 20 ¶31.

253. The IFR will cause the termination of benefits for some of the States' most needy and ill residents and will increase the cost of uncompensated care that Plaintiff States must cover. *See, e.g.*, Ex. 3 ¶¶73-74; Ex. 4 ¶56; Ex. 8 ¶18; Ex. 20 ¶31; Ex. 38 ¶17; Ex. 39 ¶37; Ex. 40 ¶19; Ex. 48 ¶19; Ex. 51 ¶18; Ex. 52 ¶19.

254. Plaintiff States' budgets will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. *See, e.g.*, Ex. 3 ¶73; Ex. 5 ¶58; Ex. 10 ¶69; Ex. 19 ¶69; Ex. 21 ¶55; Ex. 24 ¶55; Ex. 25 ¶59; Ex. 35 ¶26.

255. More members will lose coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. *See, e.g.*, Ex. 2 ¶46; Ex. 3 ¶61; Ex. 4 ¶47; Ex. 9 ¶50; Ex. 13 ¶47; Ex. 16 ¶48; Ex. 71, 1.

256. More members will lose coverage because the "significant impairment" requirement will also decrease the number of people for whom the State Medicaid agencies can automatically verify medical frailty, because, under the IFR, the verification process cannot be based on just a diagnosis code, but also other data on utilization of services and level of impairment. *See* 91 Fed. Reg. 33406. *See, e.g.*, Ex. 39 ¶¶35-37; Ex. 43, ¶18; Ex. 44 ¶¶16-17; Ex. 46 ¶¶17-18; Ex. 48 ¶¶17-18; Ex. 49 ¶17. The 12-month limitation on use of claims data will also limit State Medicaid agencies' ability to automatically verify medical frailty, increasing the burden on States to engage in costly and time-intensive member interactions to seek documentation, whereas the systems being developed to review claims for purposes of determining medical frailty can be modified to expand the use of claims data with minimal burden. *See, e.g.*, Ex. 36 ¶17; Ex. 44 ¶15.

257. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to State Medicaid agencies sicker and costlier due to the loss of health coverage needed to treat and

manage their conditions. This both raises costs for State Plaintiffs and decreases quality of care for members. *See, e.g.*, Ex. 2 ¶48; Ex. 3 ¶63; Ex. 5 ¶49; Ex. 9 ¶51; Ex. 15 ¶50; Ex. 19 ¶56.

258. As the uninsured rate increases, there will be a greater financial strain on providers—in particular rural, community, and safety net hospitals as well as community health centers—that will be called upon to provide even greater levels of uncompensated care. *See, e.g.*, Ex. 4 ¶56; Ex. 7 ¶68; Ex. 11 ¶68; Ex. 12 ¶27; Ex. 16 ¶57; Ex. 20 ¶25; Ex. 38 ¶17; Ex. 55, 5.

259. Individuals who are disenrolled in Plaintiff States will likely lose access to primary and preventive care—and care necessary to treat their statutorily recognized medical conditions—resulting in more individuals seeking high-cost, emergency care. *See, e.g.*, Ex. 8 ¶18; Ex. 33 ¶¶23-24; Ex. 38 ¶17; Ex. 39 ¶37; Ex. 44 ¶18; Ex. 49 ¶18; Ex. 50 ¶25; Ex. 51 ¶18; Ex. 53 ¶19. Ex. 54, Exh. C(ii) at 6-7.

260. State Medicaid agencies have spent years conducting outreach and building relationships with their program enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage. *See, e.g.*, Ex. 2 ¶52; Ex. 3 ¶67; Ex. 7 ¶61; Ex. 9 ¶55; Ex. 19 ¶64; Ex. 24 ¶52.

261. The lack of preventative care will result in increased communicable disease outbreaks and more strain on Plaintiff States' Medicaid agencies. Plaintiff States' Medicaid agencies will see poorer health outcomes across the State, as fewer people will be able to access appropriate care and manage chronic conditions. *See, e.g.*, Ex. 2 ¶56; Ex. 3 ¶75; Ex. 10 ¶70; Ex. 12 ¶26; Ex. 54 ¶¶21-33.

262. Finally, Plaintiff States' Medicaid agencies anticipate that the new medical frailty requirements, coupled with the new limitations on self-attestation and *ex parte* verification, will

place a significant administrative strain on treating healthcare providers. Providers may need to devote time to providing documentation to demonstrate that a member is medically frail and that the member's condition significantly impairs their ability to comply with the Work Requirement. *See, e.g.*, Ex. 3 ¶76; Ex. 13 ¶57; Ex. 15 ¶58; Ex. 18 ¶58; Ex. 21 ¶56; Ex. 24 ¶56; ECF No. 89, 9-10.

263. These additional tasks will require that providers take time away from patient care, placing additional administrative strain on providers, adding to healthcare costs and impacting access to care across Plaintiff States. *See, e.g.*, Ex. 1 ¶10; Ex. 3 ¶76; Ex. 4 ¶57; Ex. 7 ¶69; Ex. 10 ¶73; Ex. 15 ¶58; ECF No. 89, 9-10; AR, 004465.

Dated: September 1, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that this document was filed through the ECF system and will be sent electronically to the registered participants as identified in the Notice of Electronic filing (NEF).

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al., Plaintiffs, v. MEHMET OZ, M.D., et al., Defendants.	CIVIL ACTION NO. 26-12962

DECLARATION OF NITA K. KLUNDER

Pursuant to 28 U.S.C. § 1746, I, Nita K. Klunder, do hereby state:

1. I am a State Trial Counsel in the Office of the Attorney General for the Commonwealth of Massachusetts. I am admitted to the U.S. District of Massachusetts and I appear on behalf of the Commonwealth of Massachusetts in this action.

2. I submit this declaration in support of Plaintiff States' Motion for Partial Summary Judgment, pursuant to Federal Rule of Civil Procedure 56.

3. I make the following statements of my own knowledge or a review of files in my possession.

4. I have attached to this declaration true and correct copies of publicly promulgated or issued documents, factual declarations, and productions from Defendants as follows:

5. Attached as **Exhibit 1** is a true and accurate copy of the Declaration of Patricia Dennis, Arizona Health Care Cost Containment System, dated June 28, 2026.

6. Attached as **Exhibit 2** is a true and accurate copy of the Declaration of Yingjia Huang, California Department of Health Care Services, dated June 28, 2026.

7. Attached as **Exhibit 3** is a true and accurate copy of the Declaration of Adela Flores-Brennan, Colorado Department of Health Care Policy and Financing, dated June 26, 2026.

8. Attached as **Exhibit 4** is a true and accurate copy of the Declaration of Peter Hadler, Connecticut Department of Social Services, dated June 26, 2026.

9. Attached as **Exhibit 5** is a true and accurate copy of the Declaration of Andrew Wilson, Delaware Department of Health and Social Services, dated June 26, 2026.

10. Attached as **Exhibit 6** is a true and accurate copy of the Declaration of Melisa Byrd, the District of Columbia Department of Health Care Finance, dated June 26, 2026.

11. Attached as **Exhibit 7** is a true and accurate copy of the Declaration of Katherine Yager, Illinois Department of Healthcare and Family Services, dated June 26, 2026.

12. Attached as **Exhibit 8** is a true and accurate copy of the Declaration of Lisa Lee, Kentucky Department of Medicaid Services, dated June 26, 2026.

13. Attached as **Exhibit 9** is a true and accurate copy of the Declaration of Ian Yaffe, Maine Department of Health and Human Services, dated June 26, 2026.

14. Attached as **Exhibit 10** is a true and accurate copy of the Declaration of Perrie Briskin, Maryland Department of Health, dated June 26, 2026.

15. Attached as **Exhibit 11** is a true and accurate copy of the Declaration of Ryan Schwarz, Massachusetts Executive Office of Health and Human Services, dated June 26, 2026.

16. Attached as **Exhibit 12** is a true and accurate copy of the Declaration of Elizabeth Hertel, Michigan Department of Health and Human Services, dated June 26, 2026.

17. Attached as **Exhibit 13** is a true and accurate copy of the Declaration of Pamela Weiner, Minnesota Department of Human Services, dated June 26, 2026.

18. Attached as **Exhibit 14** is a true and accurate copy of the Declaration of K. Brunetti Ireland, Nevada Attorney General's Office, dated June 27, 2026.

19. Attached as **Exhibit 15.** is a true and accurate copy of the Declaration of Gregory Woods, New Jersey Department of Human Services, dated June 27, 2026.

20. Attached as **Exhibit 16** is a true and accurate copy of the Declaration of Alanna Dancis, New Mexico Health Care Authority, dated June 26, 2026.

21. Attached as **Exhibit 17** is a true and accurate copy of the Declaration of Dr. James V. McDonald, M.D., M.P.H., New York State Department of Health, dated June 26, 2026.

22. Attached as **Exhibit 18** is a true and accurate copy of the Declaration of Sarah Gregosky, M.S.P.H., North Carolina Department of Health and Human Services, Division of Health Benefits, dated June 26, 2026.

23. Attached as **Exhibit 19** is a true and accurate copy of the Declaration of Vivian Levy, Oregon Health Authority, dated June 29, 2026.

24. Attached as **Exhibit 20** is a true and accurate copy of the Declaration of Hoa Pham, Pennsylvania Department of Human Services' Office of Income Maintenance, dated June 26, 2026.

25. Attached as **Exhibit 21** is a true and accurate copy of the Declaration of Kristin Pono Sousa, Rhode Island Medicaid Program, dated June 26, 2026.

26. Attached as **Exhibit 22** is a true and accurate copy of the Declaration of Marjorie Stinchcombe, Vermont Office of the Health Care Advocate, dated June 29, 2026.

27. Attached as **Exhibit 23** is a true and accurate copy of the Declaration of Steven Ford, Virginia Department of Medical Assistance Services, dated June 26, 2026.

28. Attached as **Exhibit 24** is a true and accurate copy of the Declaration of Judy Zerzan-Thul, M.D., M.P.H., Washington State Health Care Authority, dated June 26, 2026.

29. Attached as **Exhibit 25** is a true and accurate copy of the Declaration of Debra Standridge, Wisconsin Department of Health Services, dated June 24, 2026.

30. Attached as **Exhibit 26** is a true and accurate copy of the National Health Law Program letter to Secretary Kennedy and Administrator Oz dated November 19, 2025.

31. Attached as **Exhibit 27** is a true and accurate copy of a Center for Medicaid & CHIP Services Informational Bulletin dated December 8, 2025.

32. Attached as **Exhibit 28** is a true and accurate copy of a study by Lucy Chen and Benjammin Sommers titled, "Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018." It was published in the American Journal of Public Health, 110, 1208-1210. It can be accessed at https://doi.org/10.2105/AJPH.2020.305697.

33. Attached as **Exhibit 29** is a true and accurate copy of a press release titled, "Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements," dated December 17, 2025.

34. Attached as **Exhibit 30** is a true and accurate copy of the Sickle Cell Disease Partnership letter to Administrator OZ dated October 22, 2025.

35. On July 20, 2026, pursuant to Sections 6(a)(3)(B), (C), and (E) of Executive Order 12866, I submitted a request via email to the Office of Management and Budget ("OMB") and to Dominic Mancini, Deputy Administrator, Office of Information and Regulatory Affairs ("OIRA"), OMB, at OIRA_submission@omb.eop.gov and dominic_mancini@omb.eop.gov, respectively. In that request, I sought the original version submitted to OIRA of RIN-00938-AV98, titled "Establishing Community Engagement Requirements for Certain Individuals Under

Section 1902(xx) of the Social Security Act," along with "a redline between that version and the final version with notation of any changes that were made at the request of OIRA." A true and accurate copy of my July 20, 2026 request is attached to this declaration as **Exhibit 31**. I have not yet received a response to this request.

36. Attached to this declaration as **Exhibit 32** is a true and accurate copy of the Declaration of Hannah Katch, Founder and Principal, Katch Strategies, LLC, dated July 20, 2026.

37. Attached as **Exhibit 33** is a true and accurate copy of the Declaration of Patricia Dennis, Arizona Health Care Cost Containment System, dated August 25, 2026.

38. Attached as **Exhibit 34** is a true and accurate copy of the Declaration of Yingjia Huang, California Department of Health Care Services, dated August 30, 2026.

39. Attached as **Exhibit 35** is a true and accurate copy of the Declaration of Adela Flores-Brennan, Colorado Department of Health Care Policy and Financing, dated August 19, 2026.

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41. Attached as **Exhibit 37** is a true and accurate copy of the Declaration of Andrew Wilson, Delaware Department of Health and Social Services, dated August 21, 2026.

42. Attached as **Exhibit 38** is a true and accurate copy of the Declaration of Melisa Byrd, the District of Columbia Department of Health Care Finance, dated August 25, 2026.

43. Attached as **Exhibit 39** is a true and accurate copy of the Declaration of Edie Mayeshiro, Hawai‘i Department of Human Services, dated August 28, 2026.

44. Attached as **Exhibit 40** is a true and accurate copy of the Declaration of Katherine Yager, Illinois Department of Healthcare and Family Services, dated August 18, 2026.

45. Attached as **Exhibit 41** is a true and accurate copy of the Declaration of Lisa Lee, Kentucky Department of Medicaid Services, dated August 17, 2026.

46. Attached as **Exhibit 42** is a true and accurate copy of the Declaration of Ian Yaffe, Maine Department of Health and Human Services, dated August 19, 2026.

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48. Attached as **Exhibit 44** is a true and accurate copy of the Declaration of Ryan Schwarz, Massachusetts Executive Office of Health and Human Services, dated August 24, 2026.

49. Attached as **Exhibit 45** is a true and accurate copy of the Declaration of Meghan E. Groen, Michigan Department of Health and Human Services, dated August 18, 2026.

50. Attached as **Exhibit 46** is a true and accurate copy of the Declaration of Pamela Weiner, Minnesota Department of Human Services, dated August 27, 2026.

51. Attached as **Exhibit 47** is a true and accurate copy of the Declaration of Gregory Woods, New Jersey Department of Human Services, dated August 31, 2026.

52. Attached as **Exhibit 48** is a true and accurate copy of the Declaration of Sarah Gregosky, M.S.P.H., North Carolina Department of Health and Human Services, Division of Health Benefits, dated August 25, 2026.

53. Attached as **Exhibit 49** is a true and accurate copy of the Declaration of Vivian Levy, Oregon Health Authority, dated August 19, 2026.

54. Attached as **Exhibit 50** is a true and accurate copy of the Declaration of Hoa Pham, Pennsylvania Department of Human Services' Office of Income Maintenance, dated August 25, 2026.

55. Attached as **Exhibit 51** is a true and accurate copy of the Declaration of Kristin Pono Sousa, Rhode Island State Medicaid Program, dated August 25, 2026.

56. Attached as **Exhibit 52** is a true and accurate copy of the Declaration of Steven Ford, Virginia Department of Medical Assistance Services, dated August 25, 2026.

57. Attached as **Exhibit 53** is a true and accurate copy of the Declaration of Judy Zerzan-Thul, M.D., M.P.H., Washington State Health Care Authority, dated August 25, 2026.

58. Attached as **Exhibit 54** is a true and accurate copy of the Declaration of Elizabeth A. Kaplan, Health Law and Policy Clinic at the Center for Health Law & Policy Innovation of Harvard Law School, dated August 28, 2026.

59. Attached as **Exhibit 55** is a true and accurate copy of a comment letter with the subject "Objection to CMS Medicaid Work Requirement Interim Final rules (June 3, 2026), RIN 0938-AV98, File Code No. CMS-2454-IFC, Document ID CMS-2026-2047-0002, Federal Register No. 2026-11094," which was submitted by the Plaintiff States via the Federal eRulemaking Portal on July 31, 2026.

60. Attached as **Exhibit 56** is a true and accurate copy of a slide deck by the Centers for Medicare & Medicaid Services titled, "Streamlining Enrollment and Renewal Processes in Medicaid and CHIP (CMS-2421-F2)," dated May 2024. It can be accessed at https://www.cms.gov/files/document/ee-final-rule-slides-52824.pdf.

61. Attached as **Exhibit 57** is a true and accurate copy of a webpage titled "Administration" on the official website of the Medicaid and CHIP Payment and Access

Commission, as accessed on August 27, 2026. It can be accessed at https://www.macpac.gov/medicaid-101/administration/.

62. Attached as **Exhibit 58** is a true and accurate copy of an issue brief by Jessica Mathers, Alice Burns, and Robin Rudowitz, titled "CMS' New Approach to Federal Medicaid Spending in Cases of Potential Fraud," dated May 15, 2026 and published by KFF. It can be accessed at https://www.kff.org/medicaid/cms-new-approach-to-federal-medicaid-spending-in-cases-of-potential-fraud/.

63. Attached as **Exhibit 59** is a true and accurate copy of a webpage titled "Disability Determination Process" on the official website of the Social Security Administration, as accessed on August 28, 2026. It can be accessed at https://www.ssa.gov/disability/determination.htm.

64. Attached as **Exhibit 60** is a true and accurate copy of a webpage titled "Disability Benefits: How Does Someone Become Eligible" on the official website of the Social Security Administration, as accessed on August 28, 2026. It can be accessed at https://www.ssa.gov/benefits/disability/qualify.html#anchor1.

65. Attached as **Exhibit 61** is a true and accurate copy of a webpage titled "Disability Evaluation Under Social Security" on the official website of the Social Security Administration, as accessed on August 28, 2026. It can be accessed at https://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm.

66. Attached as **Exhibit 62** is a true and accurate copy of a comment letter with the subject "American Public Health Association, Grantmakers in health, Jacobs Institute of Women's Health, National Center for Medical-Legal Partnership, and Public Health Deans and Scholars' Comments on Department of Health and Human Services 'Medicaid Program; Community

Engagement Requirement for Certain Individuals' (CMS-2454-IFC; RIN 0938-AV98)," dated July 31, 2026, which was submitted electronically via regulations.gov.

67. Attached as **Exhibit 63** is a true and accurate copy of "Executive Order Review Search Results" for the Rule titled "Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social security Act (CMS-2454)," RIN 0938-AV98, with a received date of March 31, 2026, on the official website of the Office of Information and Regulatory Affairs, as accessed on August 31, 2026. It can be accessed at https://www.reginfo.gov/public/Forward?SearchTarget=RegReview&textfield=0938-av98&image61.x=16&Image61.y=9.

68. Attached as **Exhibit 64** is a true and accurate copy of a document issued by the Nebraska Department of Health and Human Services, titled "Nebraska Medicaid Work Requirements: Medically Frail and SUD Treatment Program Exemptions," dated May 1, 2026.

69. Attached as **Exhibit 65** is a true and accurate copy of a research report by Ian Hill, Emily Burroughs, and Gina Adams titled, "New Hampshire's Experience with Medicaid Work Requirements," dated February 2020 and published by the Urban Institute. It can be accessed at https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf.

70. Attached as **Exhibit 66** is a true and accurate copy of a letter to Secretary Robert F. Kennedy Jr. from Oregon Governor Tina Kotek, Maine Governor Janet Mills, Michigan Governor Gretchen Whitmer, New York Governor Kathy Hochul, New Mexico Governor Michelle Lujan Grisham, and Washington Governor Bob Ferguson, dated May 29, 2026.

71. On August 16, 2026, pursuant to Sections 6(a)(3)(B), (C), and (E) of Executive Order 12866, I submitted a second request via email to the Office of Management and Budget

("OMB") and to Dominic Mancini, Deputy Administrator, Office of Information and Regulatory Affairs ("OIRA"), OMB, at OIRA_submission@omb.eop.gov and dominic_mancini@omb.eop.gov, respectively. In that request, I noted that I had not received the documents I requested on July 20, 2026 or any response, and I asked for an "update on status." Attached as **Exhibit 67** is a true and accurate copy of my August 16, 2026 request. I have not yet received a response to this request.

72. Attached as **Exhibit 68** is a true and accurate copy of the transcript of the July 28, 2026 motion hearing before the Honorable Richard G. Stearns, United States District Judge, in the above-captioned matter.

73. Attached as **Exhibit 69** is a true and accurate copy of a webpage titled "About the Affordable Care Act" on the official website of the U.S. Department of Health and Human Services, as accessed on August 28, 2026. It can be accessed at https://www.hhs.gov/healthcare/about-the-aca/index.html.

74. Attached as **Exhibit 70** is a true and accurate copy of a Congressional Budget Office Supplemental Cost Estimate titled, "Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid, As enacted on July 4, 2025," dated October 28, 2025.

75. Attached as **Exhibit 71** is a true and accurate copy of a report by Patti M. Boozang, Avi Herring, Adam D. Striar, and Elizabeth A. Scott, titled "CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034," dated July 2026. It was published by Manatt Health and can be accessed at https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034.

76. On August 14, 2026, pursuant to the Court's Electronic Order dated August 6, 2026, ECF No. 100, Defendants produced to Plaintiffs the Certification of the Rulemaking Record, Index to the Rulemaking Record, and the administrative record for the "Medicaid Program; Community Engagement Requirement for Certain Individuals" interim final rule that became available for public inspection on June 1, 2026, and appeared in the Federal Register on June 3, 2026 (the "Administrative Record"). A true and accurate copy of the Administrative Record will be provided to the Court under separate cover as **Exhibit 72.**

Signed under the penalties of perjury on this 1st day of September, 2026 in Boston, Massachusetts.

/s/ Nita K. Klunder
Nita K. Klunder

CERTIFICATE OF SERVICE

I hereby certify that this document was filed through the CM/ECF system and will be sent electronically to the registered participants as identified in the Notice of Electronic Filing (NEF).

/s/ Nita K. Klunder
Nita K. Klunder (BBO #689304)
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EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al., Plaintiffs, v. MEHMET OZ, M.D., et al., Defendants.	Case No. __-_____

DECLARATION OF PATRICIA DENNIS

I, Patricia Dennis, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

BACKGROUND

1. I am a resident of Arizona. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as AHCCCS Assistant Director of the Division of Member and Provider Services and serving as the agency's Executive Sponsor of H.R. 1 of information and records gathered by the Arizona Health Care Cost Containment System (AHCCCS) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) published an Interim Final Rule with Comment Period (IFR) implementing the community engagement (work requirement) provisions of P.L. 119-21 (H.R. 1), Section 71119. This rule is effective July 31, 2026. H.R. 1 requires the state to implement the community engagement provisions by January 1, 2027, and the January 1 effective date is unchanged by the IFR.

3. AHCCCS has invested nearly a year and many thousands of staff hours to comply with and implement H.R.1 and to design an implementation plan based on H.R. 1's plain text and CMS continuing guidance, including CMS's December 2025 Informational Bulletin

and multiple representations by CMS officials that states would retain broad flexibility in key areas so long as they complied with the requirements in statute.

4. The IFR materially departs from, and conflicts with, the statute and the guidance continuously communicated by CMS prior to the IFR, frustrating AHCCCS' extensive work to support and implement H.R. 1's work requirements.

THE IFR'S MEDICAL FRAILTY EXEMPTION & RESTRICTIONS ON SELF-ATTESTATIONS

5. Section 71119 of H.R.1 exempts "medically frail" individuals from community engagement requirements. Congress identified particular conditions and disorders that would constitute medical frailty, but did not require states to verify functional impairment in addition to the specified condition and disorder, except for individuals with "physical, intellectual, or developmental disability," which Congress also required must "significantly impair[] their ability to perform one or more activities of daily living."

6. Prior to June 2026, CMS repeatedly advised states that the agency would *not* further define medical frailty beyond the statutory categories, and specifically cautioned states against using the more restrictive Alternate Benefit Plan (ABP) definition.[1]

7. Since July of 2025, AHCCCS relied on the statutory language and CMS's continuing representations in seeking implementation funding from the Arizona legislature, and in developing and structuring its implementation planning and system architecture. Prior to the IFR, AHCCCS's implementation plan used standalone International Classification of Diseases, 10th Revision (ICD-10) and other diagnostic codes and indicators, without the need for complex secondary qualifiers or resource-intensive, manual clinical adjudication.

8. From H.R. 1's passage in July 2025 through present, AHCCCS procured and paid its vendors, and invested extensive employee resources in its specific implementation architecture which includes: The ICD-10-based medical frailty determination framework; a self-attestation-forward verification workflow; and IT systems built to a unified eligibility workflow.

9. Although the IFR's most restrictive verification requirements do not take effect until January 1, 2028, the required re-engineering of AHCCCS's verification workflows cannot be deferred to the 2027 planning cycle. Planning, procurement, system design, development and testing for the 2028 overhaul must proceed concurrently with the

[1]The ABP standard requires conditions that are serious *and* complex, where H.R. 1 uses the disjunctive serious *or* complex, setting a less restrictive statutory standard.

January 2027 implementation build, creating resource conflicts across IT, contracting, and staffing that neither the 2027 nor 2028 timeline can absorb independently.

10. There is significant risk that AHCCCS will not be able to comply with the new, unanticipated, and prescriptive requirements of the IFR, for several reasons, including the following:

    a. **Medical Frailty Infrastructure (New Workstream).** The IFR's functional-impairment screen requires AHCCCS to build from scratch: (a) a validated, auditable list of qualifying diagnoses with associated impairment thresholds; (b) an individualized review process for unlisted conditions; (c) a provider attestation workflow capable of capturing documentation of how a specific condition limits an individual's ability to meet the 80-hour per month standard; and (d) IT logic linking billing codes to functional severity data not currently captured in claims. None of these particular areas were specified in H.R.1 and none of these systems currently exist in the AHCCCS systems to implement H.R. 1. None are in current contract scopes, IT specifications, or staffing authorizations.

    b. Because the IFR was not published until June 1, 2026, AHCCCS did not–and could not–seek funding for these requirements, and was not appropriated funding for them in the state budget signed into law on June 13, 2026. Initial estimates to complete these requirements exceed $16 million in addition to the agency's appropriation for FY2027, driven by staffing demands and system design costs.

    c. **Urgent Deadlines.** AHCCCS faces several urgent deadlines with respect to implementing community engagement requirements. AHCCCS must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, AHCCCS must substantially finalize eligibility system requirements by July 30, 2026, in order to enable development and appropriate testing from August to November for final deployment on December 10, 2026. After July 30, 2026, AHCCCS has limited ability to make further system changes for use by January 1, 2027.

    d. **Notice Requirement.** AHCCCS is statutorily required to provide notice to members regarding community engagement requirements on or before September 1, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, AHCCCS is uncertain as to how, for example, a member might establish that they are medically frail in light of the new functional impairment requirements introduced for the first time by the IFR. AHCCCS intended to use existing known claim and encounter data with an ICD-10-based medical frailty determination framework to appropriately notify members who meet the medically frail criteria that additional

actions would not be needed by such individuals to demonstrate compliance. This process will no longer be an option in light of the IFR and accordingly, AHCCCS cannot provide clarity in the required notice to medically frail members about compliance with the new IFR requirements.

e. **IT and Operations Re-architecture For Bifurcated Eligibility Workflow.** The IFR, for the first time since enactment of H.R.1, establishes a mandatory three-step sequential eligibility determination process[2] with distinct data inputs, verification standards, and notice requirements at each step. A determination made before working through each separate and distinct step produces a potential procedural error subject to appeal and audit disallowance, and which would not be correctable.

f. In reliance on H.R.1 and CMS communications and guidance preceding the IFR, AHCCCS' current determination framework does not direct members through three separate and distinct steps, and therefore does not provide the audit trail or notice that the IFR appears to require. Complying with the new framework established by the IFR would require AHCCCS staff to expend thousands of additional hours and resources to perform eligibility determinations consistent with the IFR.

g. The IFR's proposed process adds considerable complexity to AHCCCS's Requests for Information (RFI) and decision letters[3] because the IFR requires more dependencies and variables to generate compliant letters.This added complexity arises from the IFR's requirement that notices reflect a prescribed, multi-step sequential determination process with distinct verification standards and outcomes at each stage. Compliance with these requirements necessitates the development of system logic to account for multiple conditional variables and to generate legally compliant notice content, requiring substantial system reprogramming and extensive testing to ensure accuracy and prevent erroneous

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[2] The IFR requires states to process the adult expansion population through three sequential separate and distinct eligibility steps before determining whether an individual meets the requirements through qualifying activities and finally reaching a coverage decision: First, determine whether the individual is categorically excluded from community engagement requirements; second, determine whether the individual is an applicable individual subject to those requirements, and third, determine whether a mandatory exception or hardship exemption applies. *See* 42 CFR 435.558(b)(2).

[3] Requests for Information (RFIs) are formal written notices issued by the agency requesting additional information or verification necessary to complete an eligibility or compliance determination. Decision letters are official written notices communicating the agency's determination, including eligibility, exemption, or compliance status, and any associated rights to appeal, consistent with applicable Medicaid notice and fair hearing requirements.

eligibility determinations or improper adverse actions. These provisions prescribe operational steps for applying the policy, which is normally at the discretion of the state to ensure states can operationalize policies in a way that best meets the unique populations and needs of each state.

h. To put the impact of the IFR into context, Arizona estimates that more than 429,000 adult expansion members, including an estimated 250,000 "applicable individuals" will be subject to the new community engagement requirements under H.R. 1. Of the 250,000 "applicable individuals," approximately 29% of members (about 72,000 members) are estimated to already lack sufficient claims history for the preceding 12 months required under the IFR for ex parte medical frailty determinations and will have to obtain provider documentation to establish eligibility for an exemption.

i. It is estimated that more than 70% of "applicable individuals" have substantial claims histories under H.R. 1 to support determinations of medical frailty, but the IFR now makes those histories insufficient. As a result of the IFR, which requires functional impairment verification in addition to the existence of a qualifying medical condition, AHCCCS and the affected individuals must now obtain additional documentation establishing a dual requirement: both the existence of a medical condition *and* the resulting functional impairment that limits compliance with community engagement requirements.

j. Arizona's claims data suggest approximately 34% of "applicable individuals" had 25 or more claims in the past 12 months and 10% had more than 100 claims. Thus, nearly half of "applicable individuals" have moderate to high healthcare utilization and are therefore more likely to have significant chronic conditions, functional limitations, or complex care needs. These individuals would likely have been among the populations AHCCCS would have categorized as medically frail without additional documentation.

k. The IFR now shifts the burden of proof for establishing inability to meet the community engagement requirements onto these individuals, who may already face significant health barriers. As a result, the IFR will likely require hundreds of thousands of Arizonans to obtain additional clinical documentation which is anticipated to substantially increase administrative costs, create delays in exemption determinations, and elevate the risk that medically frail individuals are hindered in reasonably satisfying community engagement requirements.

l. **Arizona Providers Cannot Complete Additional Documentation to Establish Medical Frailty.** On May 4, 2026, AHCCCS convened a daylong workshop on medical frailty with 75 chief medical officers and other leaders from Arizona's

Medicaid health plans, large hospital systems, rural and community hospitals, community health centers, non-profit social service organizations, behavioral health providers, and county health departments. Leadership from most Arizona healthcare associations were in attendance, including the Arizona Alliance for Community Health Centers, Arizona Association of Health Plans, Arizona Council of Human Service Providers, Arizona Healthcare and Hospital Association, Arizona Nurses Association, and the Health System Alliance of Arizona.

m. After seven hours of discussion, the healthcare leaders in attendance unanimously agreed that it was not practical or feasible for Arizona healthcare providers to be asked to fill out documentation for hundreds of thousands of Arizonans seeking to establish or maintain Medicaid eligibility. Providers conveyed concerns about capacity, liability risks, and patient expectations that could give rise to conflicts or dual relationships.

n. Providers also raised significant concerns about workforce shortages in almost every health profession, and what this additional burden could do to already lengthy wait times.

o. **Verification Changes Create a Second Competing Modernization Effort.** The IFR's new verification requirements effective January 1, 2028, do not align with the 2027 implementation. Compliance with the 2028 requirements will require extensive reprogramming of eligibility systems, building multimodal document intake and retention infrastructure, and training thousands of eligibility workers, providers, and community assistors on distinct categories with different verification standards. Because planning and development must begin now, AHCCCS faces two overlapping modernization initiatives with substantively different requirements competing for the same staff, funding, and vendor capacity and operational resources. Neither implementation timeline was designed to accommodate concurrent modernization efforts of this scale, creating significant execution risk and pressure on timelines that were not designed to run concurrently. Both of these efforts are also competing with AHCCCS's mainframe modernization project, which must be completed during the same time period, and has been planned for almost a decade. Unlike the Affordable Care Act implementation, which AHCCCS had four years to complete, the IFR requires

AHCCCS to build and implement two distinct and separate complex eligibility processes within a six-month period.

THE IFR'S IMPLEMENTATION FAILURES EXPOSE ARIZONA TO SIGNIFICANT COMPLIANCE AND AUDITING RISK AND FEDERAL FINANCIAL PENALTIES

11. The IFR introduces new eligibility categories, new documentation requirements, and a new verification sequence, each of which creates new and independent sources of error for Payment Error Rate Measurement (PERM) reviewers or other auditors.

12. CMS has not supplied AHCCCS with adequate documentation, system controls, reliable data sources, or complete federal guidance to ensure AHCCCS has the necessary information and adequate advance notice needed in order to become audit compliant.

13. AHCCCS cannot build a PERM or audit-compliant determination methodology for two distinct eligibility processes (2027 and 2028), on a six-month timeline. This timeframe does not permit the systems planning, design and development, staff training, and operational testing and validation necessary to demonstrate adequate documentation and quality controls.

14. Arizona is among the first cohort of states for which payment error rates will be measured against the IFR's new requirements under the PERM Review process, considerably increasing Arizona's particular audit risk in an evolving and transformational process.

15. The IFR narrows the practical value of whatever good faith effort extension relief remains. The rule indicates that CMS expects to grant only short extensions (up to six months) and only to states that demonstrate "meaningful progress" with implementation in 2026, at the discretion of the HHS Secretary. But CMS did not define "meaningful progress."

16. Given the added complexity and the unreasonable time in which the agency must comply, AHCCCS faces a heightened risk of compliance and auditing errors.

Signed this 28th day of June, 2026.

/s/ Patricia Dennis

The paper document bears my original signature.

EXHIBIT 2

DECLARATION OF YINGJIA HUANG

I, Yingjia Huang, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of California. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Director of Health Care Benefits and Eligibility of information and records gathered by the California Department of Health Care Services ("DHCS") and its staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am currently employed by the California Department of Health Care Services as Deputy Director of Health Care Benefits and Eligibility (HCBE) I have held the Deputy Director position since April 1, 2025. As Deputy Director, I am responsible for the development and implementation of a portfolio of programs, which includes benefits and eligibility policies for the Medi-Cal program. Prior to my appointment as Deputy Director, I served as Assistant Deputy Director of HCBE since 2021 and was formerly the Assistant Division Chief of the Medi-Cal Eligibility Division from 2018 to 2021. Throughout this time, I led the implementation of Medi-Cal eligibility policies across the Medi-Cal program, providing direct oversight and monitoring over all Medi-Cal eligibility policy and system operations as it relates to the administration of the Medi-Cal program.

3. DHCS is the single state agency authorized to administer California's Medicaid program under Title XIX of the federal Social Security Act, referred to in California as "Medi-Cal." Medi-Cal provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Medi-Cal's coverage

includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Medi-Cal's mission is to improve the overall health and well-being of all Californians.

4. Medi-Cal insures over 14 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. California administers the Medi-Cal program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and Section 1115 Demonstration Project. Medi-Cal receives federal Medicaid and Children's Health Insurance Program (CHIP) funding, known as "Federal Financial Participation" (FFP), which covers a projected average of 61% of Medi-Cal's expenditures on eligible enrollees based on State Fiscal Year 2026-2027 data.

Medicaid Expansion in California

6. On January 1, 2014, California implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level, known as the Affordable Care Act Expansion group.

7. Enrollees in the Affordable Care Act Expansion group receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, dental, family planning, and preventive care. Currently, eligibility for the Affordable Care Act Expansion group requires that an individual (1) be an adult 19-64 years old; (2) be an individual with satisfactory immigration status; and (3) have household income less than or equal to 133% of the Federal

Poverty Level (or 138% if the state chooses to include an optional 5% income disregard). California elected to expand Medi-Cal to households with income less than or equal to 138% of the Federal Poverty Level.

8. As of January 2026, approximately 4.7 million Medi-Cal members are enrolled in the Affordable Care Act Expansion group. For the upcoming 2026-2027 state fiscal year, the state is projected to receive approximately $42,482,000,000 in FFP funding for the Affordable Care Act Expansion group.

CMS's Pre-IFR Guidance to California

9. My staff and I at DHCS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "work and community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid program has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Medi-Cal does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected work and community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on work and community engagement requirements, which was later provided to states on December 4, 2025.

12. CMS has a practice of providing guidance to states, outside of formal rulemaking, to assist states in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, California has for many years relied on CMS guidance, and the associated

slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. California likewise relied on the guidance shared by CMS concerning H.R. 1, and I understand that other states did as well. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool."

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals also to have a significant impairment to their ability to comply with the work and community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, CMS later indicated on or around March 2026 that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty

at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the work and community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with work and community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon, and was subject to change.

19. In response to this and concerns that CMS would change its policy direction related to work and community engagement, Medi-Cal sent an email to CMS on May 27, 2026, conveying Medi-Cal's concerns with limiting the definition of medically frail and the use of self-attestation. (See *May 20 Email to CMS from DHCS*, Exhibit A.)

CMS Issues the Interim Final Rule

20. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the work and community engagement requirements. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for Medi-Cal to implement before January 1, 2027, and are expected to cause significant harm to members and Medi-Cal once implemented. These provisions include the following:

Medically Frail Definition

21. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the work and community engagement requirements." 42 CFR § 435.554(c)(5)(i).

22. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

23. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

24. The IFR provides very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior

guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

25. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

26. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with work and community engagement requirements. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

27. Thus, the IFR significantly limits members' ability to self-attest to work and community engagement eligibility factors after January 1, 2028. Of note, several work and community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

28. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

29. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

30. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g., Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the work and community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

31. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

32. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the work and community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

33. The IFR places very broad requirements on states to identify reliable data sources for verifying work and community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [work and community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of work or community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Short-term Hardship Exceptions

34. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* 42 U.S.C. § 1396a(xx)(3)(B).

35. The IFR provides that the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

36. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

37. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. For determinations that are supposed to be made regarding the preceding year, Medi-Cal may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

DHCS's Efforts to Implement the Work and Community Engagement Requirements Before and After the IFR Issued

38. Immediately following the enactment of H.R. 1, DHCS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026, notice deadline and January 1, 2027, implementation dates, given the magnitude of changes needed to implement the work and community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, DHCS began immediate work to prepare to comply with work and community engagement requirements.

39. Beginning in August 2025 and continuing until the release of the IFR, DHCS based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, DHCS has already done the following:

- DHCS released an All County Welfare Director's Letter (ACWDL) 25-30 (December 30, 2025) that provides preliminary guidance on work and community engagement requirements for California's 58 local county offices.
- DHCS helped develop an end-to-end system design in the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and the California Statewide Automated Welfare Systems (CalSAWS). Collectively, the two systems include the business rules to determine eligibility based on the work and community engagement requirements. The system design completion date for the work and community engagement requirements was May 8, 2026. This has been communicated to CMS's Data & Systems Group on DHCS's "Community Engagement Project Plan and Roadmap" update as part of the biweekly meetings between CMS and DHCS on work and community engagement system readiness.

The most recent submission of this deliverable from DHCS to CMS was May 8, 2026.

- As of June 1, 2026, the two systems are in the midst of system testing, which is a standard phase of the System Development Life Cycle for large information technology systems. System testing occurs once design is complete. It is a validation of business rules, workflows, data, and internal interfaces.
- As shared with CMS's Data & Systems Group in the biweekly meetings, California has built out a full system release schedule that outlines all the critical milestones for system implementation, with full user acceptance testing (the final phase of testing) anticipated on September 4, 2026, and a deployment of the work and community engagement functionality on September 21, 2026, pending a declaration of system readiness by DHCS.
- DHCS provided a system demo for CMS's Data & Systems Group on May 28, 2026, on the completed system design (still in testing) as part of the CMS request and review of California's system readiness as it relates to work and community engagement requirements.
- DHCS provided CalHEERS technical and functional system design artifacts for work and community engagement requirements to CMS's Data & Systems Group via CMS's Box online functionality on June 2, 2026.
- DHCS developed multiple draft notice of action snippets, outreach notices, a medical frailty screener and application insert that went through extensive community and stakeholder review, and user testing and readability. Notice of action language and the renewal form with work and community engagement

requirements have been translated into 19 Medi-Cal threshold languages and are already being programmed into the CalSAWS eligibility system.

- DHCS has begun text messaging to members to alert them that their Medi-Cal eligibility will become dependent on their compliance with work and community engagement requirements starting in January 2027.
- DHCS developed Medi-Cal budget estimates for system costs, county administration for workforce needs, and caseload projections.

40. With respect to implementing the medically frail exclusion in particular, DHCS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with prior CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data"). DHCS developed processes to convey that information to eligibility systems.

41. DHCS faces several urgent deadlines with respect to implementing work and community engagement requirements. DHCS must apply work and community engagement requirements to applications as of January 1, 2027, and to do this, DHCS needed to substantially finalize eligibility system requirements by May 8, 2026, in order to enable full system deployment, with appropriate testing (which began in March and is scheduled to be ongoing through September 4, 2026). After May 8, 2026, DHCS has only limited ability to make further system changes for use by January 1, 2027. Moreover, DHCS is required by H.R. 1 to issue notices in August 2026 addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, DHCS needs to begin sending information to members by July 2026. The draft of the notice had

to be finalized by March 2, 2026, given the length of time needed for user testing, readability, community review, and translations into 19 Medi-Cal threshold languages.

42. Nevertheless, DHCS still lacks clarity on several crucial issues from the IFR. While the IFR says that DHCS will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how DHCS should determine this. While CMS has said more subregulatory guidance will be provided, DHCS must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only DHCS, but also the messages that DHCS can provide its members: if DHCS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources DHCS is required to have integrated as of January 1, 2027, and which can be integrated later. DHCS requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

43. Of note, if DHCS is found to have built its systems inconsistently with CMS's incomplete and as-yet unissued guidance, the potential consequences are significantly heightened. If DHCS is found to have not configured its systems quickly enough or configured its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on work and community engagement requirements is making it harder for California and other states to comply.

Human Costs of Work and Community Engagement Requirements, Made Worse By the IFR

44. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the work and community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

45. As part of DHCS's caseload projections before the IFR release, caseload data suggest that at least 1.1 million of Medi-Cal's Affordable Care Act Expansion members or 23% will be disenrolled due to not providing responsive documents after the ex parte process as part of the work and community engagement process. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, this analysis likely underestimates the impact to members.

46. Indeed, DHCS expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. Medi-Cal members may think they do not qualify as "medically frail," given the added complexity, and DHCS may see an increase in non-responses from members and decreased rates of application.

47. The "significant impairment" requirement will also likely decrease the number of people DHCS can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on

utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

48. Members with conditions that meet the statutory categories of medical frailty, but who lose coverage due to inability to document CMS's additional "significant impairment" requirement may return to Medi-Cal sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for Medi-Cal and decreases quality of care for members.

49. DHCS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In DHCS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DHCS expects that more members who are actually eligible will be disenrolled simply because they are unable to meet the paperwork requirements to demonstrate their eligibility.

50. DHCS also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in Medi-Cal) develop an auto-immune disorder. Under the IFR, assuming

continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the auto-immune disorder and thus could lose coverage if they could not obtain documentation for this diagnosis.

51. DHCS is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, DHCS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

52. DHCS has spent years conducting outreach and building relationships with Medi-Cal enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on California

Burdens on DHCS

53. Because CMS had never before imposed work and community engagement requirements across eligibility categories, Medi-Cal's eligibility system was not built to support these requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate work and community engagement. As of June 1, 2026, California requested approximately $78 million Total Funds, or approximately $59 million Federal Funds and $19 million state General Funds, to build system changes to support work and community engagement. With the newly released IFR, California is expected to request more funds to support operational and system build, in addition to funding to support additional workforce at the county level for

Medi-Cal case management as a result of work and community engagement requirements. The total amount of additional state funds is unknown at this time.

54. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of what it means and how to implement it—will require DHCS to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, DHCS may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, DHCS expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, DHCS will also incur the cost of educating its members, staff, county eligibility workers, and other stakeholders about what the requirement means and how it can be met.

55. DHCS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, DHCS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules. Planning for these 2028 system adjustments and communications must start now in order to be ready in time for 2028.

Burdens on California

56. The burdens from work and community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on DHCS, but on California more generally. As noted above, Medi-Cal members will likely face increased denials and disenrollments even when they are working or eligible for exclusion —and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of Medi-Cal's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the Affordable Care Act Expansion. California's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals who are disenrolled from Medi-Cal will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on DHCS. Most importantly, DHCS expects poorer health outcomes across California, as fewer people will be able to access appropriate care and manage chronic conditions.

57. In addition, DHCS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the

ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 28th day of June 2026.

/s/Yingjia Huang
Deputy Director,
Health Care Benefits and Eligibility

EXHIBIT A

From: Huang, Yingjia@DHCS
To: Arcenas, Mary (CMS/CMCS)
Cc: Sadwith, Tyler@DHCS; Freeman, Michael@DHCS; Crow, Sarah@DHCS; Stephens, Jessica O. (CMS/CMCS); daniel.brillman@cms.hhs.gov; AnneMarie.Costello@cms.hhs.gov; caprice.knapp1@cms.hhs.gov
Subject: RE: [External]California 5/20/26 CE Update
Date: Wednesday, May 27, 2026 12:43:00 PM
Attachments: image001.png

Hi Mary,

Thanks for the notes from our biweekly check-in on May 20, 2026. As iterated on our call when discussing the content of the demos that California is preparing to share with CMS on May 28, 2026, we want to reiterate in writing our significant concerns should CMS materially alter its prior guidance on Medicaid work requirements in the forthcoming interim final rule (IFR) due June 1, 2026 with respect to medical frailty and self-attestation. DHCS has relied extensively on CMS's preliminary guidance over the last several months to design, build, and operationalize major programmatic, systems, and staffing changes needed to comply with H.R. 1 by January 1, 2027. To the extent the forthcoming IFR includes these substantial shifts, we believe those new policies would be inconsistent with the statutory requirements of H.R. 1, increase the risk of unintended coverage loss for eligible Medi-Cal individuals, and upend California's policy and operational planning efforts – making it extremely difficult for the State to meet the federal requirements by January 1, 2027. The following lays out California's Department of Health Care Services' (DHCS) significant concerns.

Recently, we have heard that CMS may be narrowing the statutory "Medically Frail" exemption to apply to individuals who cannot work due to their condition. We have significant concerns with this change. This approach seems to depart from the definition set forth in H.R. 1, which identifies specific clinical conditions, including serious or complex medical conditions, disabling mental health disorders, substance use disorders, and disabilities, without linking eligibility to work capacity. Specifically, Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act enumerates specific clinical conditions as the basis for the medical frailty exemption, without reference to individuals' ability to work. By contrast, we note that for certain other federal programs, such as SNAP or SSI, Congress expressly links eligibility to an individual's ability to work – reinforcing that Congress clearly intended to exempt individuals who have the conditions outlined in H.R. 1, regardless of their work capacity.

Further, California has necessarily relied on CMS's earlier guidance on medical frailty permitting a comprehensive, data driven approach to identifying medically frail individuals using diagnostic, procedural, and prescription information. California's approach has been both consistent with CMS's guidance and the statutory definition of "medically frail" under H.R. 1. A pivot toward manual, documentation-based assessments would require California to completely reengineer our currently developed systems, workflows, and staffing – even, potentially, requiring provider or eligibility worker certifications that would seem to upend this data-driven approach and transform medical frailty to a largely manual, paper-based system that we have not been planning for. Many states, including ours, would be unable to operationalize these changes by January 2027.

Regarding the possible elimination of the self-attestation flexibility, CMS's Minimum Viable Product written guidance (December 2025) –which required all states to develop an operational workplan and provide a monthly report – permitted states to rely on self-attestation when data were unavailable for determining work requirement compliance or exemption. California has built this flexibility into its system to meet the statutory deadline. This flexibility is not merely a matter of CMS policy discretion - Section 1902(xx)(3)(A) of the Social Security Act expressly permits

states to elect not to require individuals to verify information resulting in an exemption. If the IFR removes or severely limits this option, members will face new significant documentation burdens, increasing the risk of avoidable coverage loss. States would need to build new verification workflows, train eligibility staff, and redesign IT functionality – changes that cannot be completed within the statutory timeframe.

If CMS's IFR diverges materially from its preliminary guidance, California will likely be unable to meet the statutory deadline despite significant good faith efforts and months of preparation since H.R. 1 was enacted and since CMS issued its initial guidance. Implementing new processes on this significantly shortened timeline would heighten the risk of systems errors, improper terminations, and administrative failures affecting eligible individuals. DHCS anticipates that any major shift in direction at this stage could delay implementation by 18-24 months.

For the past several months, DHCS has advanced major systems, operational, and staffing work based on CMS's preliminary guidance. Several critical work requirements-related system builds are already nearing completion, with expected go-live dates aligned to the statutory January 1, 2027, implementation timeline. Many of these components are already in final development and testing phases, with critical dependencies on prior CMS guidance. This includes the application & eligibility systems (CalHEERS / CalSAWS), data analytics & reporting, eligibility determination logic, and ex parte renewal logic. These components are all scheduled for deployment in September 2026, to be ready for activation on January 1, 2027.

CMS was aware throughout this period that California and other states were making time-sensitive, largely irreversible implementation decisions, including vendor contracts, IT builds, and staffing commitments, in direct reliance on its guidance, and continued providing that guidance without any indication that a material policy shift was under consideration. The reliance is embedded in systems that are already in final development and testing.

These system components form the core infrastructure needed for California to administer work requirements. Each system component represents substantial state investment and has proceeded based on CMS's earlier verbal and written guidance. Any major shift in federal policy at this stage, particularly concerning medically frail identification, self-attestation, or verification requirements, would require reengineering multiple system modules already approaching finalization, jeopardizing California's ability to meet the statutory deadlines.

Given these dynamics, DHCS is deeply concerned that significant late-stage policy shifts will increase coverage losses among eligible individuals, particularly those with disabilities and chronic or complex medical needs, introduce avoidable administrative barriers through new documentation requirements, and create operational instability during a major programmatic transition affecting millions of Californians.

In light of these concerns, DHCS respectfully requests that CMS maintain consistency with its preliminary guidance and the requirements of H.R. 1 with respect to medical frailty and self-attestation. To the extent CMS intends to finalize any significant changes that are both necessary and consistent with H.R. 1, it must provide states with adequate lead time to redesign systems and operations. California will likely to pursue a good faith waiver if material changes are finalized in the interim final rule that substantially diverge from the significant investment the State has made in reliance on CMS' prior guidance and the practical inability of reengineering nearly complete systems within the statutory timeframe. We request that CMS provide states with a transparent process for requesting good faith waivers, including clear criteria and timelines.

California remains committed to implementing H.R. 1 in good faith while upholding coverage protections for eligible residents. To succeed, states require, at minimum, clarity and stability in

CMS' policy direction. Abrupt changes at this stage risk undermining both states' ability to comply and member access. As a steward of federal Medicaid funds and an administrator responsible for coverage continuity for millions of eligible Californians, DHCS has an obligation to raise these operational and legal concerns directly, and urges CMS to provide the policy stability necessary for states to implement H.R. 1 in a manner consistent with both the statute and sound program administration.

Thank you,
Yingjia

Yingjia Huang | Deputy Director
Health Care Benefits and Eligibility (HCBE)
California Department of Health Care Services
Office: (916) 954-1097

Executive Assistant's Email: Vibha.Chandra@dhcs.ca.gov

From: Arcenas, Mary (CMS/CMCS) <mary.arcenas@cms.hhs.gov>
Sent: Wednesday, May 20, 2026 1:16 PM
To: Huang, Yingjia@DHCS <Yingjia.Huang@dhcs.ca.gov>; Crow, Sarah@DHCS <Sarah.Crow@dhcs.ca.gov>; Freeman, Michael@DHCS <Michael.Freeman@dhcs.ca.gov>; Ly, Jenny@DHCS <Jenny.Ly@dhcs.ca.gov>
Subject: [External]California 5/20/26 CE Update

This Message Is From an External Sender
This message came from outside of your organization. Please be cautious with links and attachments.
Report Suspicious

Good afternoon, DHCS Partners,

Thank you for the Community Engagement (CE) updates shared today. Below is a summary of our discussion.

Demo

- **The group confirmed May 28, from 12:00–1:00 p.m. Pacific Time, for an overview of the end-to-end application process flow based on the HR1 requirements. The session will not include a live demonstration; instead, it will feature a recorded walkthrough of the**

application flow using the CalHEERS sandbox environment. Yingjia will lead the session, with support from Sarah, Michael, project staff, and Deloitte.

- The dates for the four additional demonstration sessions, scheduled approximately one month apart, are tentative and subject to change.
- Yingjia will send Mary an email before the May 28 session outlining the objectives, scope, and relevant assumptions or limitations to help align expectations.
- Mary shared the general process flow for the demonstration sessions.
    - Before the session, the state project team will identify the MVP checklist items to be covered during the demonstration and confirm participation by state policy and IT staff.
    - During the demonstration:
        - Conduct roll call.
        - The state will identify the applicable MVP checklist items and any associated acceptance criteria.
        - If issues are identified during the discussion, including demonstration gaps, defects, or incomplete workflows, the state should:
            - Describe what is not working or is not aligned with expectations.
            - Explain the root cause, if known.
            - Provide a remediation plan and timeline.
            - Confirm whether updates to the project plan are needed.
    - Upon completion of the demonstration:
        - Mary will ask state policy staff whether the released functionality meets expectations for the intended functionality based on the state's current understanding.
        - Confirm action items and follow-up questions.

APD

- Two As-Needed APDs will be submitted in June:
    - CalHEERS: Updates related to Equifax and Truv. Truv will provide verification data for gig workers.
    - MCED: Updates for county eligibility workers, including DDI and operational costs. The APD will also include a contract for surge staffing.
        - CMS is having internal discussions regarding 28G/H and will follow-up with the state
    - Separate MDBT is needed for DDI system costs.

National Student Clearinghouse

- National Student Clearinghouse (NSC) data will be available through a subscription with Equifax.
- NSC data will not be available for the January 2027 MVP release. The September 2026 release is already at capacity and could not accommodate the NSC integration. According to the tentative release timeline, integration testing is scheduled to conclude on January 15, 2027, with a targeted release date of February 22, 2027.
- Yingjia met with CMS Emmy representatives and determined that this is not the preferred approach.
- Mary shared that NSC and the VBA Disability API will be added to the hub. Additional details regarding the timeline will be provided later, but CMS is working to incorporate these capabilities before the CE requirements take effect on January 1, 2027.
- The state team expressed concern that the project schedule is already significantly compressed and that testing any new hub-related data integrations will be challenging.

Project Progress

- The project remains on track, with no schedule changes, blockers, or issues reported. However, the state team highlighted the significant risk to MVP delivery depending on guidance included in the forthcoming Interim Final Rule, expected on June 1, 2026.
- Yingjia reviewed the updated project plan shared by Sarah.
    - The updated project plan includes:
        - System Change Tracking Number cross-references for CalHEERS and CalSAWS.
        - New notes identified in red font.
        - MVP milestone dates for Volunteer and Work Program Data Sources.
- The state project team is conducting a quality review of project artifacts and will share the materials in Box once the review is complete.

Fair Hearings

- Sarah shared information regarding Fair Hearings via email on May 19, 2026. The process is managed outside of the eligibility and enrollment systems by the California Department of Social Services.
- The current process is manual, with no existing interfaces or plans for automated data exchange.

Please let me know if you have any questions or suggested revisions to this summary.

Thank you, and I look forward to the overview next week.

Sincerely,
Mary

Mary Arcenas

Medicaid Enterprise Systems (MES) State Officer

Data and Systems Group

Center for Medicaid & CHIP Services (CMCS)

Centers for Medicare & Medicaid Services (CMS)

EXHIBIT 3

DECLARATION OF ADELA FLORES-BRENNAN

I, Adela Flores-Brennan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Colorado. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Colorado Medicaid Director and from information and records gathered by the Colorado Department of Health Care Policy and Financing (HCPF) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Colorado State Medicaid program known in Colorado as Health First Colorado and Children's Health Insurance Program (CHIP) known in Colorado as the Child Health Plan *Plus* (CHP+).

3. HCPF is the single state agency responsible for administering Health First Colorado. Health First Colorado provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Health First Colorado's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Health First Colorado's mission is to improve the overall health of Colorado's residents by promoting affordable access to medically necessary care.

4. Health First Colorado provides low-income individuals with access to comprehensive healthcare coverage at no or low cost. Medicaid's coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care.

5. HCPF is the largest purchaser of health coverage in Colorado. The State's Medicaid and CHIP programs cover about 20% percent of the State's population. In total, the State's Medicaid and CHIP programs provide comprehensive health care coverage to approximately 1.3 million people, including over 542,500 children.

6. Colorado administers the Health First Colorado program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Health First Colorado receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 57.58% of Health First Colorado's expenditures on eligible enrollees.

Medicaid Expansion in Colorado

7. In January 2014, Colorado implemented Medicaid expansion under the authority of the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Health First Colorado program.

8. Expansion enrollees in Health First Colorado receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Medicaid expansion requires that an individual: (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level or (4) be a parent/caretaker relative with income between 69-133% of the Federal Poverty Level.

9. As of May 2026, approximately 371,755 of Health First Colorado members (Medicaid recipients) are enrolled in the MAGI Adult Program (Individuals up to 133% are 329,731 and Parent/Caretaker Relatives 69-133% are 42,024). For the current state fiscal year

2026, Colorado projects that approximately $3,057,000,000, or 30.0% of Health First Colorado's total federal Medicaid funding, comes from the FFP for these 371,755 members.

CMS's Pre-IFR Guidance to Colorado

10. I and my staff at Health First Colorado have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

11. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Health First Colorado does not have systems by which to verify work, volunteer, or other community engagement activities and to identify or document exclusions to and exemptions from community engagement requirements. As a result, and as discussed in more detail below, Health First Colorado has expended significant resources to design and build these systems based on the guidance from CMS over the past year.

12. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

13. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations and given the truncated timeline for implementation, and as within its common practice, Colorado relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance. The information CMS has conveyed in these calls has been particularly important for states given the extremely short timeframe for implementation of changes related to community engagement. This short timeframe required states to make IT systems and operational decisions prior to final release of the regulations.

14. In addition to these calls, CMS provided states with informational bulletins related to the community engagement requirements. On November 18, 2025, CMS provided an informational bulletin with a summary of the Medicaid and CHIP provisions in H.R. 1. CMS issued another informational bulletin on December 8, 2025 outlining the state requirements to establish the community engagement requirements.

15. States likewise relied on the guidance shared by CMS on regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

16. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

17. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

18. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that states should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

19. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

20. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

21. In response to this information and concerns that CMS would change its policy direction related to community engagement, Health First Colorado conveyed to its CMS-assigned state officer during a regular biweekly meeting on May 12, 2026 that if there were to be a change in the community engagement requirements in the Interim Final Rule ("IFR"), then significant rework would be required that would put Colorado's minimum viable product at risk. (Minimum Viable Product refers to the baseline requirements states must demonstrate for readiness for implementation on January 1, 2027). The state officer did not provide any response to these concerns.

CMS Issues the Interim Final Rule

22. On June 1, 2026, CMS promulgated the IFR relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions will be very challenging, if not impossible, and costly for Health First Colorado to design by August 31, 2026, and implement before January 1, 2027. They are expected to cause significant harm to members and Health First Colorado once implemented. These provisions include the following:

Medically Frail Definition

23. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." IFR at 42 CFR § 435.554(c)(5)(i).

24. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

25. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

26. The IFR provided very little concrete guidance for how states can verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS specified herein that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a

state can use or what would be an acceptable analysis of such data. The number of data sources and extensiveness of the data analysis required creates a great deal of additional work by Medicaid staff and yet may still not accurately identify all individuals who should be excluded. Moreover, some of the data sources a state could access are proprietary and would not hold up to audit scrutiny.

27. Since the IFR's release, CMS has told states that it is developing even more guidance on the medically frail exclusion. They have repeatedly said that some of the technical questions they received from states will require guidance, technical assistance, and continued engagement from CMS. On a June 9 call, CMS said these materials, guidance, and even sets of diagnoses codes would be shared in the coming weeks. But as of the date of this declaration, none of this has been shared with Colorado.

Self-Attestation

28. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 17-18, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with - or exemption from - community engagement requirements. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

29. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent"));

or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

30. Health First Colorado's efforts to develop screening tools for members or applicants to self-attest to medical frailty have been underway for several months. In seeking to simplify reviews of these screeners, Health First Colorado designed a number of yes/no questions that would indicate impairment sufficient to meet medical frailty requirements. These types of questions are common in online applications because it can be programmed into the eligibility logic. However, CMS has indicated verbally that yes/no questions would not satisfy self-attestation requirements. This significantly frustrates the ability to automate determinations as is contemplated in the statute.

31. Notably, Health First Colorado routinely uses yes/no-type questions to simplify eligibility determinations for other types of Medicaid benefits. CMS has allowed the use of such questions for these determinations. However, CMS has provided no meaningful explanation as to why similar types of yes/no questions cannot be used for the community engagement requirements.

32. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats members differently based on when in this period their medical impairment may arise.

33. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, six (6) months for certain individuals). In contrast, under the IFR's newly introduced

construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

34. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

35. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

36. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

37. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

38. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

39. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance"

with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

40. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

41. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

42. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis

added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

43. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

44. The requirement that the short-term hardship must be met in the month preceding application is also a significant deviation from long-standing policy and practice in Medicaid to accept current monthly income. This unexpected deviation required Health First Colorado to scrap previously designed systems intended to implement the hardship. Health First Colorado is currently reassessing whether it can redesign and implement the system in time for the January 1, 2027 statutory deadline. This is likely to result in confusion to members and stakeholders on the availability of the hardship exclusion in Colorado.

Disability Definition Discrepancies

45. The IFR applies multiple, distinct definitions of "disability," which creates operational and compliance risk for states.

46. Colorado currently applies the definition of "disability" set forth in the Social Security Act at 42 U.S.C. § 1614(a)(3). But the IFR's medical frailty standard does not account for the disability definition already set forth in the Social Security Act. In addition, for caregiver pathways, the IFR relies on the definition of disability in the Americans with Disabilities Act at 28 C.F.R. § 35.108. This definition is broader and does not require an inability to work for an individual to be considered disabled.

47. These standards differ materially in scope and threshold, resulting in multiple co-existing definitions within a single eligibility framework. Without clarification from CMS on the scope of these definitions, the current discrepancies create risk of inconsistent determinations, system complexity, member confusion, and audit exposure, particularly where similar terminology is used across contexts. The caregiver pathway also introduces an additional challenge: the disability determination applies to the person receiving care, who may not be part of the Medicaid case, and the IFR does not clearly address how states should verify or link that information.

Claims Data Delay

48. Several of the timelines set out in the IFR do not take account of the fact that providers have 365 days to submit claims data. For determinations that are supposed to be made regarding the preceding year, Health First Colorado may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

Health First Colorado's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

49. Following the enactment of H.R. 1, Health First Colorado recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, after H.R. 1 was passed in July 2025, Health First Colorado immediately began working to prepare to comply with community engagement requirements.

50. Beginning in August 2025 and continuing until the release of the IFR, Health First Colorado based its policy and system determination on the statutory language and the

subregulatory guidance provided by CMS, as detailed above. Based on this guidance, Health First Colorado has already done the following:

- Filed an Advance Planning Document (APD) with CMS on October 28, 2025, which CMS then approved on November 28, 2025.
- Worked with a vendor to augment staffing to add capacity for policy analysis, data analysis, communications and project management at a cost of $3,785,600.
- Created and launched formal workgroup structures for all H.R. 1 projects.
- Developed high level business requirements for Colorado's Benefits Management System and Program Eligibility and Application Kit System changes through extensive workgroup sessions followed by comprehensive elicitation sessions to develop business requirement documents.
- Prepared for and began execution of required system demonstrations for CMS review. These required demonstrations are intended to demonstrate progress to CMS on various components of the implementation like client correspondence, eligibility worker online portals, verifications, and reporting.
- Drafted and developed proposed eligibility and work requirement state regulations based on information received from CMS in late 2025 and early 2026. Typically this rulemaking process takes months to promulgate pursuant to state administrative procedural requirements.
- Created numerous resources for stakeholders, partners, and members, this included building an H.R. 1 resources webpage, launching a screener tool for the member facing website, working with the Center to Advance Consumer Partnership to develop an H.R. 1 Communications Toolkit, and holding multiple webinars for

stakeholders and members. These public-orientated resources were largely developed based on the CMS guidance provided to states in late 2025 and early 2026, as discussed above.

- Submitted a supplemental budget request of $45,786,371.00 total funds for FY2027 to the Colorado General Assembly for IT systems changes, call center staffing, additional appeals officers, audit and compliance support, and additional outreach resources.
- Developed required member notices which entailed extensive feedback from members and stakeholders.
- Created a medical frailty workgroup which consulted with other states, conducted a review of possible diagnosis codes to determine medical frailty, and created medical frailty questions for new Medicaid applicants. These diagnosis codes and medical frailty questions were based on the CMS guidance provided to states in late 2025 and early 2026.

51. With respect to implementing the medically frail exclusion in particular, Health First Colorado has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

52. Health First Colorado faces several urgent deadlines with respect to implementing community engagement requirements. Health First Colorado must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, Health First

Colorado must substantially finalize eligibility system requirements by July 18, 2026, in order to enable full system deployment, with appropriate testing beginning in October 2026. After October 15, 2026, Health First Colorado will only have a limited ability to make further system changes for use by January 1, 2027. Moreover, Health First Colorado is required by H.R.1 to issue notices no later than August 31, 2026[1] addressing the changes outlined in the IFR. Ideally, this information would be sent to the vendor by June 30, 2026, but Health First Colorado can make necessary changes to the information up to July 31, 2026. Any changes to the community engagement requirements after July 31, 2026 could jeopardize Health First Colorado's ability to send new information to the vendor, revise the member notices, and also meet the August deadline.

53. Nevertheless, Health First Colorado still lacks clarity on several crucial issues from the IFR. While the IFR says that Health First Colorado will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how Health First Colorado should determine this. While CMS has said more subregulatory guidance will be provided, Health First Colorado must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with Colorado's system development.

54. This lack of clarity impacts not only Health First Colorado, but also the information that Health First Colorado can provide its members. If Health First Colorado does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement.

[1] There is a discrepancy between the IFR and H.R.1 as to whether notices must be sent to members by August or September 2026. In an abundance of caution, Health First Colorado intends to issue notices by August 31, 2026.

55. Finally, the IFR does not clarify which data sources Health First Colorado is required to have integrated as of January 1, 2027, and which can be integrated later. Health First Colorado requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

56. The consequences that will result from Health First Colorado building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significant. If Health First Colorado is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Colorado and other states to comply.

57. This risk is especially heightened for Colorado given upcoming Payment Error Rate Measurement (PERM) audits conducted by CMS. PERM is a federal audit program that reviews a sample of Medicaid eligibility determinations and payments to determine whether they comply with applicable federal and state requirements and are supported by sufficient documentation. PERM produces an eligibility improper payment rate or error rate. New H.R. 1 provisions increase financial accountability for states exceeding a 3% PERM Eligibility error rate. For example, each 1/10 of a percentage over this error rate can result in a $9 million withholding of federal funding. The next PERM cycle begins in 2029 but crucially here, these audits will review eligibility determinations beginning on July 1, 2027, just six months after the community engagement requirements implementation deadline. For all the reasons discussed throughout this declaration,

the instability caused by the unexpected changes in the IFR will likely lead to eligibility errors and potentially significant financial risk for HCPF depending on the outcome of the PERM audits.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

58. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

59. In Colorado, an estimated 378,000 adults per year in the Health First Colorado expansion population will be subject to H.R. 1's community engagement and six-month redetermination requirements (a provision of H.R. 1 that requires Medicaid expansion adults' eligibility to be reevaluated every six months). Of those 378,000 individuals, approximately 155,000 will be required to demonstrate community engagement or qualify for an exclusion or exception.

60. These numbers were developed prior to the issuance of the IFR. Because the IFR goes beyond H.R. 1 in stripping away the protections provided to the medically frail and adding new limitations on self-attestation that do not appear in statute, these numbers likely underestimate the impact to members.

61. Indeed, Health First Colorado expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant

impairment" requirement will also likely increase member confusion. Health First Colorado members may think they do not qualify as "medically frail," given the added complexity, and Health First Colorado may see an increase in non-responses from members and a corresponding loss of coverage.

62. The "significant impairment" requirement will also likely decrease the number of people Health First Colorado can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

63. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to Health First Colorado sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for Health First Colorado and decreases quality of care for members.

64. Health First Colorado expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In Health First Colorado's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens,

Health First Colorado expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

65. Health First Colorado also expects the "once per enrollment period" limitation on medical frailty self-attestations to cause particular harm to members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in Health First Colorado) be diagnosed with end-stage renal disease (ESRD) or chronic obstructive pulmonary disease (COPD). Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the later-diagnosed ESRD or COPD conditions and thus could lose coverage if they could not obtain documentation for these diagnoses.

66. Moreover, and as discussed above, Health First Colorado is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing states to begin outreach no later than four or more months before December 31, 2026). At present, Health First Colorado is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

67. Health First Colorado has spent years conducting outreach and building relationships with Health First Colorado enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

68. Given that Medicaid is Colorado's single largest health care coverage program, Colorado's uninsured rates will undoubtedly increase with the number of members impacted by these unexpected changes in the IFR. As discussed below, this has negative economic and health care impacts on both Health First Colorado and the entire state.

Administrative, Operational, and Financial Burdens on Colorado

Burdens on Health First Colorado

69. Because CMS had never before imposed community engagement requirements across eligibility categories, Health First Colorado's eligibility system was not built to support community engagement requirements and it is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. Typically, eligibility systems changes require 12 months to complete, test, and implement. Given that the IFR was released only seven months prior to the effective date of these requirements, Colorado will struggle to implement IT systems changes consistent with the IFR.

70. As mentioned above, HCPF submitted its Advance Planning Document (APD) to CMS on October 28, 2025, based on then-available information and guidance from CMS. CMS approved Colorado's APD in November 2025. Since then, HCPF worked with the Colorado General Assembly during the 2026 legislative session, which ran from January to May, to secure matching state funds for systems changes and needed staff. The new and unexpected requirements in the IFR upends that planning and will require additional funds, staff, and contractors to complete, which HCPF cannot secure before the January 1, 2027 effective date of the IFR requirements. And given Colorado's already well-documented budget crisis, allocating additional state resources to implementing these work requirements will take limited state funding away from other Colorado programs or away from core Medicaid benefits and services.

71. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require Health First Colorado to rapidly change its operational approach and systems development. In addition to analyzing, developing, and implementing new ways to evaluate medical frailty, Health First Colorado may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, Health First Colorado expects more calls, more documents to process, and more administrative appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, Health First Colorado will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

72. Health First Colorado also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, application assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, Health First Colorado expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Colorado

73. The burdens from community engagement requirements imposed by H.R. 1, and made worse by the IFR, fall not just on Health First Colorado, but on Colorado more generally. As noted above, Health First Colorado members will likely face increased denials and

disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of Health First Colorado's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are part of Health First Colorado's expansion population. Colorado's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage and due to providing individuals with largely uncompensated emergency care whose health has deteriorated while they were unable to secure needed health care services as a result of the community engagement requirements. Health First Colorado also anticipates that more people will move into disability categories of coverage, which are higher cost and draw a significantly lower federal match of 50% instead of Colorado's current 90% expansion population match under the Affordable Care Act.

74. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care.

75. Furthermore, individuals who are disenrolled from Health First Colorado will likely lose access to primary and preventive care – and care necessary to treat their medical conditions – resulting in more individuals seeking high-cost, emergency care. This lack of preventative care will result in increased communicable disease outbreaks and more strain on Health First Colorado. Most importantly, Health First Colorado expects poorer health outcomes across Colorado, as fewer people will be able to access appropriate, timely care and manage chronic conditions.

76. Finally, Health First Colorado expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order

to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and experiencing significant impairment in their ability to work. This will require providers to take time away from their patient care and will increase administrative strain, adding to healthcare costs and impacting access to care. Providers are already sharing their concerns about additional paperwork, the lack of medical training for the specific purpose of opining on ability to work, and the malpractice insurance implications.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

/s/ Adela Flores-Brennan
Adela Flores-Brennan
Medicaid Director, Colorado Department of Health Care Policy and Financing

EXHIBIT 4

DECLARATION OF PETER HADLER

I, Peter Hadler, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the State of Connecticut. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Commissioner of information and records gathered by the Connecticut Department of Social Services and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Deputy Commissioner of the Connecticut Department of Social Services ("DSS").

3. DSS is the single state agency responsible for administering Connecticut's Medicaid program. In Connecticut, Medicaid and other medical assistance programs are collectively called "HUSKY Health" or simply "HUSKY." HUSKY Health provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. HUSKY Health's coverage includes medical, dental, mental health and substance use treatment, and long-term services and supports. As the State Medicaid agency, DSS is one of the largest health care coverage providers in Connecticut. In this role, DSS seeks to ensure that Connecticut residents have access to high-quality, affordable health care, and it is committed to whole-person care, integrating physical and behavioral health services for better results and healthier communities in Connecticut.

4. HUSKY Health covers approximately one million people, providing health coverage to children, families, and older adults, including some of the most vulnerable residents

in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Connecticut administers the HUSKY Health program pursuant to federal law and regulations as well as the terms of its federally approved State Plan. HUSKY Health receives federal Medicaid and Children's Health Insurance Program ("CHIP") funding, known as "Federal Financial Participation" (FFP), which, based on data available for state fiscal year 2026 (spanning July 1, 2025 to the date of this declaration) has covered approximately 59% of total HUSKY Health expenditures on eligible enrollees.

Medicaid Expansion in Connecticut

6. Connecticut implemented the early expansion option under the Affordable Care Act ("ACA"), converting its state funded health care coverage for very low-income adults to Medicaid coverage, effective on or about April 1, 2010. Connecticut's coverage of the ACA Medicaid expansion group took effect on or about January 1, 2014. This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% (with an additional 5% income disregard) of the Federal Poverty Level through the HUSKY Health Program. The ACA expansion group in Connecticut is called "HUSKY D."

7. Enrollees in HUSKY D receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for HUSKY D requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level (with an additional 5% income disregard).

8. As of May 2026, approximately 303,000 HUSKY Health members are enrolled in HUSKY D. For the current state fiscal year 2026, approximately $2.29 billion, or 44%, of HUSKY Health's federal Medicaid funding comes from the FFP for HUSKY D members.

CMS's Pre-IFR Guidance to Connecticut

9. I and my staff at DSS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, DSS does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Connecticut relied on CMS guidance from these calls,

and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025, CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to also have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025, CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as

medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for DSS to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to HUSKY D members and DSS once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition

significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) (42 U.S.C. 1396a(xx)(A)(ii)(II)(V)). In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June

3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, as of the date of this declaration, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (no more frequently than once every 12 months) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment."

That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is effectively a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

Data Feed Integration

31. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as

"information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

32. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

33. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still

cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

34. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

35. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

36. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

37. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage,

likely forgoing necessary care in the meantime or further straining our emergency health care system.

Other

38. Several of the timelines set out in the IFR do not take account of the fact that Medicaid providers have up to 12 months to submit claims. For determinations that are supposed to be made regarding the preceding year, DSS may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

Connecticut's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

39. Following the enactment of H.R. 1, DSS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026, notice deadline and January 1, 2027, implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, DSS began work to prepare to comply with community engagement requirements.

40. Beginning on or around July 2025 and continuing until the release of the IFR, DSS based its policy and system determination on the statutory language and the sub-regulatory guidance provided by CMS, as detailed above. Based on this guidance, DSS has already done the following:

- Conducted statutory analysis of H.R. 1's provisions and projected impacts on policy, operations, budgets, and systems;

- Drafted and analyzed the impact of the various exclusion and compliance rubrics on enrollment and operations, including a diagnosis-code driven approach to determining medical frailty;
- Coordinated extensive data analytics on the impact of pursuing various policy and operations pathways given extraordinarily short implementation timelines and the massive scale of changes required;
- Secured federal funding through an advanced planning document based on projected system requirements;
- Hired vendors to assist with exploring changes in the customer journey and the many aspects of operations that would be impacted;
- Allocated personnel to work on policy, communications, contracting, systems, and operational changes required by H.R. 1;
- Hired and reconfigured internal teams to meet the highly compacted timeframes necessary to complete contract bidding processes and redesign systems and operations, including moving staff from other priority work to address H.R. 1;
- Initiated extensive community outreach and client communications through traditional and social media channels, webinars, conferences, meetings, text messaging and websites.

41. With respect to implementing the medically frail exclusion in particular, DSS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty

status … available through claims data"). Furthermore, DSS has striven to design processes and systems that will align to the regulatory imperative to determine eligibility using reliable information available to the agency without requiring information from the individual pursuant to 42 CFR § 435.916(b).

42. DSS faces several urgent deadlines with respect to implementing community engagement requirements. DSS must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, DSS must substantially finalize eligibility system requirements by September 2026, in order to enable full system deployment, with appropriate testing, in December 2026. After September 2026, DSS will only have limited ability to make further system changes for use by January 1, 2027. Moreover, DSS is required by H.R. 1 to issue notices no later than August 31, 2026 addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, DSS will need at least 3 weeks (potentially 4 weeks, given the volume of notices required). This lead time is necessary to allow for notice translation, vendor file preparation, testing and mailing. .

43. Nevertheless, DSS still lacks clarity on several crucial issues from the IFR. While the IFR says that DSS will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how DSS should determine this. While CMS has said more sub-regulatory guidance will be provided, DSS must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only DSS, but also the messages that DSS can provide its members: if DSS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this

requirement. Finally, the IFR does not clarify which data sources DSS is required to have integrated as of January 1, 2027, and which can be integrated later. DSS requires clarity on these issues in order to implement community engagement requirements in a timely fashion, to ensure operational feasibility, to ensure that additional staff can be hired and trained in the event that new regulatory guidance requires more manual processes, and to ensure that its members are prepared for this implementation.

44. Of note, the consequences for DSS from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If DSS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Connecticut and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

45. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

46. Studies conducted by DSS before the IFR was released suggest that (1) at least 34% of HUSKY Health's HUSKY D members may be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1

that requires HUSKY D members' eligibility to be reevaluated every six months), and (2) Connecticut's uninsured rates may grow by up to 4.4%, nearly doubling the 2024 uninsured rate (*see* https://www.americashealthrankings.org/explore/measures/HealthInsurance/CT). Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail by adding a baseless supra-statutory overlay tied to "significant impairment" that will undermine operational efficiency and introduce vast new procedural complexity, and by adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members. A preliminary analysis conducted by DSS indicates that due to the significant impairment language included in the IFR an additional 57,000 medically frail individuals in Connecticut are now at risk of coverage loss.

47. Indeed, DSS expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition (1) may not meet the IFR's additional, non-statutory "significant impairment" threshold, (2) may not be identifiable through existing data sources which could be used for a straightforward "medical frailty" determination made by DSS, or (3) because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. HUSKY D members may think they do not qualify as "medically frail," given the added complexity, and DSS may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people DSS can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may

not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew, rather than allowing DSS to make a determination based on reliable data already available to the Department. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

48. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to HUSKY Health sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises operational and administrative costs for DSS and decreases quality of care for state residents.

49. DSS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In DSS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DSS expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

50. DSS also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in HUSKY D) suffer a stroke. Under the IFR, assuming continuous Medicaid coverage

during that period, the member *could not* self-attest to medical frailty based on the stroke and thus could lose coverage if they could not obtain documentation for this diagnosis.

51. DSS is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, DSS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

52. DSS has spent years conducting outreach and building relationships with HUSKY Health enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Connecticut

Burdens on HUSKY Health

53. Because CMS had never before imposed community engagement requirements across eligibility categories, DSS's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. DSS has budgeted, obtained and begun expending federal and state funds to support system development; every deviation from the original community engagement guidance increases costs as "change requests" are required to rebuild and reconfigure earlier designs and builds.

54. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DSS to

rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, DSS may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, DSS expects more calls, more documents to process, and more appeals of adverse actions. This will in turn cause negative impacts on the Department's ability to timely determine eligibility for all of its other clients and will likely necessitate increased state costs for additional staff and vendor capacity. And finally, in addition to the costs of operationalizing this new requirement, DSS will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

55. DSS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, DSS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Connecticut

56. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on DSS, but on the state's health insurance exchange and the State of Connecticut more generally. As noted above, HUSKY Health members will likely face

increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of HUSKY Health's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in HUSKY D. Connecticut's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from HUSKY Health will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventive care may result in an increased transmission of communicable disease and more strain on the state agencies responsible for addressing these declines in public health. Most importantly, DSS expects poorer health outcomes across Connecticut, as fewer people will be able to access appropriate care and manage chronic conditions.

57. In addition, DSS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Peter Hadler

Digitally signed by Peter Hadler
DN: cn=Peter Hadler, o=DSS, ou=Deputy Commissioner, email=peter.hadler@ct.gov, c=US
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Peter Hadler, Esq.
Deputy Commissioner

EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS; STATE OF CALIFORNIA; STATE OF NEW JERSEY; *et. al.* Plaintiffs, v. MEHMET OZ, M.D., in his official capacity of as Director of the Centers for Medicare & Medicaid Services; CENTERS FOR MEDICARE & MEDICAID SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the U.S. Department of Health & Human Services, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Defendants.	Case No.

DECLARATION OF ANDREW WILSON

I, Andrew Wilson, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Delaware. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by Department of Health and Social Services and agency staff, of the matters set forth below. I have held that position since 2023. I have a Bachelor's degree in English Writing from St. Lawrence University and a Juris Doctor from Albany Law School. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Diamond State Health Plan and Diamond State Health Plan Plus State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Delaware as Delaware Medicaid).

3. The Division of Medicaid and Medical Assistance (DMMA) is the single state agency responsible for administering Delaware Medicaid. Delaware Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Delaware Medicaid's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Delaware Medicaid's mission is to provide medical assistance to eligible low-income families and to eligible people who are aged, blind and/or disabled and whose income is too low to meet the cost of necessary medical services. Medicaid pays for: doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, mental health and substance abuse services.

4. Delaware Medicaid insures approximately 240,000 people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Delaware administers the Delaware Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Delaware Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 60% of Delaware Medicaid's expenditures on eligible enrollees.

Medicaid Expansion in Delaware

6. On January 1, 2014, Delaware implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Diamond State Health Plan program.

7. Enrollees in the Diamond State Health Plan receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the Diamond State Health Plan requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of January 1, 2026, approximately 70,000 members are enrolled through the expansion population. For the current state fiscal year 2026, approximately 90% of federal Medicaid funding comes from the FFP for expansion program members.

CMS's Pre-IFR Guidance to Delaware

9. I and my staff at DMMA have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Delaware Medicaid does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Delaware relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for Delaware Medicaid to

design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and Delaware Medicaid once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR

does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely --on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent"));

or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has

previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not take account of the fact that providers have 2 months to submit claims and claims and encounter data can take as a long as a

year to completely adjudicate. For determinations that are supposed to be made regarding the preceding year, Delaware Medicaid may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

Delaware Medicaid's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, Delaware Medicaid recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, Delaware Medicaid began work to prepare to comply with community engagement requirements.

41. Beginning in November 2025 and continuing until the release of the IFR, Delaware Medicaid based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, Delaware Medicaid has already done the following:

- Entered into $8,851,776 contracts with Deloitte to engage in extensive work to set-up system requirements, design systems, and to build and code the state's All Worker Web (AWW) eligibility system necessary to bring it into compliance with H.R. 1.
- Entered into $704,400 contracts with Gainwell Technologies LLC and engaged in extensive system design to buildand code the state's Medicaid Management Information System into compliance with H.R. 1.
- Invested and redirected significant staff time to implementing H.R.1, to the detriment of other Division mandates and requirements.

- Forecasted and budgeted the Fiscal Year 27 state budget for the funds necessary to implement H.R.1 as made in reliance on unofficial CMS guidance and urging to not wait for official guidance, in reliance on the statute and in order to comply with the statutory timelines.
- Worked on application forms (screeners) and notices.
- Conducted outreach presentations to member, staff, and stakeholders.
- Worked with vendors to help plan work and research for needed policy revisions.
- Built and launched a website.
- Finalized mass mailer to comply with HR section 71119 which are scheduled to go out August 22, 2026 and opted into CMS campaign emails that are scheduled to begin sending emails July 6, 2026.

42. With respect to implementing the medically frail exclusion in particular, Delaware Medicaid has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data".)

43. Delaware Medicaid faces several urgent deadlines with respect to implementing community engagement requirements. Delaware Medicaid must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, Delaware Medicaid must have substantially finalize eligibility system requirements by June 1, 2026, in order to enable full system deployment, with appropriate testing, by the end of 2026. As of the date of this Declaration, Delaware Medicaid will only have limited ability to make further system changes for

use by January 1, 2027. Moreover, Delaware Medicaid is required by H.R. 1 to issue timely notices addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, Delaware Medicaid needs to send information by August 31, 2026. To accomplish this, Delaware needs to have finalized content no later than July 31, 2026. This includes time for required translation, system vendor programming, and mail processing.

44. Nevertheless, Delaware Medicaid still lacks clarity on several crucial issues from the IFR. While the IFR says that Delaware Medicaid will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how Delaware Medicaid should determine this. While CMS has said more subregulatory guidance will be provided, Delaware Medicaid must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only Delaware Medicaid, but also the messages that Delaware Medicaid can provide its members: if Delaware Medicaid does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources Delaware Medicaid is required to have integrated as of January 1, 2027, and which can be integrated later. Delaware Medicaid requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

45. Of note, the consequences for Delaware Medicaid from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If Delaware Medicaid is not able to configure its systems quickly enough, or if it configures its

systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Delaware and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

46. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

47. Delaware projections conducted before the IFR was released suggest that (1) at least 14,500 of Delaware Medicaid's members in its expansion program will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires expansion members' eligibility to be reevaluated every six months), and (2) Delaware uninsured rates will increase by up to 1.4%. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

48. Indeed, Delaware Medicaid expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the

proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. Delaware Medicaid members may think they do not qualify as "medically frail," given the added complexity, and Delaware Medicaid may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people Delaware Medicaid can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

49. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to Delaware Medicaid sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for Delaware Medicaid and decreases quality of care for members.

50. Delaware Medicaid expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In Delaware Medicaid's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, Delaware

Medicaid expects that more members who are actually eligible will be disenrolled simply because they are be unable to demonstrate their eligibility.

51. Delaware Medicaid also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in Delaware Medicaid) suffer a stroke. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the stroke and thus could lose coverage if they could not obtain documentation for this diagnosis.

52. Delaware Medicaid is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, Delaware Medicaid is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

53. Delaware Medicaid] has spent years conducting outreach and building relationships with Delaware Medicaid enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Delaware

Burdens on Delaware Medicaid

54. Because CMS had never before imposed community engagement requirements across eligibility categories, Delaware Medicaid's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. Delaware funds to cover the system change requirements were previously accounted for and budgeted. The newly-released IFR would require additional funds that have not been budgeted and significantly more staff time dedicated to additional system requirement work. New vendors may also be required to be procured as the implementation of the IFR requirements are outside the scope and experience of existing vendors.

55. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require Delaware Medicaid to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, Delaware Medicaid may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, Delaware Medicaid expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, Delaware Medicaid will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

56. Delaware Medicaid also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical

frailty exclusion, Delaware Medicaid expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

57. Finally, the speed required by the IFR, to say nothing of the regulation's ambiguity, substantially increases the risk that Delaware Medical will inadvertently fail to make all the required changes within the given timeline. As a result, Delaware Medicaid is likely to incur even more costs next year and beyond, as they work to identify issues and implement changes to bring their system into compliance; issues which, given more time, they could have addressed prior to implementation.

Burdens on Delaware

58. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on Delaware Medicaid, but on Delaware more generally. As noted above, Delaware Medicaid members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of Delaware Medicaid's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the expansion program. Delaware's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and community health centers and hospitals – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from Delaware Medicaid will

likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on Delaware Medicaid. Most importantly, Delaware Medicaid expects poorer health outcomes across the Delaware, as fewer people will be able to access appropriate care and manage chronic conditions.

59. In addition, Delaware Medicaid expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

DocuSigned by:
Andrew Wilson
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Wilson
Deputy Secretary for Delaware Medicaid
Department of Health and Social Services

EXHIBIT 6

DECLARATION OF MELISA BYRD

I, Melisa Byrd, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the District of Columbia. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Senior Deputy Director and Medicaid Director at the District of Columbia Department of Health Care Finance ("DHCF") of information and records gathered by DHCF staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the District of Columbia State Medicaid program and Children's Health Insurance Program (CHIP) (known together in the District as DC Medicaid).

3. DHCF is the single state agency responsible for administering DC Medicaid. DC Medicaid provides low-income individuals and people with disabilities with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. DC Medicaid's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and pharmacy.

4. DC Medicaid insures approximately 250,000 people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the District, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. DHCF administers DC Medicaid pursuant to federal law and regulations as well as the terms of the District's federally approved State Plans and its Section 1115 Demonstration Project. DC Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial

Participation" (FFP), which covers at least 70 percent (for most populations) and up to 90 percent (for certain expansion adults) of DC Medicaid's expenditures on services for eligible enrollees.

Medicaid Expansion in the District of Columbia

6. On January 1, 2014, the District implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income childless adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level.

7. Enrollees in the District's Medicaid expansion program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the District's Medicaid expansion program requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of FY 2026, approximately 79,000 (29%) of DC Medicaid members are enrolled in the District's Medicaid expansion program in an average month. For the District's current fiscal year 2026 approved budget, approximately $1.1 billion (27%) of DC Medicaid's federal Medicaid funding for provider services comes from the FFP for the District's Medicaid expansion program members.

CMS's Pre-IFR Guidance to the District of Columbia

9. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, DHCF does not have in place systems by which to verify work, volunteer, or other community engagement activities for DC Medicaid members.

10. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On December 5, 2025, CMS began working calls with states to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. In the absence of regulations, DHCF relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

11. DHCF likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Although CMS indicated that the guidance was non-final, at no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

12. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

CMS Issues the Interim Final Rule

13. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several provisions that will be very challenging for DHCF to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to DC Medicaid members and DHCF once implemented.

14. **Medical Frailty Exclusion**: The IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must also be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

15. **Self-Attestation:** The IFR also significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for DC Medicaid members and difficult for DHCF to implement. The IFR also significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028, including for those factors where documentation is unlikely to be available, such as the precise number of hours that a family caregiver provides assistance to a family member or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

16. **Data Feed Integration:** The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR appears to require DHCF to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that DHCF has never assessed before, such as school attendance, community volunteer work, and job program enrollment.

17. **Renewal Process:** The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny DC Medicaid members the full window of time they are granted in H.R. 1 to

demonstrate they comply with work requirements. The effect of this structure is that electronic information for members will be evaluated for compliance with work requirements before—often months before—the end of the time period in which they are entitled to comply with work requirements is complete.

18. **Short-term Hardship Exceptions:** Although H.R. 1 allows states to apply exceptions for certain short-term hardship events, under the IFR, the short-term hardship exception requires a new applicant to demonstrate the exception for at least one, but not more than three consecutive months. An applicant also cannot demonstrate the exception for the same month in which they apply to Medicaid. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage.

DHCF's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

19. Following the enactment of H.R. 1, DHCF recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, after H.R. 1 was passed in July 2025, DHCF began work to prepare to comply with community engagement requirements.

20. Beginning in November 2025, and continuing until the release of the IFR, DHCF based its DC Medicaid policy and system determination on the statutory language and the subregulatory guidance provided by CMS. Based on this guidance, DHCF has already done the following:

- Conducted public outreach meetings based on statutory interpretation and preliminary guidance from CMS
- Drafted rulemaking for publication in the DCMR
- Drafted policy and procedure document based on statutory interpretation and preliminary guidance from CMS
- Drafted updates to application questions, eligibility notices, noncompliance letter, and adverse action letters and submitted documents for legal sufficiency review
- Developed eligibility system design for community engagement implementation, which included weeks of Joint Application Design and Joint Application Review with inter-agency stakeholders and DCAS contractors
- Allocated DHCF staff and contractor application development resources to ensure timely release of communication engagement system infrastructure (delaying other key releases to ensure federal compliance)
- Drafted RFP and contracted with public outreach firm to ensure broad communication of community engagement requirements in the District

21. With respect to implementing the medically frail exclusion in particular, DHCF has worked extensively to review clinical and systems information that will support a process to identify individuals who could be considered "medically frail." This information is based largely on claims data, in line with initial CMS guidance, but must now be substantially updated to accommodate new requirements proposed by CMS related to impairment.

22. DHCF faces several urgent deadlines with respect to implementing community engagement requirements for DC Medicaid. DHCF must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, DHCF must

substantially finalize eligibility system requirements by June 26, 2026, in order to enable full system deployment, with appropriate testing, in December 2026. After June 26, 2026, DHCF will only have limited ability to make further system changes for use by January 1, 2027. Moreover, DHCF is required by H.R. 1 to issue notices by August 31, 2026 addressing the changes occasioned by the IFR.[1] In order to issue notices by August 31, 2026, DHCF would need the content of the notice finalized by July 31, 2026, so that it can be sent for translation by August 15, 2026, and provided to the vendor for mailing by August 27, 2026.

23. Nevertheless, DHCF still lacks clarity on several crucial issues from the IFR. While the IFR says that DHCF will need to evaluate whether a DC Medicaid member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how DHCF should determine this. While CMS has said more subregulatory guidance will be provided, DHCF must develop its DC Medicaid eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only DHCF, but also the messages that DHCF can provide DC Medicaid members: if DHCF does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources DHCF is required to have integrated as of January 1, 2027, and which can be integrated later. DHCF requires clarity on these issues in order to implement community engagement

[1] CMS has indicated in guidance and in the IFR that certain Medicaid agencies can issue notices in September 2026, *see* 91 Fed. Reg. 33,420, and DHCF has relied on this guidance to prepare to send information to DC Medicaid enrollees by September 4, 2026. For the reasons noted above, adjusting the timeline to send notices by the August 31, 2026 deadline in H.R. 1 would be even more challenging.

requirements in a timely fashion and to ensure that its members are prepared for this implementation.

24. Of note, the consequences for DHCF from building its DC Medicaid systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If DHCF is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for the District and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

25. DHCF expects the "significant impairment" requirement to result in more DC Medicaid program members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. DC Medicaid program members may think they do not qualify as "medically frail," given the added complexity, and DHCF may see an increase in non-responses from DC Medicaid members and decreased rates of application and renewal. The "significant impairment" requirement will also likely decrease the number of people DHCF can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may

not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

26. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to DC Medicaid sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment raises costs for DC Medicaid.

27. DHCF expects the IFR's limitations on self-attestation to increase DC Medicaid member confusion and coverage loss as well. In DHCF's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DHCF expects that more DC Medicaid members who are actually eligible will be disenrolled simply because they will be unable to demonstrate their eligibility.

28. Beginning in 2028, DHCF also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm DC Medicaid members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in DC Medicaid) be diagnosed with congestive heart failure. Under the IFR, assuming continuous Medicaid coverage during that period, the

member *could not* self-attest to medical frailty based on the congestive heart failure and thus could lose coverage if they could not obtain documentation for this diagnosis.

29. Under H.R. 1, DHCF is required to provide notice to DC Medicaid members regarding the changes occasioned by the IFR by August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A). At present, DHCF is uncertain as to how, for example, a DC Medicaid member might establish that they are medically frail in accordance with the IFR. Accordingly, the content of this notice may not have the clarity required to communicate to members how they can comply with the new requirements.

30. DHCF has spent years conducting outreach and building relationships with DC Medicaid enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on the District

31. Because CMS had never before imposed community engagement requirements across eligibility categories, DC Medicaid's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. In addition to the federal grant funds for system implementation, DHCF anticipates at least another $2 million in system-related costs.

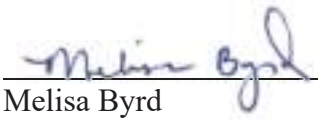
32. With respect to the medical frailty exclusion, the additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DC Medicaid to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, DC Medicaid may need to integrate new data sources to evaluate members' eligibility for the medical frailty

exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, DHCF expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, DHCF will also incur the cost of educating DC Medicaid members, staff, and other stakeholders about what the requirement means and how it can be met.

33. DHCF also expects the new, complex, and variable limitations on self-attestation to increase DC Medicaid's operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, DHCF expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.



Melisa Byrd
Senior Deputy Director and Medicaid Director
District of Columbia Department of Health Care Finance

EXHIBIT 7

DECLARATION OF KATHERINE YAGER

I, Katherine Yager, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Illinois. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Administrator of Medical Eligibility of information and records gathered by the Illinois Department of Healthcare and Family Services ("HFS") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Administrator of Medical Eligibility for the Illinois State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Illinois as the Illinois Medical Assistance Program). In this role, I oversee eligibility determinations and enrollment into Illinois medical assistance programs, consisting of Medicaid and numerous other medical programs. My educational background includes a Master of Arts degree in Economics from the University of Missouri – Kansas City (2005) and Bachelor of Arts degree in Economics from the State University of New York – Binghamton (2001). I have worked in the health care field since 2018. During that time, I have served the public in state and city government and nonprofit positions, including as the Director of Medicaid for Chicago Public Schools, a board member of the National Alliance for Medicaid in Education (NAME), and a state health policy advocate in Illinois.

3. HFS is the single state agency responsible for administering the Illinois Medical Assistance Program. HFS's mission is to improve access to quality healthcare for the individuals enrolled in its programs, while simultaneously containing costs and maintaining program integrity.

4. The Illinois Medical Assistance Program covers approximately 3 million people, providing health coverage to children, families, and older adults--including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Illinois administers the Illinois Medical Assistance Program in accordance with federal law and regulations as well as the terms of its federally approved State Plan and Medicaid waivers. A significant portion of the Illinois Medical Assistance Program is authorized and funded through the Medicaid federal-state partnership. The State of Illinois, through HFS, receives Medicaid dollars, known as "Federal Financial Participation" (FFP) which reimburses Illinois for an average of 60% of its expenditures on eligible enrollees.

6. HFS operates a single integrated eligibility system ("IES") in partnership with our sister agencies, the Illinois Department of Human Services and Illinois Department of Innovation and Technology, to administer the Illinois Medical Assistance Program, Supplemental Nutrition Assistance Program ("SNAP"), and Temporary Assistance for Needy Families ("TANF") program. Additionally, the three state agencies must jointly coordinate with a third-party vendor with their own contractual limitations, to manage the day-to-day system management, updates, and improvements, and the incorporation of updates needed to meet the new H.R. 1 requirements placed on the Illinois Medical Assistance Program and SNAP. Due to the complexity of the IES system and its effect on multiple state agencies and programs, the changes required by HR 1, and the compressed timeframe in which HFS has to implement them, place an inordinate strain on Illinois' system and processes.

Medicaid Expansion in Illinois

7. On January 1, 2014, the Illinois Medical Assistance Program expanded coverage to a new group of individuals eligible for Medicaid under the Affordable Care Act ("ACA"). This expansion extended federally funded health coverage under the federal Medicaid program to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level. As of May 2026, approximately 660,000 of about 3 million Illinois Medical Assistance Program customers are in the ACA Adult Eligibility Group.

8. Individuals who are eligible for the Illinois Medical Assistance Program under the ACA Adult Eligibility Group receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the ACA Adult Eligibility Group in Illinois requires that an individual meet certain financial and nonfinancial requirements, including but not limited to (1) being an adult 19 to 64 years old; (2) being a citizen or qualified immigrant; (3) not being a parent or caretaker relative to minor children living in the home, and (4) having household income less than or equal to 133% of the Federal Poverty Level.

CMS's Pre-IFR Guidance to Illinois

9. I and my staff at HFS have been closely following the enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or "community engagement" requirements for adults covered under the Medicaid expansion provisions of the ACA (the "work requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required otherwise eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, the Illinois Medical Assistance Program does not

have existing systems capable of making eligibility determinations with regard to the work requirements included in H.R. 1.

11. Since November 2025, the Center for Medicaid and Medicare Services ("CMS") has been providing guidance on the expected work requirements policy. On November 19, 2025, CMS presented a slide deck on work requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing work requirements. These community engagement workgroup calls generally took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. In addition to participating in these calls, from January 2026 through June 2026, the Illinois Medical Assistance Program engaged with CMS staff directly, including through biweekly one-on-one meetings with CMS staff, a meeting with senior CMS staff, and by sharing Illinois' Minimum Viable Product ("MVP") materials, which included a draft project plan and roadmap specific to Illinois. The Illinois Medical Assistance Program staff also provided additional information and clarification to these submissions upon CMS' request.

13. On January 7, 2026, the Illinois Medical Assistance Program sent its project plan and roadmap to CMS with design, production, testing, and implementation details and timelines for system changes. On January 30, 2026, the Illinois Medical Assistance Program sent the completed MVP checklist to CMS. Additional information and details on the state implementation schedule were sent to CMS throughout May 2026. As of the date of this declaration, the Illinois Medical Assistance Program has received no comments or concerns from CMS regarding these submissions.

14. In a one-on-one meeting on May 11, 2026, senior CMS staff leadership inquired about our readiness to meet the January 1, 2027 implementation date, based on the previously submitted release schedule, to which Illinois Medical Assistance Program staff responded that design for the most significant eligibility system changes began in January 2026 and would continue through June 2026 to ensure adequate time for production, testing and implementation before January 1, 2027. CMS staff raised no additional concerns about the phased implementation schedule in this conversation.

15. In the same one-on-one meeting, and in subsequent bi-weekly meetings, CMS expressed urgency in having Illinois demonstrate the functionality of completed system changes for CMS staff.

16. At CMS' recommendation, Illinois Medical Assistance Program staff documented policy decisions and working assumptions for these system changes made from January 2026 through May 2026 to document the state's good faith effort to implement work requirements timely. These working assumptions were submitted to CMS on May 31, 2026.

17. These interactions, as well as remarks provided by CMS at conferences and other state meetings, represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, to aid in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Illinois has historically looked to CMS subregulatory guidance, including those methods noted above, to inform how we can comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

18. In keeping with past practice, HFS used the guidance shared by CMS on these regular calls, their communications in our one-on-one meetings, remarks in national meetings and

conferences, and their written materials concerning H.R. 1, to inform us of our implementation strategy. This guidance was consistent with the plain language of H.R. 1 itself, which HFS also used as the basis of our design and implementation to date.

19. Specifically, regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language regarding medical frailty. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

20. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate to the Illinois Medical Assistance Program that it would require medically frail individuals to have a "significant impairment" to their ability to comply with work requirements. Nor did CMS indicate that Illinois would need to verify that significant impairment when determining eligibility for the medical frailty exclusion.

21. Regarding the use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated during the community engagement workgroup call on March 27, 2026, that self-attestation would be an acceptable verification method when data was not available.

22. During the community engagement workgroup call on March 27, 2026, CMS reiterated that states may use auditable self-attestation in the absence of data to verify medical frailty. CMS specifically noted that states could use such an auditable self-attestation "*to confirm*

ongoing medical frailty" in addition to when a customer newly identifies as medically frail. CMS also noted that states should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate customers would be limited to only one self-attestation per enrollment period, even if they developed multiple and/or sequential medical frailty conditions.

23. On Friday, May 1, 2026, during the community engagement workgroup call, CMS presented a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with work requirements.

24. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

25. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to work requirements. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and/or are more restrictive than statutory language. To achieve compliance with the IFR, Illinois would have to reverse and rebuild significant system design, which will be costly, time consuming and could delay our ability to communicate the details of program changes to customers by August 31, 2026, and to implement before January 1, 2027. These provisions are also expected to cause significant harm to customers and to the Illinois Medical Assistance Program once implemented. These provisions include the following:

Medically Frail Definition Changes

26. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail"

individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with" the work requirements. 42 CFR § 435.554(c)(5)(i). This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance communicated to the Illinois Medical Assistance Program before the IFR was published, this includes the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

27. Because this requirement was unknown to Illinois until June 1, 2026, the extensive policy and system design undertaken prior to that date to meet statutory deadlines did not include it.

28. The IFR itself provides very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states would have discretion in clinical standards for verification of medical frailty, including using claim-based data, such as diagnosis codes, to verify whether an individual meets the medical frailty exemption. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a customer's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that

assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

29. Since the IFR's release, CMS has informed states on multiple occasions that it is developing significantly more guidance on the medically frail exclusion. However, as of the date of this declaration, this guidance has not yet been provided to the Illinois Medical Assistance Program.

Self-Attestation Changes

30. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 21-22, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with the work requirements. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for customers and difficult to implement.

31. Specifically, the IFR significantly limits customers' ability to self-attest to work requirement eligibility factors after January 1, 2028 by newly introducing the construct of a "period of enrollment" that can last several renewal cycles as long as the individual remains enrolled in Medicaid. The IFR limits self-attestation frequency to once in any customer's "period of enrollment."

32. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment," and Illinois's eligibility system is not designed to implement one and cannot be so designed without a significant

new level of effort from HFS staff and our eligibility system vendor. The "period of enrollment" concept is used in a way that hinders Illinois's operational ability to effectively and timely administer eligibility determinations for the Medicaid program, puts medically at-risk customers in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

33. Generally, a renewal of Medicaid eligibility involves a review of all eligibility factors. However, the IFR creates different sets of rules that Illinois must apply in conducting eligibility determinations related to the work requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the customers.

34. Prior to the IFR and its introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

35. Furthermore, the new requirements regarding the frequency of self-attestation, particularly as they relate to medical frailty, will likely create confusion around eligibility and compliance which can lead to disruptions in the continuity of care.

Data Integration Changes

36. The IFR places very broad requirements on states to identify reliable data sources for verifying work requirement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency

has access *or should have access*." 42 CFR § 435.557(a) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of work requirements, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this, and implementation in Illinois will impose operational challenges, risk our implementation schedule, and subject the state to additional cost.

Renewal Process Changes

37. The IFR lays out procedures for states to evaluate customer compliance with work requirements at renewal. However, these procedures will, in effect, deny customers the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

38. If a state cannot verify whether a customer is still eligible for Medicaid through its *ex parte* data sources, the state sends the customer a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a customer's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). Illinois sends renewals out 60 days before a customer's renewal is due. According to the IFR, if a state cannot *ex parte* verify compliance with work requirements, the state may either send "a notice of noncompliance" with this renewal form or as a follow-up after the customer returns the renewal form if the state still cannot verify work requirements compliance. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides customers with only 30 days to respond, after which the customer must be disenrolled if compliance with work requirements still cannot be verified. Social Security

Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "[s]tates must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412 (June 3, 2026).

39. The effect of this structure is that customers will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible customers.

Short-term Hardship Exception Changes

40. H.R. 1 allows states to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

41. The IFR provides that the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

42. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage,

likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other Changes

43. Several of the timelines set out in the IFR, including those for determining medical frailty and short-term hardships, do not take account of the fact that providers generally have 180 days to submit claims data. For determinations that are supposed to be made regarding the preceding year, the Illinois Medical Assistance Program may not have the most accurate and up-to-date claims data included in our system to process. Once again, the revised timelines associated with determining these exceptions will increase the risk of coverage loss for otherwise eligible individuals, particularly in light of the IFR's restrictions on self-attestation.

The Illinois Medical Assistance Program's Efforts to Implement Work Requirements Before and After the IFR Issued

44. Following the enactment of H.R. 1, the Illinois Medical Assistance Program recognized that it would be extraordinarily challenging to complete the necessary policy, system, and other process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation date. Given the short period of time afforded by H.R. 1 and the magnitude of changes needed to implement work requirements, along with other H.R. 1 mandated changes that impact the state's integrated eligibility and enrollment system, including changes to noncitizen eligibility, redetermination periods, retroactive coverage, and the SNAP program, the Illinois Medical Assistance Program began preparation to comply with work requirements immediately after the July 2025 passage of H.R. 1.

45. Moreover, the Illinois Medical Assistance Program is required by H.R. 1 to issue customer notices addressing the work requirements in H.R. 1 in August 2026. In order to meet this deadline, the Illinois Medical Assistance Program must have complete and accurate information

for inclusion in the notice by July 1, 2026. Case workers, call centers, and other state staff will need adequate time to train and be prepared to respond to customer and stakeholder inquiries after the notice is sent.

46. The Illinois Medical Assistance Program based its policy and system design on the statutory language and the guidance provided by CMS, as detailed above. Based on this guidance and in a good faith effort to meet the January 1, 2027 implementation deadline, the Illinois Medical Assistance Program has completed the following:

- Developed a project plan and roadmap detailing the technical buildout and timeline for our eligibility and enrollment system. The project plan and roadmap included a phased approach for design and development with the core design and build of the functionalities, as outlined in CMS' MVP checklist, scheduled for completion in the first half of calendar year 2026 to ensure adequate time for testing and implementation to enable full system deployment by January 1, 2027.
- Developed and shared with CMS a comprehensive release schedule encompassing all technical changes to its enrollment and eligibility system;
- Developed charters for each scheduled release that include detailed scopes of work and level of effort required by state agencies and the system vendors;
- Engaged in more than 60 design sessions and counting, making necessary policy and operational decisions based on existing guidance to ensure sufficient development, testing, and implementation time, including creating eligibility flows, processing logic, and language to program work requirements into the following:
  - Revised application (paper and online);
  - The work requirements screener;

- The client and caseworker portals;
- Eligibility determination logic and change in circumstances processes;
- *Ex parte* renewal logic;
- Six-month redetermination logic and processes;
- Verification logic and exemption assessment; and
- New and revised language for our notice of decision, redetermination forms, and request for additional verification notices, many others.

- Developed and launched a comprehensive customer and stakeholder engagement strategy. This engagement effort initiated broad communications with stakeholders to socialize H.R. 1 requirements and our working assumptions and progress, began development of customer centered tools for H.R. 1 requirements, and completed phase one of our customer outreach plan.
- Conducted comprehensive staffing assessments, including evaluation of health services caseworker hiring needs, staff training and other resources.
    - These assessments did not include the additional specialized staffing resources required to meet the new administrative burdens in the IFR due to the changes to medical frailty and self-attestation noted above.

47. With respect to implementing the medically frail exclusion in particular, the Illinois Medical Assistance Program has worked extensively with consultants, HFS' actuarial vendor, and internal claims systems personnel to build a process to verify an individual's "medical frailty." This process is built largely on existing claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

48. The Illinois Medical Assistance Program faces several urgent deadlines with respect to implementing work requirements. The Illinois Medical Assistance Program must apply work requirements to applications and renewals as of January 1, 2027. At this time, the Illinois Medical Assistance Program has very limited ability to make system changes outside of the current scope of work, which is based on the previous guidance. Any significant deviations from that previously provided guidance will require extensive policy and systems changes that jeopardize the state's ability to meet the January 1, 2027 deadline.

49. While the IFR signals a significant departure from this guidance, the Illinois Medical Assistance Program still lacks clarity on several crucial issues from the IFR. While the IFR says that the Illinois Medical Assistance Program will need to evaluate whether a customer's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how the Illinois Medical Assistance Program should determine this. While CMS has said more subregulatory guidance will be provided, the Illinois Medical Assistance Program is finalizing its eligibility systems and processes now, without knowing what this future guidance is—bearing the risk that the *future* guidance will also conflict with the systems changes already in place.

50. This lack of clarity impacts not only the administration of the Illinois Medical Assistance Program, but also the information that the Illinois Medical Assistance Program can provide its customers, stakeholders, and staff: if the Illinois Medical Assistance Program does not understand what it means for a medical condition to "significantly impair" a customer's ability to work, it cannot educate its customers about how to demonstrate compliance with this requirement, nor train its caseworkers and other staff responsible for processing applications and redeterminations in compliance with the new guidelines.

51. Finally, the IFR does not clarify which data nor which data sources will be considered adequate to support a determination of significant impairment sufficient to build an *ex parte* verification process within our claims system and integrate those verifications into individual cases in our eligibility and enrollment system. The Illinois Medical Assistance Program requires clarity on these issues in order to implement work requirements in a timely fashion and to ensure that its customers are prepared for this implementation.

52. Of note, the consequences for the Illinois Medical Assistance Program building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If the Illinois Medical Assistance Program is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on work requirements is making it harder for Illinois to comply.

Human Costs of Work Requirements, Made Worse By the IFR

53. The purpose of the ACA was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the work requirements included in H.R. 1 are expected to result in large-scale disenrollment of customers, including customers who are eligible but unable to verify their eligibility in a manner that satisfies the stringent requirements in H.R. 1.

54. Illinois studies conducted before the IFR was released suggest that (1) approximately 330,000 individuals or 50% of the Illinois Medical Assistance Program's ACA Adult Eligibility Group could be disenrolled at some point due to the combination of work

requirements and six-month redeterminations (a provision of H.R. 1 that requires ACA Adult Eligibility Group customers' eligibility to be reevaluated every six months), and (2) Illinois uninsured rates could grow from approximately 6% of the state's population to over 14%, reflective of pre-ACA uninsured levels. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, there will be significant additional detrimental impacts that cannot be fully estimated at this time.

55. Indeed, the Illinois Medical Assistance Program expects the "significant impairment" requirement to result in more customers losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired.

56. The "significant impairment" requirement will also likely increase customer confusion. The Illinois Medical Assistance Program customers may think they do not qualify as "medically frail," given the added complexity, and the Illinois Medical Assistance Program may see an increase in non-responses from customers and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people the Illinois Medical Assistance Program can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code or claims data, but also other and as yet unidentified data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing customers. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, customers with complex medical conditions

can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

57. Customers with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to the Illinois Medical Assistance Program sicker and costlier due to the loss of health coverage and inability to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for the Illinois Medical Assistance Program and decreases the health and quality of life of customers.

58. The Illinois Medical Assistance Program expects the IFR's limitations on self-attestation to increase customer confusion and coverage loss as well. In the Illinois Medical Assistance Program's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible customers. Thus, as the use of self-attestation becomes more restricted, the Illinois Medical Assistance Program expects that more customers who are indeed eligible will be disenrolled due to barriers created by the new requirements.

59. The Illinois Medical Assistance Program also expects the "once per enrollment period" limitation on medical frailty self-attestations to be particularly harmful to customers with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a customer could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in the Illinois Medical Assistance Program) suffer from a new condition that takes time to be diagnosed and have associated claims. Under the IFR, assuming continuous Medicaid coverage during that period, the customer *could not* self-attest to

medical frailty based on the new condition and thus could lose coverage if they could not obtain adequate documentation for this diagnosis.

60. The Illinois Medical Assistance Program is statutorily required to provide notice to customers regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, the Illinois Medical Assistance Program is uncertain as to how, for example, a customer might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to customers how they can comply with the new requirements.

61. The Illinois Medical Assistance Program has spent years conducting outreach and building relationships with Illinois Medical Assistance Program customers. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Customers who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Illinois

Burdens on the Illinois Medical Assistance Program

62. Because CMS had never before imposed work requirements across eligibility categories, the Illinois Medical Assistance Program's eligibility and enrollment system was not built to support work requirements and is not easily configured to incorporate the numerous changes necessary to administer a work requirements program.

63. The State of Illinois operates within a July 1 – June 30 fiscal year, which required the passage of a fiscal year budget for 2027 by the Illinois State Legislature in advance of May 31, 2026, the end of our annual legislative session. For fiscal year 2027, HFS requested state

appropriations to fund additional system enhancements, additional headcount, and customer outreach and communication resources based on operating assumptions that stemmed from H.R. 1's statutory requirements, as well as information and guidance we received from CMS staff in writing and orally in both public and one-on-one meeting settings. At the time the state budget was passed, HFS could not anticipate the increased appropriations for additional programming and specialized staffing that would be required to implement the significant and surprising new requirements presented in the IFR, thus exacerbating the budget impact on the State.

64. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—would require the Illinois Medical Assistance Program to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, the Illinois Medical Assistance Program may need to integrate new data sources to evaluate customers' eligibility for the medical frailty exclusion, which will add development costs, as well as potential costs associated with accessing new data. Making such substantive changes puts our implementation schedule at grave risk.

65. Post implementation, as more individuals are impacted and denied coverage or disenrolled as a result of this requirement, the Illinois Medical Assistance Program expects more calls, more documents to process, and more appeals of adverse actions. These increased burdens on our staff and systems will demand additional caseworker, policy, and appeals staff resources and the need for ongoing and costly system updates.

66. Finally, in addition to the costs of operationalizing this new requirement, the Illinois Medical Assistance Program will also incur the cost of educating its customers, staff, and other stakeholders about what the requirement means and how it can be met. State caseworkers do not

have the qualifications nor expertise necessary to evaluate medical records. The Illinois Medical Assistance Program will incur additional costs in the training and hiring of staff with clinical expertise to perform these evaluations, as well as implementing systems changes to be able to accept this required documentation.

67. The Illinois Medical Assistance Program also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train caseworkers, staff, vendors, enrollment assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, the Illinois Medical Assistance Program expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals.

Burdens on Illinois

68. The burdens from work requirements imposed by H.R. 1 and made worse by the IFR fall not just on the Illinois Medical Assistance Program, but on Illinois more generally. As noted above, the Illinois Medical Assistance Program customers will likely face increased denials and disenrollments with the IFR likely disproportionately impacting customers with disabilities and chronic health conditions who are enrolled in the ACA Adult Eligibility Group and unable to verify the "significant impairment" requirement for medical frailty. As the uninsured rate increases, there will likely be a greater strain on providers – in particular, rural, community, and safety net hospitals as well as community health centers – that could be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from the Illinois Medical Assistance Program will likely lose access to primary and preventive care, resulting in more individuals seeking high-cost, emergency care. Most importantly, the Illinois

Medical Assistance Program expects poorer health outcomes across Illinois, as fewer people will be able to access appropriate care and manage chronic conditions.

69. In addition, the Illinois Medical Assistance Program expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations on medical frailty self-attestation—will place a significant administrative strain on healthcare providers and Illinois human services staff. In order to support members seeking medical frailty exemptions, providers may need to devote uncompensated time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase their administrative strain adding to healthcare costs and impacting access to care.

70. As noted above, the Illinois Medical Assistance Program will need to create an appropriately staffed infrastructure for the medical frailty evaluation and make eligibility system updates to accept customer and provider submitted content, which HFS neither contemplated prior to the IFR nor budgeted for.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Katherine Yager
Administrator of Medical Eligibility
Illinois Department of Healthcare and Family Services

EXHIBIT 8

DECLARATION OF LISA LEE

I, Lisa Lee, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the Commonwealth of Kentucky. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Commissioner of the Kentucky Department for Medicaid Services of information and records gathered by our agency and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Kentucky State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Kentucky as the Department for Medicaid Services or DMS).

3. DMS is the single state agency responsible for administering the Medicaid program. Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Medicaid's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Medicaid's mission is to provide comprehensive healthcare coverage for a wide range of services, including, but not limited to: primary care; hospitalization; laboratory tests; x-rays; prescriptions; mental health care, including substance use disorder or addiction treatment; dental care; hearing care; vision care; and preventive screenings for Kentucky's residents who need this coverage.

4. DMS insures approximately 1,436,949 million Kentucky residents, providing health coverage to children, families, and older adults, including some of the most vulnerable

residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Kentucky administers the Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Kentucky Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers a percentage of Kentucky's expenditures on eligible enrollees. The current blended FFP across all populations for Kentucky is approximately 80% federal and 20% state.

Medicaid Expansion in Kentucky

6. On January 1, 2014, Kentucky implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Kentucky Medicaid program.

7. Enrollees in Kentucky's Medicaid Expansion program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Kentucky's Medicaid Expansion program requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of June 22, 2026 approximately 443,570 of Kentucky's Medicaid program members are enrolled in Medicaid Expansion. For the current state fiscal year 2026, approximately $6.5 billion (32%) of Kentucky Medicaid's budget is spent on Medicaid Expansion members. Of this amount, 90% is funded by federal dollars.

CMS's Pre-IFR Guidance to Kentucky

9. Me and my staff at DMS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, DMS does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since enactment of H.R. 1, my staff and I have been developing and designing a system to support work and community engagement requirements for Medicaid Expansion members based on preliminary information and informal communications from CMS, pending the issuance of formal federal guidance.

CMS Issues the Interim Final Rule

12. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions will also be very challenging and costly for DMS to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and DMS once they are implemented. These provisions include the following:

- The medical frailty provisions contained in the federal final rule differ significantly from the preliminary information and informal communications that Kentucky had previously received from CMS. The final rule establishes more prescriptive requirements for identifying, evaluating, documenting, and maintaining medical

frailty exemptions than Kentucky anticipated during our initial planning efforts. As a result, the Department must reassess system designs, operational workflows, staffing models, and member communication strategies to ensure compliance with the finalized federal requirements.

- From an administrative perspective, the final rule will increase implementation and ongoing operational costs for Kentucky Medicaid. DMS will need to develop new screening and assessment processes, modify eligibility and case management systems, train staff, coordinate with managed care organizations and providers, establish appeal and review procedures, and maintain documentation demonstrating compliance with federal standards. These activities require significant information technology investments and additional administrative resources that were not fully contemplated under earlier planning assumptions.
- The requirements will likely also create challenges for Medicaid members. Individuals seeking a medical frailty exemption may be required to navigate additional documentation, verification, and reporting processes, which can be particularly difficult for individuals with serious physical health conditions, behavioral health conditions, cognitive impairments, substance use disorders, unstable housing, or limited access to healthcare providers. Increased administrative complexity can lead to confusion, delays in obtaining exemptions, and a greater risk that eligible individuals may experience interruptions in coverage if they are unable to successfully complete the required processes.
- The final rule's treatment of educational activities differs from the assumptions Kentucky Medicaid had been using during implementation planning. Based on

prior discussions and available information, DMS anticipated having greater flexibility in recognizing a broad range of educational pursuits as qualifying community engagement activities. However, the Interim Final Rule appears to define educational programs more narrowly, focusing on high school completion, GED programs, and traditional post-secondary education, such as two-year and four-year degree programs and community, technical, or career institutions.

- This narrower interpretation raises questions regarding whether graduate and professional education programs qualify as educational activities for purposes of meeting community engagement requirements. Excluding graduate-level education would create an inconsistency in policy, as individuals pursuing advanced degrees are engaged in rigorous educational activities specifically designed to improve workforce participation, increase earning potential, and address critical workforce shortages, including in healthcare, education, and other high-demand fields.
- From an administrative perspective, a narrower definition would require Kentucky Medicaid to develop additional eligibility and verification processes to distinguish between qualifying and non-qualifying educational programs. This increases operational complexity, requires modifications to eligibility systems and member guidance materials, and may create confusion among beneficiaries attempting to comply with community engagement requirements.
- For Medicaid members, the distinction may be difficult to understand and could result in individuals enrolled in graduate or professional programs being subject to work requirements despite actively participating in educational activities that support long-term economic self-sufficiency. Allowing graduate school to qualify

as an educational activity would better align with the underlying goals of community engagement, reduce administrative burden on the state, and provide clearer, more equitable treatment of individuals pursuing advanced education.

- The final rule's application of community engagement verification requirements to individuals receiving presumptive eligibility (PE) is particularly concerning because it does not adequately account for the temporary and preliminary nature of PE determinations. PE is designed to provide short-term access to healthcare services while a full Medicaid eligibility determination is completed. At the time PE is granted, the state has not yet completed all eligibility verifications and, in many cases, cannot determine with certainty whether an individual will ultimately qualify for Medicaid, let alone whether they will be enrolled in the expansion population subject to community engagement requirements.
- Requiring individuals receiving PE to demonstrate compliance with work and community engagement requirements is therefore neither practical nor operationally efficient. Kentucky Medicaid would be required to establish verification processes for individuals whose coverage may last only a matter of weeks and who may ultimately be determined ineligible for Medicaid or eligible under a coverage category exempt from community engagement requirements. This would require significant investments in systems, staffing, training, and administrative oversight to track and verify activities for individuals who may never become subject to the requirements.
- The IRF also creates unnecessary burden for applicants. Individuals seeking PE are often experiencing immediate healthcare needs and are focused on obtaining access

to medical services. Requiring these individuals to navigate community engagement reporting or verification processes before a final eligibility determination has been completed may create confusion, discourage participation, and delay access to needed care. The result is additional administrative complexity for Kentucky Medicaid and beneficiaries without a corresponding program integrity benefit.

The Kentucky Department for Medicaid Service's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

13. Following the enactment of H.R. 1, Kentucky DMS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, after H.R. 1 was passed in July 2025, DMS began work to prepare to comply with community engagement requirements.

14. Beginning in November 2025 and continuing until the release of the IFR, DMS based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, DMS has already done the following:

- Since the enactment of H.R. 1, Kentucky has undertaken substantial planning and implementation activities to prepare for the community engagement requirements applicable to Medicaid expansion members. These efforts began immediately following enactment and were based on the statutory requirements and the information available from CMS at the time. The Commonwealth has devoted significant staff time and resources across policy, eligibility, operations,

information technology, legal, communications, and program integrity functions to ensure timely compliance with federal requirements.

- Kentucky has initiated extensive modifications to its Integrated Eligibility and Enrollment System (IEES) to support the identification, tracking, administration, and reporting of community engagement requirements. These system changes include the development of functionality to identify individuals potentially subject to the requirements, capture exemption information, track compliance activities, support eligibility determinations related to community engagement, and facilitate required reporting and oversight activities. In addition, the Commonwealth has evaluated and begun modifying system interfaces and data-sharing processes necessary to support verification and compliance monitoring.
- The Commonwealth has also undertaken significant planning related to beneficiary communications and outreach. Draft member notices, educational materials, correspondence templates, and operational guidance have been developed to inform beneficiaries of their rights and responsibilities under the new requirements. These materials are intended to ensure members understand who is subject to community engagement requirements, available exemptions, reporting obligations, and the consequences of noncompliance. Kentucky has also begun preparing training materials and operational procedures for eligibility staff, call center personnel, managed care organizations, and other partners responsible for assisting members.
- Recognizing the importance of stakeholder input, Kentucky has conducted outreach and engagement activities with providers, managed care organizations, advocacy organizations, beneficiary representatives, and other interested parties to discuss

implementation considerations and identify potential operational challenges. These discussions have informed system design decisions, member communication strategies, and implementation planning efforts.

- The Commonwealth has further dedicated resources to policy development, legal analysis, business process redesign, project management, and operational readiness activities. These efforts have included assessing federal requirements, developing implementation timelines, identifying necessary system enhancements, evaluating staffing and training needs, and coordinating across multiple state agencies and contractors.

15. DMS faces several urgent deadlines with respect to implementing community engagement requirements. DMS must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this DMS must substantially finalize eligibility system requirements by July 1, 2026, in order to enable full system deployment, with appropriate testing, in October and November of 2026. After August 15, 2026, DMS will only have limited ability to make further system changes for use by January 1, 2027. Moreover, DMS is required by H.R. 1 to issue notices in July of 2026 addressing the changes occasioned by the IFR.

16. Of note, the consequences for Kentucky DMS from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If Kentucky DMS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear

and timely guidance on community engagement requirements is making it harder for Kentucky and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

17. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost.

18. Based on my professional experience, I believe that the requirements of IFR will harm the Commonwealth of Kentucky by creating a significant chilling effect that will result in individuals foregoing benefits for which they are eligible or seeking to disenroll themselves and their families from Kentucky Medicaid. Some people will also avoid critical preventative care and necessary medical treatment, and in some cases may even avoid emergency medical services, possibly resulting in death or serious injury.

19. This will also likely increase the risk of adverse health impacts for people in Kentucky. Deferring care can result in late-stage disease detection, unintended pregnancy, adverse health effects during pregnancy and childbirth, overdose, and increased morbidity and mortality for late-stage disease. Decreased access to prenatal care will lead to increased rates of premature births, low birth weight infants, and congenital defects.

20. These adverse health impacts will further strain scarce resources, negatively impact the budgeting assumptions underlying a managed care-dominant Medicaid program, and create worse health outcomes for Kentucky Medicaid members. For example, effective prenatal care lowers risks of premature births and NICU stays—each more expensive per capita. Managing chronic conditions (e.g., diabetes, hypertension) early and providing high quality preventive care can prevent expensive hospitalizations and more expensive episodes of care. Without Medicaid

coverage, these costs fall on state healthcare systems, community health centers, and local public health funds, undermining the cost-savings that Medicaid normally delivers. To the extent the treatment is left uncompensated, the cost of which will ultimately be shifted to the broader healthcare delivery system and the state.

Administrative, Operational, and Financial Burdens on Kentucky

Burdens on Kentucky DMS

21. Because CMS had never before imposed community engagement requirements across eligibility categories, DMS's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. Kentucky has requested $18.4 million and has spent $517,804, to date.

22. Implementation of Medicaid work and community engagement requirements imposes substantial administrative, operational, technological, and financial burdens on state Medicaid agencies. Unlike traditional eligibility determinations, community engagement requirements require ongoing monitoring, verification, exemption determinations, beneficiary education, and compliance tracking for a large population of members whose circumstances may change frequently.

Key administrative burdens include:

Information Technology and Systems Changes

- Modifying eligibility and enrollment systems to identify individuals subject to the requirements.
- Developing functionality to track participation hours, exemptions, good-cause exceptions, and compliance status.

- Creating interfaces with external data sources used to verify employment, education, training, volunteer activities, and other qualifying activities.
- Programming notices, alerts, workflows, reporting functions, and adverse action processes.
- Conducting testing, quality assurance, and ongoing system maintenance.

Eligibility and Case Management Operations

- Determining which beneficiaries are subject to community engagement requirements.
- Evaluating and processing exemption requests, including medical frailty determinations and other statutory exemptions.
- Reviewing and documenting good-cause exceptions.
- Monitoring compliance on an ongoing basis.
- Processing changes in circumstances that affect compliance status.
- Conducting eligibility redeterminations and coverage actions related to noncompliance.

Verification and Documentation Requirements

- Collecting and reviewing documentation from beneficiaries.
- Verifying employment, educational participation, volunteer activities, caregiving responsibilities, and other qualifying activities.
- Resolving discrepancies between self-attestation and third-party data sources.
- Maintaining documentation sufficient to satisfy federal oversight and audit requirements.

Member Communications and Education

- Developing and distributing beneficiary notices explaining requirements and exemptions.
- Updating websites, member handbooks, FAQs, and educational materials.
- Responding to beneficiary inquiries through call centers and eligibility workers.

- Conducting outreach to ensure beneficiaries understand reporting obligations and deadlines.

Staffing and Training

- Training eligibility workers, supervisors, call center staff, managed care organizations, and contractors.
- Developing policies, procedures, manuals, and job aids.
- Hiring or reallocating staff to manage increased workloads associated with verification, exemptions, appeals, and compliance monitoring.
- Providing ongoing training as federal guidance evolves.

Appeals, Fair Hearings, and Due Process

- Processing appeals related to exemption determinations and compliance findings.
- Preparing documentation and evidence for administrative hearings.
- Responding to beneficiary challenges and requests for reconsideration.
- Ensuring compliance with federal notice and due process requirements.

Managed Care Coordination

- Coordinating implementation activities with managed care organizations.
- Establishing data-sharing protocols and reporting requirements.
- Training managed care partners regarding beneficiary outreach and support responsibilities.
- Monitoring contractor performance and compliance.

Federal Reporting and Oversight

- Producing reports required by CMS.
- Responding to federal audits, reviews, and monitoring activities.

- Maintaining documentation demonstrating compliance with federal requirements.
- Tracking program outcomes and performance measures.

Project Management and Governance

- Coordinating implementation across multiple state agencies, contractors, and stakeholders.
- Managing information technology projects, procurement activities, and vendor contracts.
- Monitoring implementation timelines and regulatory compliance.
- Updating policies and procedures in response to new federal guidance.

Collectively, these requirements represent a significant expansion of Medicaid administrative responsibilities. They require substantial investments in technology, staffing, training, communications, and operational infrastructure that extend well beyond traditional Medicaid eligibility administration. The burden is particularly significant because compliance must be monitored continuously, exemptions must be evaluated on an ongoing basis, and beneficiary circumstances often change from month to month, requiring repeated review and verification activities.

Burdens on Kentucky

23. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on DMS, but on Kentucky in general.

24. These negative health outcomes will also harm the overall health of all residents, by both straining Kentucky's healthcare delivery system as well as by increasing the potential risks of the spread of infection and illness.

25. Community-wide health suffers when individuals avoid care. The healthcare system will be overload in emergency departments and public clinics. There will be a rising disease

transmission risks, particularly for conditions detectable via routine screening as well as delays in addressing infectious outbreaks, due to underutilized testing and treatment services.

26. Hospitals are legally obligated to treat patients regardless of their ability to pay for emergency medical care. When individuals receive care at hospitals and cannot pay or refuse to enroll in Medicaid given the chilling effect of federal policies, the uncompensated care costs are pushed onto hospitals already operating on slim margins, potentially impacting service capacity and resulting in budget cuts, staffing reductions, and increased service costs for all individuals receiving care at the facility.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Lisa Lee, Commissioner
Kentucky Department of Medicaid Services

EXHIBIT 9

DECLARATION OF IAN YAFFE

I, Ian Yaffe, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Maine. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Director of the Office for Family Independence (OFI) within the Maine Department of Health and Human Services (DHHS) and information provided by agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director of OFI, which oversees eligibility for and enrollment in Maine's Medicaid program and Children's Health Insurance Program (CHIP), both of which are collectively referred to as "MaineCare."

3. Maine DHHS is the single state agency responsible for administering MaineCare. MaineCare provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. MaineCare's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. MaineCare's mission is to help to ensure that all Maine people are able to access the critical health services, both preventative and emergency, that help them stay healthy and safe.

4. MaineCare insures approximately 385,000 people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Maine administers the MaineCare program pursuant to federal law and regulations, as well as the terms of its federally approved State Plans and waivers under Section 1115 and Section 1915(c). MaineCare receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 66% of MaineCare's expenditures on eligible enrollees.

Medicaid Expansion in Maine

6. In January 2019, Maine implemented Medicaid expansion under the Affordable Care Act (the "ACA"), with retroactive State Plan Amendment (SPA) approval to July 2018. This expansion, hereafter referred to as MaineCare Expansion, extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level.

7. Enrollees in MaineCare Expansion receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for MaineCare Expansion requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; (3) have household income less than or equal to 133% of the Federal Poverty Level, and (4) be not otherwise eligible for or enrolled in mandatory MaineCare coverage.

8. As of March 2026, approximately 79,000 or 21% of MaineCare members are enrolled in MaineCare through MaineCare Expansion. For the current state fiscal year 2026, approximately $679 million in federal Medicaid funding comes from the FFP related to MaineCare Expansion members.

CMS's Pre-IFR Guidance to Maine

9. I and staff across Maine DHHS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, MaineCare does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Maine relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-

attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

19. In response to this and concerns that CMS would change its policy direction related to community engagement, MaineCare sent a letter to CMS on May 29, 2026, conveying MaineCare's concerns with limiting the definition of medically frail and the use of self-attestation. This letter is attached as Exhibit A.

CMS Issues the Interim Final Rule

20. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for MaineCare to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and MaineCare once implemented. These provisions include the following:

Medically Frail Definition

21. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition

significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

22. This "significant impairment" requirement does not exist in the text of Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

23. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

24. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June

3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

25. Furthermore, one of the five categories enumerated in H.R. 1 that can be met to qualify for the medically frail exclusion is an individual "with a substance use disorder." As with the other categories under medical frailty, the statute does not condition this exclusion on a determination that the individual is functionally unable to work. The IFR further limits this exception for individuals with a substance use disorder to exclude individuals "in stable recovery (which means, an individual who is in recovery for 5 or more years)." The text of the statute does not establish any time limit for individuals with substance use disorder and adding this additional limitation establishes significant operational and analytic burdens to the requirement that OFI automate the exception process using existing data whenever possible.

26. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided as of the date of this declaration.

Self-Attestation

27. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

28. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

29. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

30. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

31. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (*e.g.,* Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously

submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

32. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

33. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

34. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-

centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

35. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

36. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

37. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

38. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

39. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

40. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

41. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. For determinations that are supposed to be made

regarding the preceding year, MaineCare may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

MaineCare's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

42. Following the enactment of H.R. 1, OFI recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, OFI began work to prepare to comply with community engagement requirements.

43. Beginning in July 2025 and continuing until the release of the IFR, Maine based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, MaineCare has already done the following:

- Statutory analysis
- Impact estimates
- Policy rules development
- System specifications, design, and building with vendor
- Personnel planning and allocation, including legislative approval, for permanent staff; hiring of temporary staff
- Ongoing leadership planning
- Drafting application questions
- Developing communication plans, including gathering feedback from a sample of MaineCare clients, in partnership with a contracted vendor

- Partner communications
- Staff training plans
- Drafting noticing language and other communications
- Data vendor planning and exploration of data connections and agreements
- Extensive medical frailty code development
- Vendor contract extension for business technology needs
- Contracting vendor for policy and project management needs

44. With respect to implementing the medically frail exclusion in particular, Maine has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This developing system is based on both claims data and/or electronic health records, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

45. OFI faces several urgent deadlines with respect to implementing community engagement requirements. MaineCare must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, MaineCare must substantially finalize eligibility system requirements by July 24, 2026, in order to enable full system deployment, with appropriate testing, on November 13, 2026. After July 24, 2026, MaineCare will only have limited ability to make further system changes for use by January 1, 2027. Moreover, OFI is required to send initial outreach notices to MaineCare members that may be subject to Community Engagement Requirements in September 2026. These notices must contain information about how to comply with the requirements, including an explanation of the exceptions under section 1902(xx), and the consequences of noncompliance, among other items

mandated by the IFR and H.R. 1. In order to issue these notices in September 2026, Maine needs to finalize the content of these notices by July 31, 2026 so that there is enough time to deploy the letters in OFI's technology system (which typically takes at least one month) and allow sufficient time for the letters to be processed by the state's print and postal service since there is already a high volume of notices that are sent out between September and October each year.

46. Nevertheless, Maine still lacks clarity on several crucial issues from the IFR. While the IFR says that Maine will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how Maine DHHS should determine this. While CMS has said more subregulatory guidance will be provided, OFI must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only Maine DHHS, but also the messages that MaineCare can provide its members: if MaineCare does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources OFI is required to have integrated as of January 1, 2027, and which can be integrated later or with or without a waiver. OFI requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

47. CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Maine and other states to comply at the same time that financial consequences for not complying with guidance are rising. If Maine is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's

eventual guidance, it could face negative audit findings and significant financial penalties under Section 71106.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

48. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

49. Prior to the IFR being issued, Maine DHHS estimated that at least 39% of MaineCare Expansion members will be at high risk of disenrollment due to community engagement requirements. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

50. OFI expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. MaineCare members may think they do not qualify as "medically frail," given the added complexity, and MaineCare may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people MaineCare can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not

just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

51. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to MaineCare sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for Maine DHHS and decreases quality of care for members.

52. OFI expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In OFI's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, OFI expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

53. OFI also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in MaineCare) experience debilitating anxiety. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical

frailty based on debilitating anxiety and thus could lose coverage if they could not obtain documentation for this diagnosis.

54. OFI is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, OFI is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

55. Maine DHHS has spent years conducting outreach and building relationships with MaineCare enrollees. Confusion over eligibility determinations risks harming those relationships and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Maine

Burdens on MaineCare

56. Because CMS had never before imposed community engagement requirements across eligibility categories, OFI's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. Approximately $10.4M funds have already been allocated for various staff, contractor, and system needs for HR1 implementation. The newly released IFR would require more funds for business technology vendor contracts to update the technology build; staffing and existing staff time to interpret increased medical documentation tying medical frailty to community engagement compliance, and more communications funds to explain the increasingly complex rule.

57. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require OFI to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, Maine DHHS may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, OFI expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, Maine DHHS will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

58. OFI also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, OFI expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Maine

59. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on Maine DHHS, but on Maine more generally. As noted above, MaineCare members will likely face increased denials and disenrollments—and, due to the

"significant impairment" requirement for medical frailty, many of those disenrollments could be of some of MaineCare's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from MaineCare will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care, and requiring inpatient hospitalization. In addition, the lack of preventive care will result in increased communicable disease outbreaks and more strain on MaineCare. Most importantly, MaineCare expects poorer health outcomes across the Maine, as fewer people will be able to access appropriate care and manage chronic conditions.

60. In addition, Maine DHHS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on healthcare providers delivering care. In order to support members seeking medical frailty exemptions, providers will require training in the assessment of ability to work, and would need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026, in South Portland, Maine.

Ian Yaffe
Director, Office for Family Independence

Exhibit A

From: Probert, Michelle
Sent: Friday, May 29, 2026 11:34 AM
To: Brillman, Dan (CMS/CMCS) <daniel.brillman@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <annemarie.costello@cms.hhs.gov>; Gagne-Holmes, Sara <Sara.Gagne-Holmes@maine.gov>; Hamm, Bethany L <Bethany.L.Hamm@maine.gov>; Yaffe, Ian <Ian.Yaffe@maine.gov>
Subject: Potential Community Engagement Policy Changes

Dear Dan,

Thank you, and the broader CMS team, for the sustained engagement with states on implementation of work and community engagement requirements. I write because we understand the interim final rule may include policy positions that depart significantly from the guidance CMS has provided over the past several months, and that would directly undermine implementation choices Maine has already made in reliance on that guidance. Specifically, we understand CMS may be considering: (1) reinterpreting the medical frailty exemption under Section 1902(xx)(9)(A)(i)(V) of the Social Security Act to impose an ability to work standard; and (2) eliminating or restricting self-attestation as a permissible verification pathway. We are writing to share our concerns on both approaches.

Medical Frailty. On medical frailty, the statutory text does not support the interpretation under consideration. Section 1902(xx)(9)(A)(i)(V) defines medical frailty through clinical categories: serious or complex medical conditions, substance use disorders, disabling mental health disorders, and disabilities. Congress did not condition that exemption on a determination that the individual is functionally unable to work. Tying an ability to work standard onto the statute would be a material departure from the plain language of H.R. 1.
As you know, H.R. 1 requires that states use data, such as claims data, to identify medically frail individuals. Those data sources describe clinical condition and treatment history; they say nothing about an individual's capacity for employment. A work standard would render the statutory data-driven verification model unworkable in Maine. Importantly, it converts what Congress designed as an automated, code-based determination into a document-intensive process requiring providers or eligibility workers to make employability judgements. Maine's eligibility infrastructure, including the systems and workflow builds currently underway, is premised on the automated, data-driven model CMS has described in its verbal guidance. We have no workable path to operationalize a provider certification or employability determination model by January 1, 2027.

Self-Attestation. Further, on self-attestation, the statutory basis is equally clear. Section 1902(xx)(3)(A) expressly permits states to elect not to require verification of information that results in an exemption from work or community engagement requirements. CMS's Minimum Viable Product guidance issued in December 2025 extended that flexibility to compliance and exemptions for 2027 where data are unavailable, and Maine incorporated that framework directly into its verification strategy and system design. A rule foreclosing self-attestation would conflict not only with the statute but with the tiered verification framework codified at 42 C.F.R. § 435.952, which has long recognized self-attestation as a permissible pathway across Medicaid eligibility criteria.
Maine's implementation timeline leaves no room to absorb a reversal of this kind. A shift away from the data-driven and self-attestation approaches that CMS has communicated would require Maine to re-evaluate in-progress system builds, develop new provider certification and documentation standards, redesign eligibility determination logic, retrain and hire additional eligibility and call center staff, including staff with the clinical knowledge necessary for determining the adequacy of documentation, and revise member notices, all on a timeline that does not permit it. Maine may need to consider submitting a good faith waiver if there is a material departure in the interim final rule from the approaches CMS has communicated to states.

Maine respectfully requests written confirmation from CMS of its intended approach on both the medical frailty and self-attestation questions prior to issuance of the interim final rule, and strongly urges CMS to adopt the approaches it has communicated verbally over the past several months. Maine remains committed to good faith implementation and requests the policy clarity necessary to do so in a manner consistent with both the statute and the implementation commitments the State has already made.

Sincerely,

Michelle Probert

MaineCare
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EXHIBIT 10

DECLARATION OF PERRIE BRISKIN

I, Perrie Briskin, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Maryland. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Secretary for Healthcare Financing and Medicaid Director of information and records gathered by the Maryland Department of Health ("MDH" or the "Department") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Maryland State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Maryland as the "Maryland Medical Assistance Program" or "Maryland Medicaid").

3. MDH is the single state agency responsible for administering Maryland Medicaid. Maryland Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Maryland Medicaid's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Maryland Medicaid's mission is to improve the overall health of the state's residents by promoting affordable access to medically necessary care.

4. Maryland Medicaid insures approximately 1.5 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Maryland administers its Medicaid Program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Maryland Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP).Relevant here, the FFP, or the share of federal Medicaid funding, for those covered under the Affordable Care Act expansion is 90 percent.

Medicaid Expansion in Maryland

6. On January 1, 2014, Maryland implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level, which, after applying the adjustment required in 42 U.S.C. § 1396a(e)(14)(I), results in an effective upper income threshold of 138% of the Federal Poverty Level.

7. Enrollees in Maryland Medicaid's ACA expansion receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Maryland's ACA expansion requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 138% of the Federal Poverty Level.

8. As of May 31, 2026, approximately 318,000 people—or 22% of Maryland Medicaid's enrollees—are enrolled in Maryland Medicaid's ACA expansion group. For the ACA expansion group, Maryland Medicaid receives a 90 percent federal match on funding. Due to this high federal match for the ACA expansion group, in the current state fiscal year 2026, more than 40 percent of Maryland Medicaid's overall federal Medicaid funding comes from the FFP for Medicaid ACA expansion members.

CMS's Pre-IFR Guidance to Maryland

9. I and my staff at Maryland Medicaid have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Maryland Medicaid does not have in place systems by which to verify work, volunteer, or other community engagement activities, in order to verify eligibility.

11. Since November 2025, CMS has been providing guidance on its expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Maryland relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws,

implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. Maryland likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty

at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for Maryland Medicaid to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and Maryland Medicaid once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition

significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June

3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, as of June 22, 2026, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. The IFR does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is

introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period

and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high

unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months from the date of service to submit claims data. For determinations that are supposed to be made regarding the preceding year, Maryland Medicaid may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

Maryland Medicaid's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, Maryland Medicaid recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period

of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, Maryland began work to prepare to comply with community engagement requirements.

41. Beginning in July 2025 and continuing until the release of the IFR, Maryland Medicaid based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, Maryland Medicaid has already done the following:

- Established leadership workgroup teams with sister state agencies, including Maryland Health Benefits Exchange ("MHBE") and the Department of Human Services ("DHS");
- Conducted a full statutory analysis to evaluate changes needed to state processes and systems;
- Allocated personnel to work on H.R. 1 on a full-time basis;
- Created policy, systems, communications, and workforce plans;
- Developed a budget for H.R. 1 implementation;
- Created a staffing proposal for H.R. 1 implementation;
- Developed a definition of medical frailty in accordance with earlier CMS guidance released prior to the IFR;
- Initiated work with the State Health Information Exchange, CRISP, to facilitate a real time Application Programming Interface ("API") to allow *ex parte* verification of medical frailty on the basis of the medical frailty definition developed as described above;

- Engaged in contract negotiations to establish data linkages to enhance income data through Equifax and access student enrollment data available through the National Student Clearinghouse;
- Established discussions with Maryland Department of Labor ("DLR") on available data for work training programs and barriers to data exchange due to Family Educational Rights and Privacy Act ("FERPA") restrictions;
- Developed and released a consumer and provider facing communications plan to alert individuals about coming H.R. 1 changes;
- Established a self-screening tool to support enrollees and prospective applicants in self-identifying whether they may be subject to work requirements; and
- Sought authorization for federal funding through a Community Engagement Advanced Planning Document.

42. With respect to implementing the medically frail exclusion in particular, Maryland Medicaid has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data."

43. Maryland Medicaid faces several urgent deadlines with respect to implementing community engagement requirements. Maryland Medicaid must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, Maryland Medicaid must substantially finalize eligibility system requirements by July 1, 2026, in order to enable full system deployment, with appropriate testing, on October 16, 2026. After October 16, 2026,

Maryland Medicaid will only have limited ability to make further system changes for use by January 1, 2027. Moreover, Maryland Medicaid is required by H.R. 1 to issue notices by August 31, 2026 addressing the changes occasioned by the IFR. In order to issue these notices on time, Maryland Medicaid must finalize the notice language by August 1, 2026, to allow sufficient time for drafting, leadership review and approval, printing, and mail preparation.

44. Nevertheless, Maryland Medicaid still lacks clarity on several crucial issues from the IFR. While the IFR says that Maryland Medicaid will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how Maryland Medicaid should determine this. While CMS has said more subregulatory guidance will be provided, Maryland Medicaid must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its current system development.

45. This lack of clarity impacts not only Maryland Medicaid, but also the messages that Maryland Medicaid can provide its members: if Maryland Medicaid does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement.

46. Finally, the IFR does not clarify which data sources Maryland Medicaid is required to have integrated as of January 1, 2027, and which can be integrated later. Maryland Medicaid requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

47. Of note, the consequences for Maryland Medicaid from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If Maryland Medicaid is not able to configure its systems quickly enough, or if it configures its

systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial risks for not complying with future guidance are rising, CMS's failure to issue clear and current guidance on community engagement requirements is making it harder for Maryland and other states to comply with the law.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

48. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are now expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

49. Maryland's internal analyses conducted before the IFR was released suggest that (1) at least 36% of Maryland Medicaid's ACA adult expansion members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires ACA adult expansion members' eligibility to be reevaluated every six months), and (2) Maryland uninsured rates will increase by up to 2.3%.

50. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, Maryland internal analysis conducted after the IFR was released now suggest that 150,000 ACA adult expansion members or at least 45 percent of Maryland Medicaid's ACA adult expansion members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires ACA adult expansion members' eligibility to be reevaluated every six months). Prior to the IFR's

release, it was estimated the coverage loss due to community engagement requirements and six-month redeterminations would be 115,000 ACA adult expansion members. This internal analysis conducted before and after the IFR release likely underestimate the impact to members.

51. Indeed, Maryland Medicaid expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. For example, certain enrollees' condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or they cannot obtain the proof required to demonstrate their ability to work is significantly impaired.

52. The "significant impairment" requirement will also likely increase member confusion. Maryland Medicaid members may think they do not qualify as "medically frail," given the added complexity, and Maryland Medicaid may see an increase in non-responses from members and decreased rates of application as a result.

53. The "significant impairment" requirement will also likely decrease the number of people Maryland Medicaid can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew.

54. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult for them and Maryland to assess whether their condition meets the "significant impairment" threshold. This inherent complexity imposed by the IFR will increase coverage loss as well.

55. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to determine, document, or sufficiently demonstrate "significant impairment" will likely return to Maryland Medicaid sicker and costlier as a result of the loss of health coverage. This type of "churn" in Medicaid enrollment both raises costs for Maryland Medicaid and decreases quality of care for members.

56. Maryland Medicaid expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In Maryland Medicaid's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation becomes less available, Maryland Medicaid expects that more members who are actually eligible will be disenrolled simply because they will be unable to demonstrate their eligibility.

57. Maryland Medicaid also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in Maryland Medicaid) develop heart failure. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the heart failure and thus could lose coverage if they could not obtain sufficient documentation for this diagnosis.

58. Maryland Medicaid is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026).

At present, Maryland Medicaid is uncertain as to how, for example, a member might establish that they are both medically frail and incapable of working or participating in community engagement activities. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

59. Maryland Medicaid has spent years conducting outreach and building relationships with Maryland Medicaid enrollees. Confusion over eligibility determinations will undermine that relationship and lower institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage, or decline to reenroll at a later date due to a lack of trust and understanding.

Administrative, Operational, and Financial Burdens on Maryland

Burdens on Maryland Medicaid

60. Because CMS had never before imposed community engagement requirements across eligibility categories, Maryland Medicaid's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement.

61. $10.5 million in state funds and $32.5 million in total funds have already been expended from the state's FY27 budget to ensure compliance with H.R. 1.

62. However, the newly released IFR would require an estimated 20% increase in cost (at least an additional $2 million in state funds alone) due to increased member calls, appeals, caseworker time, system changes, and requiring utilization of outside income data (e.g., Equifax data) because of the increased paperwork requirements required under IFR to demonstrate medical frailty.

63. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require Maryland Medicaid to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, Maryland Medicaid may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add significantly more development costs as well as potential costs from accessing new data, all on top of the anticipated 20% increase in costs noted above.

64. As more individuals are impacted and denied coverage or disenrolled as a result of the IFR's "significant impairment" requirement, Maryland Medicaid and the Maryland Health Benefit Exchange—which administers most applications and redeterminations for Maryland Medicaid—expect more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, Maryland Medicaid will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

65. Maryland Medicaid also expects the IFR's new, complex, and variable limitations on self-attestation to significantly increase costs to the agency. Specifically, these limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, Maryland Medicaid expects the self-attestation limitation to lead to more calls, more documentation needed to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Maryland

66. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on Maryland Medicaid, but on Maryland more generally.

67. As noted above, Maryland Medicaid members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments will likely impact some of Maryland Medicaid's most medically needy members.

68. Because the "significant impairment" requirement targets medically frail individuals, the IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the ACA expansion.

69. In turn, Maryland's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care.

70. Furthermore, individuals that are disenrolled from Maryland Medicaid will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care, which the state will be required to cover.

71. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on the Maryland Department of Health. Most importantly, Maryland Medicaid expects poorer health outcomes across Maryland, as fewer people will be able to access appropriate care and manage chronic conditions.

72. In addition, Maryland Medicaid expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers.

73. In order to support members seeking medical frailty exemptions, providers will liekly need to devote time to providing documentation to demonstrate their patients' medically frailty and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Perrie Briskin
Deputy Secretary of Health Care Financing,
Medicaid Director, Maryland Department of Health

EXHIBIT 11

DECLARATION OF RYAN SCHWARZ

I, Ryan Schwarz, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Massachusetts. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by EOHHS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Massachusetts State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Massachusetts as MassHealth), and Assistant Secretary for the Massachusetts Executive Office of Health and Human Services (EOHHS).

3. EOHHS is the single state agency responsible for administering MassHealth. MassHealth provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. MassHealth's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. MassHealth's mission is to improve the health outcomes of our members for their families through services which sustainably and equitably promote health, well-being, independence, and quality of life.

4. MassHealth insures approximately 1.8 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Massachusetts administers the MassHealth program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. MassHealth receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 55% of MassHealth's expenditures on eligible enrollees.

Medicaid Expansion in Massachusetts

6. On January 1, 2014, Massachusetts implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the MassHealth CarePlus program.

7. Enrollees in MassHealth CarePlus receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for MassHealth CarePlus requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; (3) be a resident of Massachusetts; and (4) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of May 2026, approximately 270,000 (14%) of MassHealth members are enrolled in CarePlus. For the current state fiscal year 2026, approximately $2.2 billion / 18% of MassHealth's federal Medicaid funding comes from the FFP for CarePlus members.

9. Since the passage of the ACA, Massachusetts has led the nation with the highest percentage of residents covered by health insurance, including MassHealth, commercial insurance, Medicare or other coverage. Currently, 97.9% of Massachusetts residents have health insurance.

New Community Engagement Requirement

10. In July 2025, the One Big Beautiful Bill Act, also known as H.R. 1, was signed into law. H.R. 1 included a provision, Section 71119, newly imposing community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA as well as adults enrolled in certain 1115 demonstrations (the "community engagement requirements").

11. Section 71119 is summarized by the Congressional Research Service as follows[1]:

> This section requires, beginning not later than the first quarter after December 31, 2026 (or earlier, at the option of the state), individuals who are eligible for Medicaid as part of the Medicaid expansion population to engage in community service, work, or other activities in order to qualify for Medicaid.
>
> Specifically, the section requires these individuals to, on a monthly basis, (1) work at least 80 hours, (2) complete at least 80 hours of community service, (3) participate in a work program for at least 80 hours, (4) be enrolled at least half-time in an educational program, or (5) engage in any combination thereof for a total of at least 80 hours. Individuals may also qualify if they have a monthly income (or, for seasonal workers, an average monthly income over six months) that is at least as much as the equivalent of minimum wage multiplied by 80 hours.
> ...
>
> The section excludes certain individuals from these requirements, including those with serious medical conditions or with dependent children aged 13 or younger.

12. As noted by the Congressional Research Service's summary, through H.R. 1, Congress provided that certain individuals would be exempt from the community engagement requirement. Among other exemptions, the law exempted any individual "who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual—(aa) who is blind or disabled (as defined in section 1614); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability

[1] *See* H.R.1 - 119th Congress (2025-2026): An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. | Congress.gov | Library of Congress.

that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition." Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)].

13. H.R. 1 required CMS to promulgate an interim final rule implementing Section 71119 no later than June 1, 2026. H.R. 1 § 71119(d).

CMS's Pre-Interim Final Rule (IFR) Guidance to States

14. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, MassHealth does not have in place systems by which to verify work, volunteer, or other community engagement activities.

15. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began participating in a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

16. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. Since at least the passage of the Families First Coronavirus Response Act (the "FFCRA", Public Law No. 116-127 (03/18/2020)), which created immediate pandemic-era protections upon enactment for Medicaid beneficiaries and continuing after the enactment of the

Consolidated Appropriations Act of 2023 (the "CAA", Public Law No: 117-328 (12/23/2022)), which required states to fully re-evaluate Medicaid eligibility for all beneficiaries at the end of pandemic-era enrollment protections, these calls and accompanying slide decks have been vital tools for state compliance with major changes in federal Medicaid law. In the absence of regulations, Massachusetts relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with the FFCRA and CAA, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

17. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, 11; *see also* 17 ("medical frailty status … available through claims data" or "medical screener.")

18. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

19. Regarding use of self-attestation, while initially CMS signaled that only limited use of self-attestation would be permitted (*see* Nov. 19, 2025 CMS Slide Deck, 16), in February 2026

CMS indicated that self-attestation would be an acceptable verification method when data was not available. Specifically, CMS informed states that, when data was not available, auditable self-declaration would be one of two paths available to states for verification (the other path being requesting documentation).

20. In March 2026, CMS reiterated that states may use auditable self-attestation to verify medical frailty in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation *to confirm ongoing medical frailty* in addition to when a member newly identifies as medically frail. CMS also noted that states should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

21. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

22. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

23. In response to this and concerns that CMS would change its policy direction related to community engagement, MassHealth sent a letter to CMS on May 29, 2026, conveying MassHealth's concerns with limiting the definition of medically frail and the use of self-attestation. This letter is attached as Exhibit A.

CMS Issues Interim Final Rule

24. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for MassHealth to implement before January 1, 2027, and are expected to cause significant harm to members and MassHealth once implemented. These provisions include the following:

Medical Frailty Definition

25. With respect to the medical frailty exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

26. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

27. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

28. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373. This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg 33,406. It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals" (*id.*) but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

29. Since the IFR's release, CMS has told states that it is developing more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

30. Other than the IFR implementing H.R. 1, CMS allows state Medicaid agencies to accept self-attestation "without requiring further information (including documentation) from the individual" except "where the law requires other procedures (such as for citizenship and immigration status information)." 42 CFR 435.945(a).

31. Apart from laws regarding verification of citizenship and immigration status, there are no other laws that prohibit or limit the use of self-attestation to verify other aspects of Medicaid eligibility, including H.R. 1's community engagement requirements.

32. Unlike the guidance provided by CMS in winter and spring 2026, which indicated that an auditable self-declaration could generally be used when reliable data was unavailable, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework that will be harmful for members and difficult to implement.

33. Before January 1, 2028, the IFR says that states may accept self-attestation of compliance with community engagement requirements as well as eligibility for exceptions and exclusions, including medical frailty, if reliable data is not available to the state. *See* 42 CFR § 435.557(b)(2)(i), (f)(i).

34. After January 1, 2028, however, the IFR promulgates much more limited rules for when self-attestation may be used:

- For verifying the medically frail exclusion, states may accept self-attestation "only once during the beneficiary's period of enrollment." 42 CFR § 435.557(f)(1)(ii). A beneficiary's period of enrollment is defined as "a continuous period of enrollment in coverage … without the individual being disenrolled." 42 CFR § 435.557(a). In other words, a member can only self-attest to medical frailty once during a period of enrollment, even if a member later develops a new condition for which claims and other administrative data is not yet available.
- For verifying other community engagement factors apart from the medically frail exclusion, states "must require documentation whenever documentation is

reasonably available." 42 CFR § 435.557(b)(2)(ii). Only if documentation is not reasonably available must states accept "information other than documentation." 42 CFR § 435.557(b)(2)(ii)(A). In other words, a state must require a member to provide documentation whenever it cannot verify a community engagement eligibility factor via reliable data sources; only if no documentation is available can a state accept "other information" such as self-attestation from a member.

35. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

36. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

37. A renewal cycle generally lasts 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

38. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g., Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. The IFR's distinction regarding when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

39. Prior to the IFR and the introduction of the new concept of a "period of enrollment", the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in the current renewal.

40. However, under the IFR, an individual who self-attests to medical frailty in, for example, 2028, and remains in the same period of enrollment through 2032 will be prohibited from self-attesting to medical frailty at a renewal in 2032, even if the individual is trying to attest to an entirely different medical frailty condition. The result of the IFR's "period of enrollment" limitation is that members will be treated differently in their first attestation than in later renewals, even if they develop or experience new or different conditions that may qualify them for medical frailty exemptions later in their period of enrollment.

41. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period

and is subsequently terminated because the individual cannot obtain documents to verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR has the potential to disrupt an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

42. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources (*see* 11/19/2025 CMS Slide Deck, 28), the new regulation does not expressly permit this.

Renewal Process

43. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members with the full window of time they are granted in H.R. 1 to demonstrate they comply with community engagement requirements.

44. H.R. 1 states that members only need to demonstrate compliance with community engagement requirements for one month "between such individual's most recent determination … of eligibility and such individual's next regularly scheduled redetermination of eligibility[.]" Social Security Act Section 1902(xx)(1)(B)(i) [42 U.S.C. 1396a(xx)(1)(B)(i)].[2] The IFR interprets this timeframe to mean that a member must demonstrate compliance with community engagement requirements "during the period between the effective date of such individual's most recent determination … and the date the individual's renewal is due." 42 CFR 435.556(a)(2)(i). In prior published guidance on community engagement requirements, CMS has emphasized that it interprets H.R. 1 to mean that "the state *may not dictate* the specific months during which an applicable individual must demonstrate community engagement" between renewal periods. CMS Informational Bulletin regarding Community Engagement Requirements, pg. 7 (emphasis added), dated Dec. 8, 2025, (available at State Requirements to Establish Medicaid Community Engagement Requirements).

45. However, the IFR's process for evaluating community engagement requirements at renewal denies members this statutorily mandated opportunity to demonstrate compliance with community engagement requirements during any month since their last renewal and before their next renewal is due.

46. As part of standard eligibility processes, if a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90

[2] States may elect to have members demonstrate compliance with community engagement requirements for more than one month. Social Security Act Section 1902(xx)(1)(B) [42 U.S.C. 1396a(xx)(1)(B)]. Massachusetts does not intend to do so.

days before a member's renewal is due. 91 Fed. Reg. 33,390. According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412.

47. The effect of this structure is that members will be evaluated for compliance with community engagement requirements before—often *months* before—the time period in which they are entitled to comply with community engagement requirements is complete. For example, if a state starts renewal processes 90 days before an individual's renewal period expires, and sends the member a prepopulated renewal form and notice of noncompliance at this time, the member will be asked to demonstrate community engagement requirements when they are *only halfway through* the months in which they are entitled to comply with community engagement requirements (assuming they are on a 6 month renewal schedule).

48. The IFR expressly acknowledges this scenario: "Because most States currently take between 60 and 90 days to complete all steps in the renewal process for a cohort, an individual subject to renewals once every 6 months may only have been enrolled in their current eligibility

period for approximately 3 months when the State initiates the next renewal and begins checking reliable information available to the State." 91 Fed. Reg. 33,390.

49. Per H.R. 1 and the IFR, members are required to respond to the notice of noncompliance within 30 days. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]; 42 CFR § 435.558(a)(2). Thus, a member could be required to report on their community engagement activities *two months before* the period when they are allowed to engage in these activities is complete. For example, a member whose eligibility period began on January 1, could be asked on April 1 whether they have done work, school, or volunteering during any month between January and June, and the member could be required to report this information by May 1 – before May and June have even happened. The structure of the rule thus deprives members of two months in which they could meet or demonstrate exclusion from the community engagement requirements in order to maintain their coverage.

Claims Data

50. The IFR limits states to using claims data that has been "adjudicated in the preceding 12 months." 42 CFR § 435.557(f). This provision prohibits MassHealth from accessing claims data relevant to determining a member's status as medically frail. For example, some individuals have permanent disabling conditions, such as quadriplegia, that do not require ongoing treatment—they may not have any claims data in the past 12 months that reflects their condition. This provision thus increases the risk of coverage loss for eligible individuals.

51. Several of the provisions set out in the IFR do not take account of the fact that providers have 90 days to submit claims data. For individuals who have acquired a medically frail condition within the past 90 days, there may not be claims data available reflecting that condition. While permitting self-attestation could address this gap, as described above, the IFR has placed

stringent limits on when and how members may self-attest to medical frailty. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

MassHealth's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

52. Following the enactment of H.R. 1, MassHealth recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the January 1, 2027 implementation date, given the magnitude of changes needed for community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, MassHealth began work to prepare to comply with community engagement requirements.

53. Beginning in November 2025 and continuing until the release of the IFR, MassHealth based its policy and system determination on the statutory language and the guidance provided by CMS, as detailed above. Due both to internal development timelines and timelines imposed by our eligibility system vendor, MassHealth did a large amount of work to implement community engagement requirements before the IFR was released. Based on pre-IFR guidance, MassHealth did the following:

- Conducted in-depth analysis of statutory text and CMS guidance, translating it into policy, operational, and system specification documents, requiring significant time and resources from MassHealth policy, clinical, systems, operations, fiscal/budget, strategy, legal, and leadership teams;
- Developed and programmed significant system functionality that was designed to enable MassHealth to determine if a member is subject to, excluded from, or compliant with community engagement requirements, based on MassHealth's

understanding of the statutory provisions and CMS guidance provided prior to the release of the IFR;

- Began actively developing integrations with new data sources;
- Drafted new notices and new application questions;
- Initiated public outreach and education campaigns in partnership with stakeholders to inform members, including presentations for thousands of members, advocates, plans, providers, community groups, municipalities, and other stakeholders;
- Expanded the contract with our contact center vendor to account for increased call volume; and
- Began the hiring process to increase number of state staff to account for increased documentation review.

54. With respect to implementing the medically frail exclusion in particular, MassHealth has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, 11; *see also* 17 ("medical frailty status … available through claims data").

55. MassHealth faces several urgent deadlines with respect to implementing community engagement requirements. MassHealth must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, MassHealth must substantially finalize eligibility system requirements by mid-August, in order to enable full system deployment, with appropriate testing, in December 2026. After mid-August, MassHealth will only have limited ability to make further system changes for use by January 1, 2027. Moreover,

MassHealth is required by H.R. 1 to issue notices by August 31, 2026 addressing the changes occasioned by the IFR. Given the volume of notices being sent, MassHealth plans to begin sending notices in early August, which will require finalizing the notice by the beginning of August.

56. Nevertheless, MassHealth still lacks clarity on several crucial issues from the IFR. While the IFR says that MassHealth will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how MassHealth should determine this. While CMS has said more guidance will be provided, MassHealth must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the future guidance will conflict with its system development. This lack of clarity impacts not only MassHealth, but also the messages that MassHealth can provide its members: if MassHealth does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources MassHealth is required to have integrated as of January 1, 2027, and which can be integrated later. MassHealth requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

57. The consequences for MassHealth from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significant. If MassHealth is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not

complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Massachusetts to comply.

Harms to MassHealth's Members

58. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. It transformed Medicaid into a program designed to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It formed a central building block of a comprehensive national plan to provide universal health insurance coverage. However, the community engagement requirements included in H.R. 1 are expected to result in large scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

59. Massachusetts studies conducted before the IFR was released suggest that (1) at least half of MassHealth's CarePlus members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires CarePlus members' eligibility to be reevaluated every six months), and (2) Massachusetts uninsured rates will increase by up to 50%.[3] Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

60. Indeed, MassHealth expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory

[3] 90325_SixMonth_Redetermination_and_Work_Requirements_Impact_on_Massachusetts.pdf

definition of medical frailty. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. MassHealth members may think they do not qualify as "medically frail," given the added complexity, and MassHealth may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people MassHealth can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406, which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

61. MassHealth expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In MassHealth's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, MassHealth expects that more members who are actually eligible will be disenrolled simply because they are be unable to demonstrate their eligibility.

62. MassHealth also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions,

especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis in order to ensure immediate coverage for treatment, and then later (while still enrolled in MassHealth) develop major depressive disorder. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the major depressive disorder and thus could lose coverage if they could not obtain documentation for this diagnosis.

Harm to MassHealth's Reputation with its Members and the Community

63. MassHealth has spent years conducting community-based outreach and building relationships with MassHealth members and member-serving organizations across the state. These efforts have also emphasized connecting with communities that historically face barriers to accessing and/or maintaining coverage, such as members experiencing homelessness and speakers of languages other than English. Confusion over eligibility determinations risks materially harming that relationship by lowering institutional trust, inserting confusion, and rolling back years of work to ensure that eligible members have the support and information necessary to stay covered. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Massachusetts

Burdens on MassHealth

64. Because CMS had never before imposed community engagement requirements across eligibility categories, MassHealth's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. MassHealth is already expending

significant funds and resources toward implementing community engagement requirements—by way of example, MassHealth requested additional funding from the state legislature for fiscal year 2027 for purposes of implementing community engagement requirements—and expects those burdens to increase in the future. Now, the newly released IFR imposes an even greater burden on MassHealth, in particular by deviating from the statutory language and prior CMS guidance, adding a "significant impairment" requirement to the medically frail exclusion, and limiting the use of self-attestation.

65. With respect to the medical frailty exclusion, the added "significant impairment" requirement—plus the uncertainty of how to implement it—will require MassHealth to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, MassHealth may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, MassHealth expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, MassHealth will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

66. CMS has provided little guidance to date on what will be required for states to implement the "significant impairment" requirement for medical frailty. However, to the extent CMS requires MassHealth to make individualized determinations of members' ability to work based on medical documentation, MassHealth expects that would be very costly and challenging. MassHealth eligibility workers do not currently have expertise in, or capacity for, reading

extensive medical documentation or determining how a members' ability to work is affected by certain medical conditions. Nor do eligibility workers have expertise in evaluating the physical and mental requirements for various potential work or community engagement activities necessary to determine whether an individual is significantly impaired in their ability to engage in those efforts. Developing this expertise and hiring enough workers to handle this additional workload would require a significant and unexpected expenditure of time and resources.

67. MassHealth also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, MassHealth expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Massachusetts

68. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on MassHealth, but on Massachusetts more generally. As noted above, MassHealth members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of MassHealth's most medically needy members. As the uninsured rate increases, there will likely be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are

disenrolled from MassHealth will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. Most importantly, MassHealth expects poorer health outcomes across the Commonwealth, as fewer people will be able to access appropriate care and manage chronic conditions.

69. In addition, MassHealth expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will likely place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Ryan Schwarz
Assistant Secretary for MassHealth
Executive Office of Health and Human Services

EXHIBIT A

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
OFFICE OF MEDICAID
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MAURA T. HEALEY
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LIEUTENANT GOVERNOR

KIAME MAHANIAH, MD, MBA
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MIKE LEVINE
UNDERSECRETARY
FOR MASSHEALTH

May 29, 2026

Dan Brillman
Deputy Administrator and Director, Center for Medicaid & CHIP Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Massachusetts Feedback on Forthcoming CMS Interim Final Rule Regarding Medicaid Community Engagement Requirements

Dear Director Brillman,

I am writing in reference to the forthcoming interim final rule regarding Medicaid Community Engagement requirements, which the Centers for Medicare and Medicaid Services (CMS) will issue as required by Public Law 119-21, also known as the "Working Families Tax Cut" (WFTC) legislation. Since the WFTC legislation was enacted last summer, Massachusetts has devoted considerable resources toward preparing for compliance with the new requirements, effective January 1, 2027, by responding to iterative guidance released by CMS and working in good faith to develop system, policy, and operational changes in a manner consistent with both the underlying statute and CMS' operational expectations as expressed through CMS interim guidance. I am writing this letter to share Massachusetts' perspective on the upcoming interim final rule and share some concerns about the potential impact of any significant deviation from the statute and CMS guidance shared to date.

One of the key assumptions impacting states' preparations for new Community Engagement requirements is related to the application of a "medically frail" exclusion, as described at Section 71119(a)(xx)(9)(A)(ii)(V) of the WFTC legislation. The statute excludes from the Community Engagement requirements "medically frail" individuals who have special medical needs as defined in five categories, including individuals 1) who are blind or disabled (as defined in section 1614 of the Social Security Act); 2) with a substance use disorder; 3) with a disabling mental disorder; 4) with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or 5) with a "serious or complex" medical condition.

Massachusetts appreciates CMS staff highlighting Louisiana as a model for implementing the "medically frail" exclusion, where state officials have proposed using available data from claims and encounters (including ICD-10, CPT, and HCHPC codes) to identify members who meet the definitional categories for medical frailty. Additional CMS information provided to states, such as recommended strategies to

identify individuals with chronic conditions using CMS' Chronic Conditions Warehouse, have also helped inform our approach to implementation.

After reflecting on these inputs from CMS since the law's passage, Massachusetts believes that leveraging clinical data derived from claims and encounters provides the strongest strategy to ensure compliance with Community Engagement rules. Massachusetts is building system functionality to ingest claims- and encounter-based clinical information to inform whether members are excluded from the Community Engagement requirements taking effect on January 1, 2027. By leveraging these data to identify individuals who meet the five statutory categories for "medically frail," as well as accepting self-reported information from applicants with no available claims history, Massachusetts believes it can achieve broad, auditable compliance with federal rules, while minimizing the burden on members and providers impacted by Community Engagement requirements and allowing eligible Medicaid members to maintain their coverage.

Another key concept impacting states is the use of self-declaration in establishing eligibility criteria related to Community Engagement requirements. Historically, and unless otherwise required by law, CMS has allowed states to accept self-declaration to verify eligibility factors (*see* 42 CFR 435.945(a)). Massachusetts believes that the acceptance of self-declaration in certain situations is a critical tool to facilitate enrollment of new members, keep eligible members covered, and reduce administrative churn where eligible members may experience gaps in coverage due to paperwork issues. Allowing self-declaration is consistent with CMS' guidance since the passage of the WFTC legislation and reflects our shared commitment to preventing unintended member coverage loss.

Given the need for Massachusetts to meet statutory deadlines related to the WFTC legislation, we appreciate CMS' consideration of these points and ongoing partnership, as we continue our extensive system and policy development work in anticipation of CMS' interim final rule. We are well into the development process and have very limited time remaining before the January 1, 2027 effective date; as such, any material shift in federal policy regarding Medicaid Community Engagement requirements could result in a significant increase in implementation costs and disruptions to Massachusetts.

Sincerely,

Mike Levine
Undersecretary for MassHealth

EXHIBIT 12

DECLARATION OF ELIZABETH HERTEL

I, Elizabeth Hertel, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Michigan. I am over the age of 18 and have knowledge of all the facts stated herein, either personally or in consultation with staff at the Michigan Department of Health and Human Services (MDHHS) and/or based on documents that I have reviewed. If called as a witness, I could and would testify competently to the matters stated herein.

Professional and Agency Background

2. I am the Director of MDHHS. In this role, I oversee Michigan's Medicaid programs.

3. MDHHS is responsible for providing services and administering programs to improve the health, safety, and prosperity of the residents of the State of Michigan. One of these programs is Michigan's Medicaid program. Collectively, Michigan's Medicaid program and its Children's Health Insurance Program (CHIP) typically are referred to as Michigan Medicaid.

4. Michigan Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Coverage includes medical, dental, mental health, substance use disorder treatment, long-term services and supports, and long-term care. MDHHS's mission is to improve the overall health and well-being of all Michiganders, which includes maintaining health care coverage for Michigan's residents using all relevant scientific and other data.

5. Michigan Medicaid covers approximately twenty-five percent of Michigan's population. In total, MDHHS insures more than 2.4 million people, including over 1 million children—almost half of Michigan's kids—and almost half a million seniors and people with

disabilities. Michigan Medicaid recipients include some of Michigan's most vulnerable residents, such as those experiencing homelessness or those with serious or complex medical conditions.

6. MDHHS administers Michigan Medicaid pursuant to federal law and regulations, as well as the terms of its federally approved State Plans. Michigan Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of seventy-one percent of Michigan Medicaid's expenditures.

Medicaid Expansion in Michigan

7. In 2013, Michigan implemented Medicaid expansion under the Affordable Care Act (ACA). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Healthy Michigan Plan program (HMP).

8. Enrollees in HMP receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for HMP requires that an individual (1) be an adult 19 to 64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

9. As of May 2026, approximately 650,000 or 26% of Michigan Medicaid enrollees are enrolled in HMP. For State fiscal year 2025, approximately $6 Billion or 32% of Michigan Medicaid's federal Medicaid funding comes from the FFP for HMP enrollees.

CMS Issues the Interim Final Rule

10. On June 1, 2026, CMS promulgated the Interim Final Rule (IFR) related to the new community engagement requirement contained within Section 71119 of H.R. 1. The IFR includes several provisions that are vague or are more restrictive than H.R. 1's requirements, including:

a. *Medically Frail Definition*: The IFR defines "medically frail" as "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i). The IFR provided little guidance for States about how to verify whether an individual meets this new "significant impairment" requirement. CMS has indicated that it is developing more guidance, though none has been provided.

b. *Self-Attestation Limitation*: A State's ability to accept a self-attestation related to the community engagement requirements is limited, as the IFR prohibits States from accepting a self-attestation if an individual has already used one during that enrollment period.

c. *Data Feed Integration*: States must identify reliable data sources, to which it "has or should have access," 42 CFR § 435.557(b), for verifying community engagement eligibility factors. These factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies do not typically assess, such as school attendance, community volunteer work, and job program enrollment. Although CMS has indicated its intention to develop national data interfaces to streamline access to these various verification sources, current federal guidance confirms that little of this infrastructure will be operational by January 1, 2027, leaving States without the integrated data supports contemplated under the IFR.

d. *Renewal Process*: The procedure for evaluating enrollee compliance with the community engagement requirements—including the IFR's deadlines, notice requirements, and documentation submission requirements, *e.g.*, 91 Fed. Reg.

33,390, 33,411–12 (June 3, 2026)—artificially abbreviates the time period enrollees may actually comply with the community engagement requirements. Under these procedures, enrollees may be evaluated for compliance with the community engagement requirements months before the deadline for demonstrating compliance.

e. *Short-Term Hardship Exemption*: The IFR prohibits States from allowing a short-term hardship exception for an individual in the same month they apply to Medicaid. 91 Fed. Reg. 33473. Additionally, H.R. 1 grants discretion to States to adopt some, all, or none of the exemptions; however, the IFR requires States to adopt all of them together, removing the flexibility built into H.R. 1.

f. *Timelines*: Several timelines fail to account for the 12-month claims data submission period. For determinations that must be made regarding the preceding year, MDHHS may not have the complete set of relevant data.

MDHHS's Efforts to Implement the Community Engagement Requirements

11. Following the enactment of H.R. 1, MDHHS recognized that it would be challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation date, given the magnitude of changes needed. Therefore, after H.R. 1 was passed in July 2025, MDHHS promptly began work to prepare to comply with the community engagement requirements. For example, MDHHS has reviewed and mapped its eligibility and verification workflows, identified the system modifications needed to incorporate new work-activity reporting and exemption-validation fields, and began coordinating with its systems vendors to define the technical requirements. MDHHS has also engaged program, legal, and IT staff in design sessions to ensure that the necessary policy changes,

data pathways, and notice templates can be developed within the statutory timelines. In addition, MDHHS has convened cross-agency workgroups, including representatives from workforce programs and education partners, to assess feasible data-sharing pathways and broader partnership opportunities.

12. With respect to implementing the medically frail exclusion in particular, MDHHS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail," leveraging claims data and other sources that reflect significant medical or functional vulnerabilities.

13. MDHHS faces several urgent deadlines with respect to implementing the community engagement requirements. MDHHS must apply community engagement requirements to applications and renewals as of January 1, 2027. As the deadline for identifying and defining required system changes has already passed, MDHHS is currently operating within a compressed period in which only narrowly targeted system changes can feasibly be implemented by January 1, 2027.

14. Moreover, MDHHS is required by H.R. 1 to issue notices by August 31, 2026, addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, MDHHS will send an early awareness mailing in early July 2026 and will begin sending the formal member notices on August 17, 2026.

15. Following the issuance of the IFR, MDHHS has continued to develop its eligibility systems and processes and is striving to comply with the IFR's new requirements. However, MDHHS lacks clarity on certain aspects of the IFR, including, for example, how to implement the significant impairment requirement.

Impact to Michigan Medicaid Enrollees

16. Michigan initially estimated that at least 200,000 Michigan Medicaid enrollees will be disenrolled at some point due to H.R. 1's combination of community engagement requirements and six-month redeterminations. MDHHS expects the "significant impairment" requirement to result in even more Michigan Medicaid enrollees losing coverage for a variety of reasons, including because the individual's condition may not meet the IFR's "significant impairment" threshold, because the "significant impairment" requirement limits the State's ability to verify the exclusion automatically, or because the individual cannot obtain the requisite proof to demonstrate such "significant impairment."

17. Enrollees with conditions that meet the statutory categories of medical frailty, but who lose coverage due to inability to document "significant impairment" may return to Michigan Medicaid with more advanced health needs, increasing the cost and complexity of their care.

18. MDHHS further expects that the limitations on self-attestation will increase Michigan Medicaid enrollee confusion. In MDHHS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible enrollees.

19. MDHHS is statutorily required to provide notice to enrollees regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). But MDHHS does not have the necessary clarity on the IFR's requirements to effectively communicate the changes.

20. MDHHS has spent years conducting outreach and building relationships with Michigan Medicaid enrollees. Confusion over eligibility determinations risks harming that

relationship and lowering institutional trust. Enrollees who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Harms to Michigan

21. When H.R. 1 was enacted, MDHHS's eligibility system was not built to support community engagement requirements and required significant reconfiguration to incorporate the numerous eligibility factors necessary to evaluate community engagement. At the same time, MDHHS's eligibility workforce was already operating at capacity, limiting its ability to absorb the substantially increased workload associated with implementing community engagement determinations.

22. Michigan Governor Gretchen Whitmer's FY2027 budget proposal included substantial investments to support the increased administrative and operational demands associated with H.R. 1, including $80.3 million for ongoing Medicaid and SNAP staffing (589.0 FTEs); $11.7 million for beneficiary outreach, education, hearings, oversight, project management, and technical assistance; $30 million for workforce training and apprenticeship expansion; $2 million for a new data-sharing platform in the Michigan Department of Technology, Management and Budget; and an additional $2.8 million to upgrade the Bridges eligibility system to meet CMS technical requirements for H.R. 1 implementation.

23. Moreover, MDHHS is attempting to configure its eligibility system without a full understanding of the requirements of the IFR and, in particular, the significant impairment requirement. While additional guidance is forthcoming, the deadlines for MDHHS to design and define the eligibility system changes needed for the January 1, 2027 effective date have already passed, and MDHHS is now operating under significantly constrained timelines. MDHHS must rapidly change its operational approach and systems development; analyze, develop, and

implement new ways to evaluate medical frailty; and integrate new data sources, adding development costs as well as potential costs from accessing new data. If MDHHS is not able to reconfigure its systems quickly enough, or if it reconfigures its systems inconsistent with future CMS guidance on implementation, MDHHS could face negative audit findings and significant financial penalties under H.R. 1 Section 71106.

24. Additionally, as more individuals are impacted and denied coverage or disenrolled due to the significant impairment requirement, MDHHS expects more calls, more documents to process, and more appeals of adverse actions. MDHHS will also incur the cost of educating Michigan Medicaid enrollees, staff, and other stakeholders.

25. MDHHS further expects the limitations on self-attestation to increase its operational complexity, making it harder to train staff, vendors, assisters, and community organizations on eligibility processes. MDHHS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals.

26. Michigan Medicaid enrollees will likely face increased denials and disenrollments, and many of those disenrollments could be of some of Michigan Medicaid's most medically needy. Individuals that are disenrolled from Michigan Medicaid will likely lose access to primary and preventive care, resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on MDHHS. MDHHS expects poorer health outcomes across Michigan, as fewer people will be able to access appropriate care and manage chronic conditions.

27. As the uninsured rate increases, there will be a greater financial strain on providers—in particular rural, community, and safety net hospitals as well as community health

centers—that will be called upon to provide even greater levels of uncompensated care. MDHHS also expects that the new medical frailty requirements will place an administrative strain on providers, who may need to devote time that otherwise would be spent treating patients to document both medical frailty and significant impairment in the ability to work.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Elizabeth Hertel
Director, Michigan Department of Health and Human Services

EXHIBIT 13

DECLARATION OF PAMELA WEINER

I, Pamela Weiner, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Minnesota. I am over the age of 18 and have personal knowledge, or knowledge based on review—in my capacity as the Minnesota Department of Human Services ("DHS") Deputy Assistant Commissioner for Eligibility and Compliance—of information and records gathered by DHS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. DHS is the single state agency responsible for administering Minnesota's state Medicaid program and the Children's Health Insurance Program, which are known together as Medical Assistance, or MA. MA provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. MA's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. DHS's mission is to support all Minnesotans in living their healthiest and fullest lives.

3. MA is the largest single source of health insurance in Minnesota. Today, MA provides health coverage for almost 1.2 million Minnesotans, or approximately one in every five state residents. MA's coverage includes children and families, pregnant women, adults without children, seniors, and people who are blind or have disabilities. Its members include some of the most vulnerable residents in the state, such as those experiencing homelessness, living with significant disabilities, or who have a serious or complex medical condition.

4. Minnesota administers the MA program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. MA receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 57 percent of MA's expenditures on eligible enrollees.

Medicaid Expansion in Minnesota

5. On January 1, 2014, Minnesota implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level who did not already meet other eligibility criteria.

6. Enrollees in the expansion population receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

7. As of 2025, approximately 19 percent of MA members are in the expansion population. For the current state fiscal year 2026, approximately $3.3 billion or 24% of Minnesota's federal Medicaid funding comes from the FFP for expansion population members.

CMS's Pre-IFR Guidance to Minnesota

8. I and my staff at DHS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

9. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, DHS does not have in place systems by which to verify work, volunteer, or other community engagement activities.

10. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

11. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Minnesota relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

12. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical

claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

13. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

14. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

15. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

16. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty

exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

17. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

18. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for DHS to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and DHS once implemented. These provisions include the following:

Medically Frail Definition

19. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

20. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual

be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

21. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

22. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

23. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

24. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was

unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

25. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

26. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

27. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

28. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid

agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

29. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

30. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

31. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as

"information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

32. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

33. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still

cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

34. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

35. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

36. The IFR provides that the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

37. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage,

likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

38. Several of the timelines set out in the IFR do not take account of the fact that providers have up to 12 months to submit claims data. For determinations that are supposed to be made regarding the preceding year, DHS may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

DHS's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

39. Following the enactment of H.R. 1, DHS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, DHS began work to prepare to comply with community engagement requirements.

40. Beginning in September 2025 and continuing until the release of the IFR, DHS based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, DHS has already done the following:

- Completed statutory analysis related to the various provisions impacting eligibility;
- Provided policy updates to eligibility workers and the larger community;
- Developed full system specifications and completed development of intake functionality related to the community engagement requirements;

- Enhanced consumer support tools to assist with the intake of community engagement related eligibility determinations;
- Sought and received state legislative direction and appropriation to implement the new requirements;
- Drafted new member notices including finalizing the one-time mailing required under the law;
- Updated online and paper applications;
- Conducted outreach to community, provider, and managed care organizations; and
- Issued an RFP to solicit vendor support with verifying the community engagement requirements on an ongoing basis.

41. With respect to implementing the medically frail exclusion in particular, DHS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data".

42. DHS faces several urgent deadlines with respect to implementing community engagement requirements. DHS must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, DHS must substantially finalize eligibility system requirements by mid-August, in order to enable full system deployment, with appropriate testing, in September. After September 2026, DHS expects it will only have limited ability to make further system changes for use by January 1, 2027. Moreover, DHS is required by H.R. 1 to issue notices by August 31, 2026 addressing the changes occasioned by the IFR. In order to issue those

notices in a timely fashion, DHS needs to have information finalized by July 1, 2026. DHS internal process necessitates that language is finalized 2 months prior to the notice being mailed in order to, among other things, complete translations, coordinate with printing, and do systems work needed to format and generate the notices. Our notices are already at the Operations Center for mailing, but we may have to send an additional mailing if it is determined there is additional information from the IFR required to be included in the mailing.

43. Nevertheless, DHS still lacks clarity on several crucial issues from the IFR. While the IFR says that DHS will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how DHS should determine this. While CMS has said more subregulatory guidance will be provided, DHS must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only DHS, but also the messages that DHS can provide its members: if DHS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources DHS is required to have integrated as of January 1, 2027, and which can be integrated later. DHS requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

44. Of note, the consequences for DHS from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If DHS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under

H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Minnesota and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

45. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

46. Minnesota studies conducted before the IFR was released suggest that (1) at least 19% of MA's expansion population members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires expansion population members' eligibility to be reevaluated every six months), and (2) Minnesota uninsured rates will increase as a result. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

47. Indeed, DHS expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. MA members may think they do not

qualify as "medically frail," given the added complexity, and DHS may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people DHS can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

48. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to MA sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for MA and decreases quality of care for members.

49. DHS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In DHS's experience, the requirement to obtain third-party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DHS expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

50. DHS also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second

medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in MA) be diagnosed with a separate disabling medical condition. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the disabling condition and thus could lose coverage if they could not obtain documentation for this diagnosis.

51. DHS is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, DHS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

52. DHS has spent years conducting outreach and building relationships with MA enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Minnesota

Burdens on DHS

53. Because CMS had never before imposed community engagement requirements across eligibility categories, DHS's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. DHS has completed some IT development related to the new requirements, and the newly released IFR requires new development previously

not identified requiring additional funding and development work. Moreover, DHS has already submitted advanced planning documents (APDs) to CMS and received approval for the community engagement work identified prior to the release of the IFR. DHS may need to update the APDs and seek additional federal approvals due to the IFR, we are still determining the impacts.

54. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DHS to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, DHS may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, DHS expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, DHS will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

55. DHS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, DHS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Minnesota

56. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on MA, but on Minnesota more generally. As noted above, MA members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of MA's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the MA expansion population. Minnesota's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from MA will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on DHS. Most importantly, DHS expects poorer health outcomes across Minnesota, as fewer people will be able to access appropriate care and manage chronic conditions.

57. In addition, DHS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significantly impaired in the

ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26 day of June 2026.

/s/ Pamela Weiner
Pamela Weiner
Deputy Assistant Commissioner for Eligibility and Compliance
Minnesota Department of Human Services

EXHIBIT 14

DECLARATION OF K. BRUNETTI IRELAND

I, K. Brunetti Ireland, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Nevada. I am over the age of 18 and have personal knowledge of the matters set forth below.

2. I am Chief of Special Litigation at the Nevada Attorney General's Office, counsel of record for Plaintiff State of Nevada in this action.

3. Attached as Exhibit 1 is a true and correct copy of the Nevada Division of Medicaid's *Nevada Medicaid Operations* data dashboard, available at https://tinyurl.com/5n6ku765.

4. Attached as Exhibit 2 is a true and correct copy of KFF's report *5 Key Facts About Medicaid Expansion*, available at https://tinyurl.com/49f7bfmn.

5. Attached as Exhibit 3 is a true and correct copy of the State of Nevada's Medicaid—Administration budget for the 2025–2027 biennium, available at https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Budget/10426/Overview.

6. Attached as Exhibit 4 is a true and correct copy of Assembly Bill 591 of the Nevada Legislature's 83d regular session, as enrolled, which appropriated funds for the 2025–2027 biennium, available at https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/12954/Text#.

7. Attached as Exhibit 5 is a true and correct copy of KFF's table *Federal and State Share of Medicaid Spending*, available at https://tinyurl.com/2mtb7xwu.

I declare under penalty of perjury under the laws of the United States that, to the best of

my knowledge, the foregoing is true and correct.

Executed this 27th day of June 2026.

K. Brunetti Ireland Digitally signed by K. Brunetti Ireland
Date: 2026.06.27 14:12:56 -07'00'

K. Brunetti Ireland

EXHIBIT 1

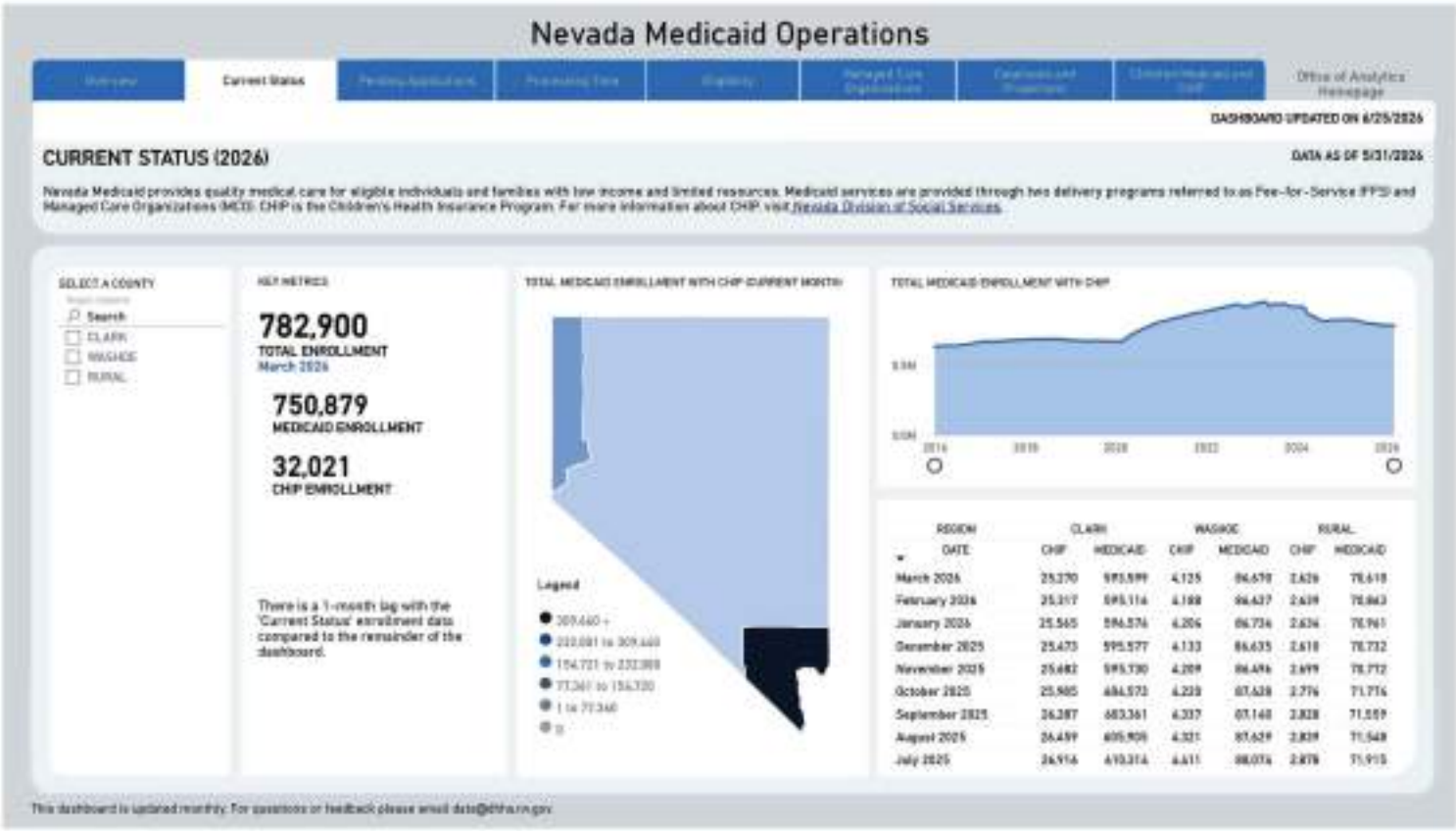
Nevada Medicaid Operations
Current Status
DASHBOARD UPDATED ON 6/25/2026
CURRENT STATUS (2026)
DATA AS OF 5/31/2026
Nevada Medicaid provides quality medical care for eligible individuals and families with low income and limited resources. Medicaid services are provided through two delivery programs referred to as Fee-for-Service (FFS) and Managed Care Organizations (MCO). CHIP is the Children's Health Insurance Program. For more information about CHIP, visit Nevada Division of Social Services.
SELECT A COUNTY
Search
CLARK
WASHOE
RURAL
KEY METRICS
782,900
TOTAL ENROLLMENT
March 2026
750,879
MEDICAID ENROLLMENT
32,021
CHIP ENROLLMENT
There is a 1-month lag with the 'Current Status' enrollment data compared to the remainder of the dashboard.
TOTAL MEDICAID ENROLLMENT WITH CHIP (CURRENT MONTH)
Legend
TOTAL MEDICAID ENROLLMENT WITH CHIP
REGION
CLARK
WASHOE
RURAL
DATE
CHIP
MEDICAID
March 2026
February 2026
January 2026
December 2025
November 2025
October 2025
September 2025
August 2025
July 2025
This dashboard is updated monthly. For questions or feedback please email data@dhcfp.nv.gov

EXHIBIT 2

KFF The independent source for health policy research, polling, and news.

5 Key Facts About Medicaid Expansion

Authors: Jessica Mathers, Jennifer Tolbert, Priya Chidambaram, and Sammy Cervantes

Published: Apr 25, 2025

Congress has passed a budget resolution that targets up to $880 billion or more in federal spending cuts from Medicaid over ten years. While specific proposals are not yet known, policies under discussion could limit financing and coverage for the Affordable Care Act (ACA) expansion group. Recent KFF polling shows there is little support for cuts to federal Medicaid spending overall, and a majority of adults (59%) oppose eliminating the enhanced federal match rate for adults covered under Medicaid expansion specifically.

The ACA expanded Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level ($21,597 for an individual in 2025) and provided states with an enhanced federal matching rate (FMAP) of 90% for their expansion populations over time, which is greater than the matching rate for Medicaid generally. While federal funding finances 90% of spending on the expansion population, states are responsible for the remaining 10% of costs for enrollees eligible under Medicaid expansion. As a result of a Supreme Court ruling in [illegible]ely optional for states, and as of April 2025, all but 10 states have adopted the expansion. While expansion has led to higher government spe[illegible]aid, a large body of literature shows that it is linked to reduced rates of uninsurance, increased health care affordability, improvements in access and health and outcomes, and economic benefits for states and providers. KFF polling shows that of people living in non-

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expansion states, two-thirds (66%) said their state should expand Medicaid to cover more low-income uninsured people.

This issue brief examines Medicaid expansion enrollment and Medicaid spending in expansion and non-expansion states and describes the characteristics of adults covered by the Medicaid expansion.

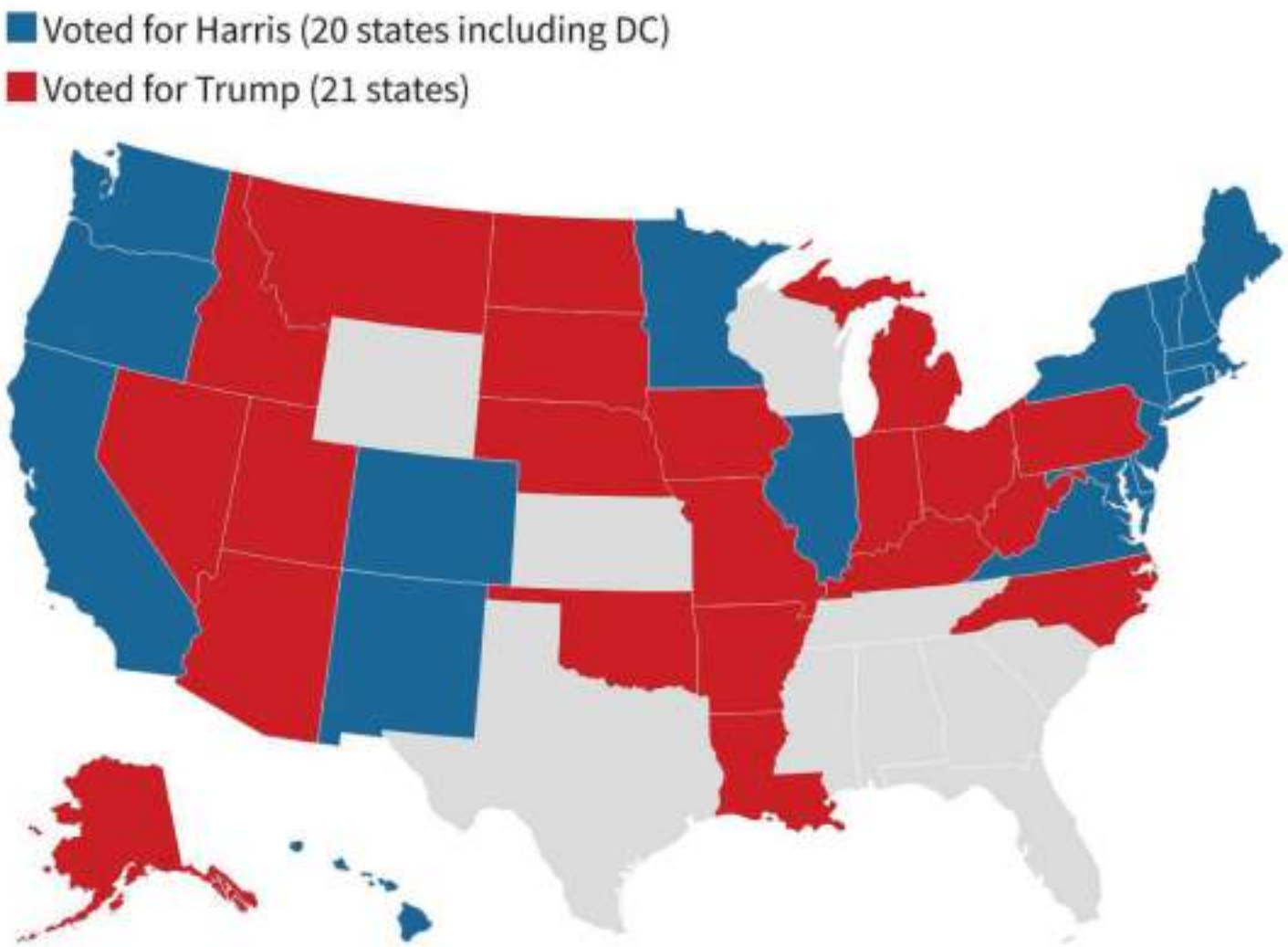
1. Medicaid expansion is widely adopted by both red and blue states.

Over the past 11 years, Medicaid expansion has been broadly adopted. The 41 states including the District of Columbia that have adopted Medicaid expansion are split nearly evenly between states that voted for Trump (21 states) and those that voted for Harris (20 states) in the 2024 Presidential election (Figure 1). Over half (27) of states adopted Medicaid expansion in 2014, while 14 states have implemented expansion since 2014, with South Dakota and North Carolina adopting most recently in 2023. Most states adopted expansion through legislation; however, in seven states, the expansion was adopted via a ballot measure. As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states.

Medicaid expansion is linked to gains in coverage, access, increased health care affordability, and economic benefits for states and providers. Although establishing direct causality between health insurance and health outcomes is complex, evidence generally shows Medicaid expansion is associated with improved health outcomes, including increased early-stage cancer diagnosis, improved disease management, and lower mortality rates for many chronic conditions.

Figure 1

Medicaid Expansion is Widely Adopted by Both Red and Blue States



Source: KFF tracking of state Medicaid expansion decisions

KFF

2. Medicaid median income eligibility for children, pregnancy, and parents, and Medicaid spending per enrollee are

higher in expansion states compared to non-expansion states.

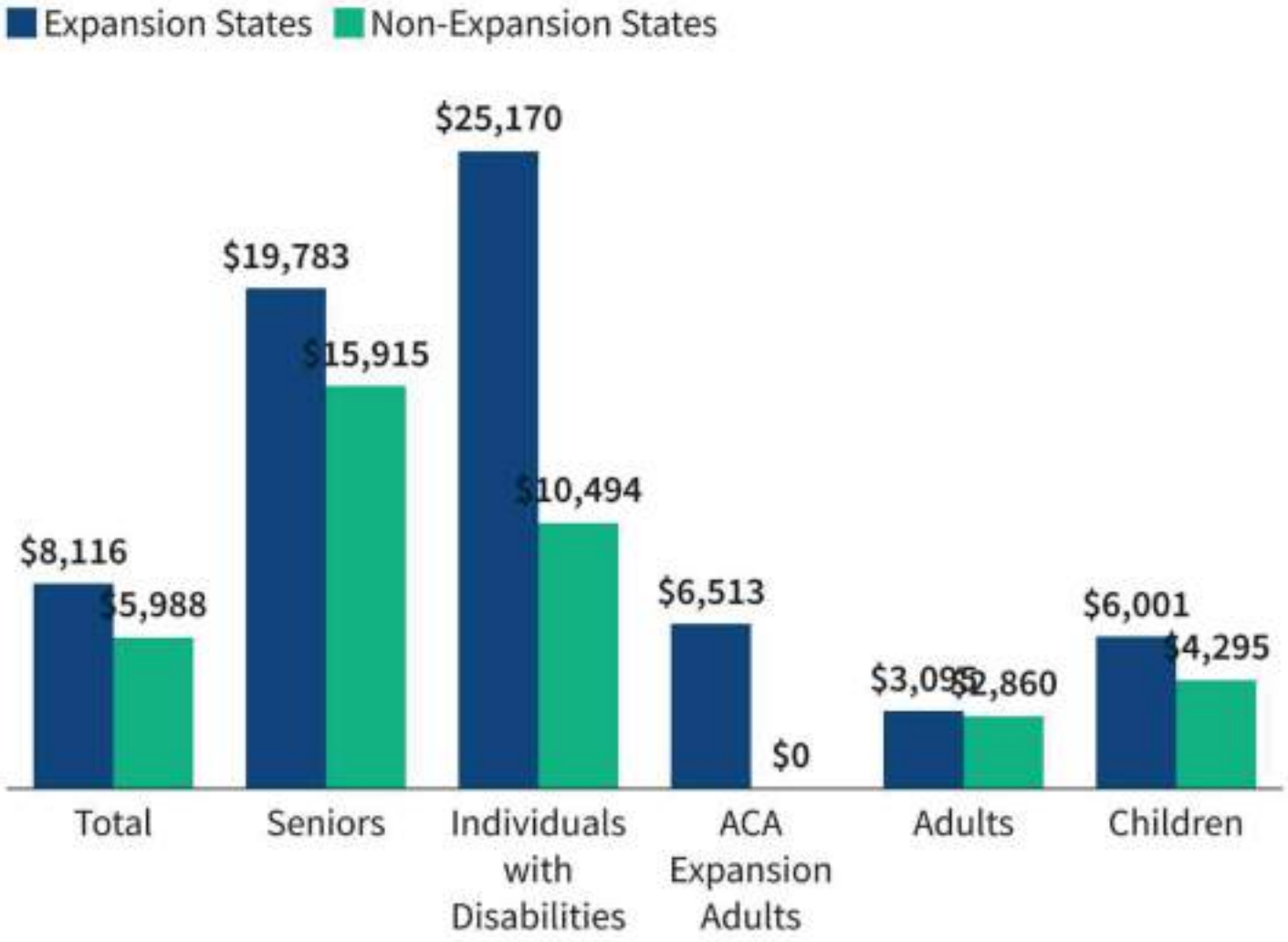
Overall, per enrollee spending for the expansion group was higher than for other adults and children but well below per enrollee spending for enrollees over age 65 and people with disabilities. While some critics of Medicaid expansion have argued that expansion diverts resources away from other groups of Medicaid enrollees, including people with disabilities and children, data show that expansion states spend more per enrollee overall and on each eligibility group than non-expansion states. Per enrollee spending for people with disabilities in expansion states is nearly 2.5 times the spending in non-expansion states ($25,170 per enrollee vs. $10,494) (Figure 2). The difference in per-enrollee spending for expansion and non-expansion states holds true for more detailed eligibility pathways for people based on age or disability. Expansion states also spent nearly $2,000 more per child enrollee than non-expansion states ($6,001 vs $4,295). The differences in per enrollee spending may reflect state policy choices about benefits and eligibility, in addition to payment rates, regional variation in health care costs, and state demographics.

In addition to difference in spending, expansion states have higher median income-based eligibility limits compared to non-expansion states for children (266% FPL in expansion states compared to 234% in non-expansion states), pregnant individuals (213% FPL compared to 203% FPL), and parents (138% FPL compared to 33% FPL). There is substantial variation in adoption of optional eligibility and other policies for seniors and people with disabilities, with state expansion status not a strong predictor of these policy choices.

Figure 2

Per-Enrollee Spending in States That Expanded Medicaid Is Higher for All Eligibility Groups Than in Non-Expansion States

Per-enrollee spending by eligibility group and Medicaid expansion status



Note: Data include full-benefit enrollees who were enrolled in at least one month of Medicaid in 2021. They may not have actually used any services during this period, but they are reported as enrolled in the program. Per-enrollee spending data exclude West Virginia or Mississippi. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, CY 2021

KFF

3. Nearly four in ten women of reproductive age and over six in ten 50-64 year olds enrolled in Medicaid are covered through Medicaid expansion.

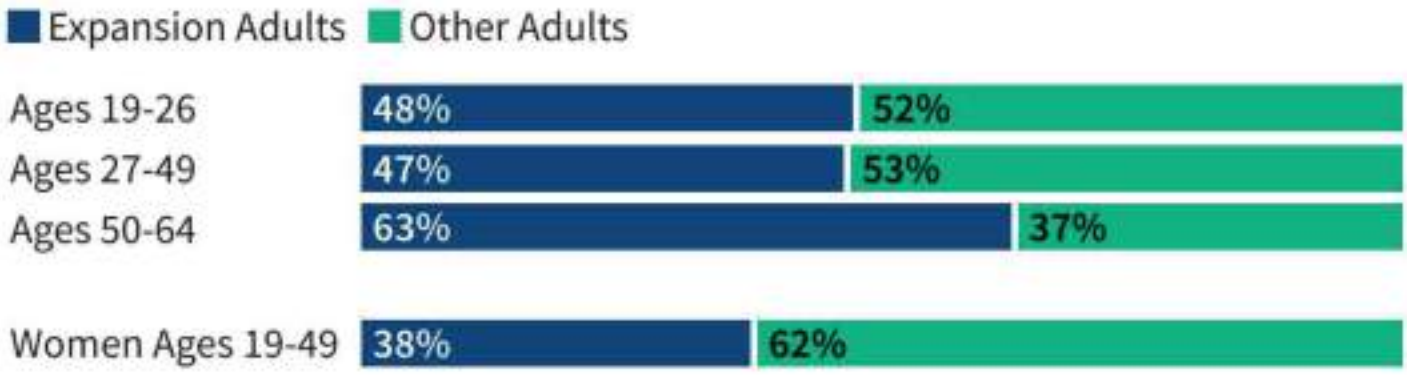
Medicaid expansion provides coverage across age groups for those 19 to 64 (Figure 3). Many expansion adults are working; however, they work for employers and in industries that are less likely to offer health insurance, leaving them without affordable health coverage options. As discussed below, older enrollees are more likely to have chronic conditions and may face more barriers to work.

Medicaid expansion also provides an important eligibility pathway for women of reproductive age, covering 38% of women ages 19-49 enrolled in Medicaid. For those who become pregnant, Medicaid coverage prior to pregnancy can promote pre-pregnancy health care, which can lead to healthier pregnancies and help reduce the risk of complications. Previous KFF analyses show that in expansion states, pregnant individuals are more than twice as likely to be enrolled in Medicaid prior to pregnancy (59%) than in non-expansion states (26%) (the difference in income eligibility levels for pregnant adults vs. other adults is large in non-expansion states, explaining the difference in pre-pregnancy enrollment rates). Medicaid expansion can provide stable coverage to pregnant individuals after the postpartum coverage period ends. Medicaid expansion coverage of parents also increases enrollment of their children: evidence shows that if children are eligible for Medicaid or CHIP coverage but unenrolled, when their parents gain coverage through Medicaid expansion it has a spillover, or "welcome mat" effect, increasing the number of children who enroll in health coverage. Medicaid expansion also covers adults as they age – more than six in ten Medicaid enrollees ages 50-64 are covered through expansion - and before they become eligible for Medicare.

Figure 3

Nearly Four in Ten Women of Reproductive Age and Over Six in Ten Adults Ages 50-64 Enrolled in Medicaid are Covered Through Medicaid Expansion

Adults enrolled through the Medicaid expansion pathway and other eligibility pathways, by age and sex.



Note: Enrollees were included if they were coded as receiving Medicaid through the ACA expansion in a state that expanded Medicaid in 2021 or earlier. Idaho and Virginia expanded Medicaid prior to 2021, but are not reflected in this figure. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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4. One third of Medicaid expansion enrollees have a chronic physical health condition and a quarter have a chronic behavioral health condition.

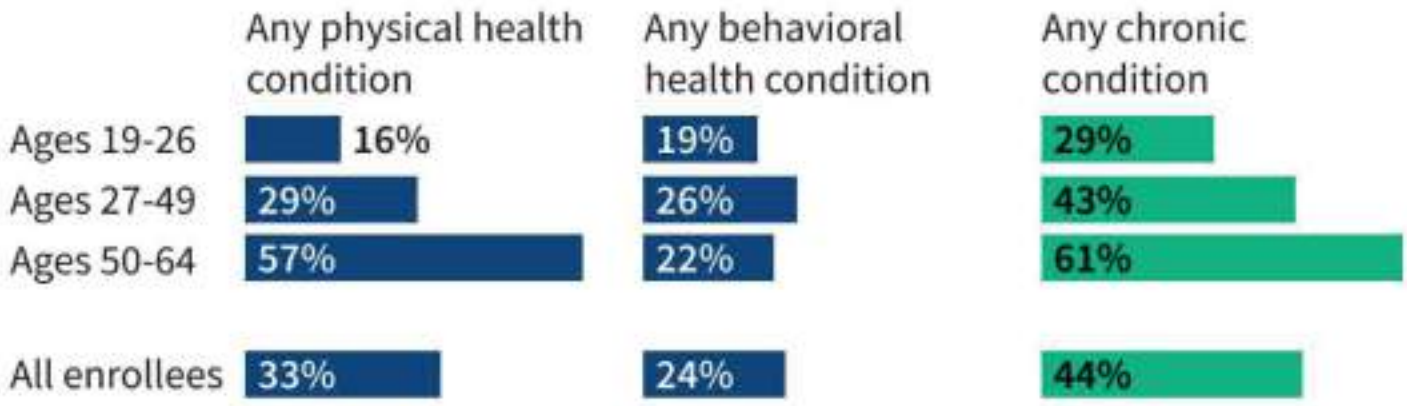
Nearly half (44%) of expansion adults have at least one chronic condition, including 33% that have a chronic physical condition and 24% that have a behavioral health condition. Of Medicaid enrollees with at least one chronic condition, 53% are enrolled through Medicaid expansion (data not shown). Similar to all adults on Medicaid, the share of expansion adults with at least one chronic physical condition

increases with age (Figure 4). Nearly six in ten (57%) expansion adults ages 50-64 have at least one physical health condition compared to just 16% of expansion adults ages 19-26. While the share of expansion adults with physical health conditions increases with age, the share with behavioral health conditions remains relatively stable, ranging from 19% to 26% across age groups.

Figure 4

One Third of Medicaid Expansion Enrollees Have a Diagnosed Chronic Physical Health Condition and One in Four Have a Diagnosed Chronic Behavioral Health Condition

Share of expansion adults with a physical, behavioral, or any chronic condition, by age



Note: Enrollees were included if they were coded as receiving Medicaid through the ACA expansion in a state that expanded Medicaid in 2021 or earlier. Idaho and Virginia expanded Medicaid prior to 2021, but are not reflected in this figure. There are a total of 35 chronic conditions captured in this figure. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

KFF

Research finds that expansion is associated with improved access to care and outcomes related to behavioral health conditions. For other chronic conditions, expansion has positive impacts on access to care and may improve certain health outcomes. Medicaid coverage helps expansion enrollees manage chronic conditions and supports workforce participation. Medicaid expansion also provides coverage to individuals who have chronic conditions or disabilities that may limit their ability to

work. Although some people with disabilities qualify for Medicaid because they receive Supplemental Security Income, most are eligible for Medicaid through other pathways, including the expansion group. While many adults who need long-term care may qualify for coverage through other Medicaid pathways, Medicaid expansion covers some individuals with costly health needs who may otherwise be unable to afford care; two percent (2%) of expansion enrollees, or 395,000 individuals, use long-term care services (LTC) which support activities of daily living such as eating, bathing, or dressing (data not shown). Medicaid expansion is also the primary pathway for Medicaid coverage for people with HIV.

5. Policy changes targeting Medicaid expansion would reduce government spending but also could put coverage for 20 million enrollees at risk.

There are several options under consideration in Congress to reduce federal Medicaid spending that could have implications for enrollees in the expansion group, including work requirements and changes in financing for the expansion. Congress may debate federal legislation requiring states to impose work requirements as a condition of Medicaid coverage. Most adult Medicaid enrollees are already working without a work requirement; estimates of national work requirements show $109 billion in federal savings over 10 years, and an increase in the number of uninsured, but no increase in employment. Beyond legislative changes, a number of states are pursuing waivers to condition Medicaid expansion coverage on meeting work requirements since work requirement waivers were encouraged and approved during the first Trump administration.

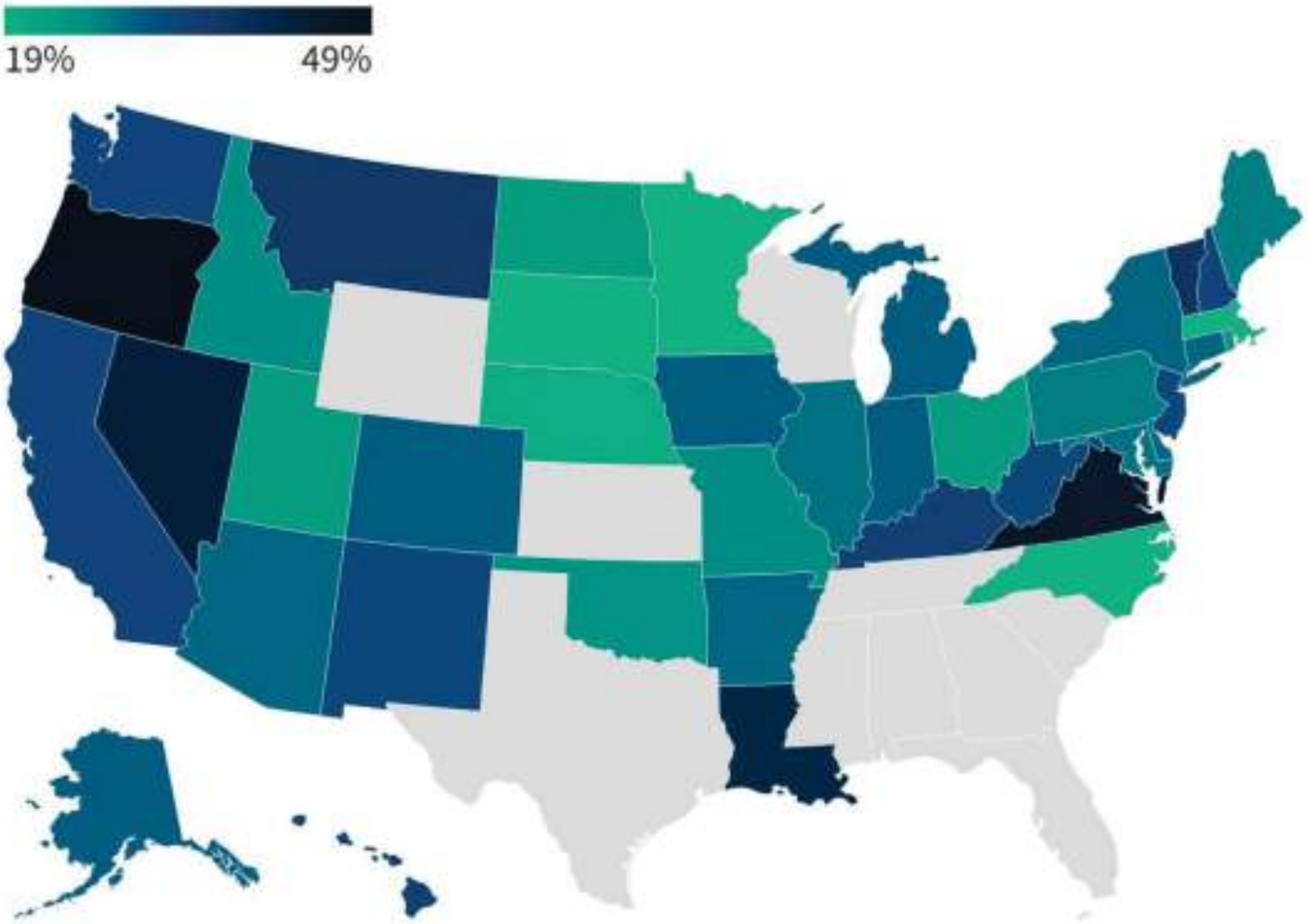
Congress may also consider proposals that would alter the financing for the Medicaid expansion. Any approach to reduce federal Medicaid spending for the expansion would shift costs to states, forcing governors to make tough choices about whether to

drop the ACA Medicaid expansion, provide alternative coverage options or make up the loss of federal funding by cutting other state programs or raising taxes. Twelve states have “trigger” laws in place that would automatically end expansion or require other changes if the share of federal funding drops below 90%, and two additional states, Ohio and South Dakota, are considering similar action. But all states, including those without trigger laws in place, would examine their ability to maintain the ACA Medicaid expansion if Medicaid expansion financing was altered. An analysis of the impact on Medicaid enrollment if all states eliminated the expansion shows the decline in enrollment would vary across states, ranging from 19% in Massachusetts, Minnesota, North Carolina, and South Dakota to 49% in Oregon (Figure 5).

Figure 5

Eliminating the ACA Expansion Match Rate Could Reduce Total Medicaid Enrollment By 19% to 49% Across Expansion States

Estimated percent decline in Medicaid enrollment (FY 2034) if current expansion states dropped the expansion



Source: KFF analysis of Medicaid enrollment and spending data from various sources. See Methods of "Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates " for more information about projections and assumptions.

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If states eliminate the Medicaid expansion, individuals with incomes 100-138% FPL would be eligible for subsidies in the Marketplace, but could face barriers transitioning to Marketplace coverage and could face higher out of pocket costs, especially if the enhanced subsidies expire at the end of 2025. However, current Medicaid expansion enrollees with incomes below 100% FPL are not eligible for

subsidies in the Marketplace and could fall into the “coverage gap” and become uninsured if they are unable to qualify for Medicaid under a different eligibility pathway, for example based on a disability. Currently, 1.4 million adults are in the coverage gap in the ten non-expansion states; however, that number would likely increase significantly under proposed policy changes targeting the Medicaid expansion. Eliminating the Medicaid expansion could have additional spillover effects, including children whose eligibility status is unchanged but become uninsured after their parents lose Medicaid coverage. People without insurance have more difficulty accessing care and are more likely to have medical debt, with almost one in four uninsured adults in 2023 not receiving needed medical treatment due to cost. Uninsured individuals are also less likely than those with insurance to receive preventive care and treatment for major health conditions and chronic diseases.

Methods

Medicaid Claims Data: This analysis uses the 2021 T-MSIS Research Identifiable Demographic-Eligibility and Claims Files (T-MSIS data) to identify Medicaid expansion enrollees, spending, and chronic conditions in Figures 2-4.

State Inclusion Criteria:

Expansion states: Though Idaho and Virginia expanded Medicaid prior to 2021, adult expansion enrollees primarily show up in the traditional adult eligibility group. Therefore, those expansion states are excluded from Figures 2-4. West Virginia is excluded from Figure 2 (but included in Figures 3-4) of this analysis due to unusable spending data, according to quality assessments from the DQ Atlas.

Non-expansion states: Mississippi was also excluded from Figure 2-3 this analysis due to data quality concerns flagged by the DQ Atlas.

Enrollee Inclusion Criteria: Enrollees were included if they were ages 19-64, had full Medicaid coverage for at least one month, and were not dually enrolled in Medicare. Dually enrolled individuals were excluded from these calculations since they may not have had sufficient claims in T-MSIS to identify chronic conditions.

Calculating Spending (Figure 2): This figure reflects spending from all states except Idaho, Virginia, West Virginia, and Mississippi. Average annual per capita spending calculations include fee-for-service spending and payments to managed care plans. Spending was calculated by summing the total spending of all claims per enrollee in the T-MSIS claims files. Estimates here do not include prescription drug rebates and most supplemental payments to providers.

Defining Chronic Conditions (Figure 4): This figure reflects chronic conditions from all expansion enrollees in expansion states that expanded prior to 2021 except for Idaho and Virginia. This analysis used the CCW algorithm for identifying chronic conditions (updated in 2020). This analysis also included in its definition of chronic conditions substance use disorder, mental health, obesity, HIV, hepatitis C, and intellectual and developmental disabilities. In total, 35 chronic conditions were included and were further grouped into 3 broad categories: behavioral health, physical health, and cognitive impairment conditions. Specific conditions within these groupings include:

Behavioral health conditions: Any mental health condition and any substance use disorder. See KFF's brief, "5 Key Facts About Medicaid Coverage for Adults with Mental Illness," KFF brief "SUD Treatment in Medicaid: Variation by Service Type, Demographics, States and Spending," and the Urban Institute, Behavioral Health Services Algorithm for additional details (Victoria Lynch, Lisa Clemans-Cope, Doug Wissoker, and Paul Johnson. Behavioral Health Services Algorithm. Version 4. Washington, DC: Urban Institute, 2024).

Physical health conditions: Hypertension, transient ischemic attack, acute myocardial infarction, hyperlipidemia, ischemic heart disease, atrial fibrillation, heart failure, obesity, chronic obstructive pulmonary disease, pneumonia, asthma, diabetes, arthritis, hip fracture, osteoporosis, cataracts, glaucoma, chronic kidney disease, colorectal cancer, endometrial cancer, urologic cancer, prostate cancer, lung cancer, breast cancer, hepatitis, HIV, anemia, hypothyroidism

Cognitive impairment conditions: Alzheimer's, intellectual and developmental delay, Parkinson's, and dementia

Appendix

Appendix Table 1

Medicaid Expansion Enrollment

Location	Expansion Group Enrollment	Total Medicaid Enrollment	State Election Result	Footnotes
United States	20,271,616	83,121,984		
Alabama	N/A	1,097,436	Trump	
Alaska	71,212	236,414	Trump	
Arizona	631,710	2,156,441	Trump	
Arkansas	242,602	812,769	Trump	
California	4,956,615	14,478,012	Harris	
Colorado	350,083	1,142,953	Harris	
Connecticut	322,407	1,085,951	Harris	
Delaware	70,019	237,013	Harris	
District of Columbia	118,303	256,959	Harris	
Florida	N/A	4,343,214	Trump	
Georgia	N/A	2,240,163	Trump	
Hawaii	156,126	441,394	Harris	
Idaho	93,337	354,682	Trump	
Illinois	843,458	2,941,752	Harris	
Indiana	568,700	1,833,150	Trump	
Iowa	182,541	603,298	Trump	
Kansas	N/A	358,416	Trump	
Kentucky	488,080	1,394,715	Trump	
Louisiana	784,585	1,855,653	Trump	
Maine	112,072	395,873	Harris	

Maryland	422,601	1,469,244	Harris	
Massachusetts	392,790	1,989,455	Harris	
Michigan	742,156	2,386,748	Trump	
Minnesota	221,348	1,170,996	Harris	
Mississippi	N/A	666,722	Trump	1
Missouri	326,915	1,223,109	Trump	
Montana	79,606	218,449	Trump	2
Nebraska	72,113	346,451	Trump	
Nevada	312,696	737,583	Trump	
New Hampshire	60,857	181,309	Harris	
New Jersey	567,989	1,721,810	Harris	
New Mexico	289,236	877,577	Harris	
New York	2,111,796	6,985,692	Harris	3
North Carolina	480,836	3,011,926	Trump	
North Dakota	24,356	105,070	Trump	
Ohio	729,295	3,081,179	Trump	4
Oklahoma	245,688	984,181	Trump	
Oregon	641,243	1,268,286	Harris	
Pennsylvania	831,819	2,986,165	Trump	
Rhode Island	78,989	308,855	Harris	
South Carolina	N/A	1,310,481	Trump	5
South Dakota	24,241	125,473	Trump	
Tennessee	N/A	1,524,162	Trump	
Texas	N/A	4,419,948	Trump	
Utah	78,443	336,538	Trump	
Vermont	64,675	167,586	Harris	

Virginia	683,528	1,519,807	Harris	
Washington	625,573	1,860,025	Harris	
West Virginia	170,977	522,117	Trump	
Wisconsin	N/A	1,278,155	Trump	
Wyoming	N/A	70,627	Trump	

Note: Enrollment from the Medicaid Budget and Expenditure System (MBES) is reported for each month.
1. Missouri expanded its Medicaid program by adopting the VIII Group on October 1, 2021.
2. Nebraska expanded its Medicaid program by adopting the VIII Group on October 1, 2020.
3. North Carolina expanded its Medicaid program by adopting the VIII Group on December 1, 2023.
4. Oklahoma expanded its Medicaid program by adopting the VIII Group on July 1, 2021.
5. South Dakota expanded its Medicaid program by adopting the VIII Group on July 1, 2023.

Source: KFF analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES)

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Appendix Table 2

Medicaid Expansion Spending

Location	Expansion Group - Federal Spending	Expansion Group - State Spending	Traditional Medicaid - Federal Spending
United States	$158,331,563,500	$19,910,232,500	$432,862,903,000
Alabama	N/A	N/A	$6,115,858,000
Alaska	$619,243,700	$38,918,200	$1,381,949,900
Arizona	$6,742,457,500	$709,590,200	$11,123,060,900
Arkansas	$2,329,491,100	$277,126,900	$4,562,147,600
California	$28,775,203,200	$3,268,018,800	$50,713,624,800
Colorado	$2,914,745,700	$332,704,000	$5,293,192,500
Connecticut	$2,477,498,500	$484,935,900	$4,096,914,100
Delaware	$826,860,500	$92,409,500	$1,539,699,900
District of Columbia	$696,915,300	$77,432,200	$2,401,120,600
Florida	N/A	N/A	$22,566,038,000
Georgia	N/A	N/A	$11,399,940,300
Hawaii	$929,989,300	$103,935,500	$1,287,827,300
Idaho	$775,087,100	$86,314,200	$2,060,471,200
Illinois	$8,708,492,500	$1,895,262,700	$11,270,177,000
Indiana	$3,947,067,200	$453,552,600	$9,522,057,000
Iowa	$1,416,242,700	$158,525,300	$3,640,257,200
Kansas	N/A	N/A	$3,373,617,700
Kentucky	$5,189,196,600	$578,826,600	$8,031,034,100
Louisiana	$5,485,590,600	$708,047,200	$6,602,937,600

Maine	$665,752,700	$92,354,200	$2,355,402,300
Maryland	$3,591,477,500	$399,059,600	$6,894,196,400
Massachusetts	$3,369,682,700	$373,670,100	$10,756,437,900
Michigan	$5,658,509,000	$710,094,100	$11,191,489,400
Minnesota	$3,263,687,500	$354,687,500	$8,341,536,700
Mississippi	N/A	N/A	$4,505,694,800
Missouri	$2,530,045,500	$281,864,300	$9,585,913,300
Montana	$932,547,900	$94,964,700	$978,281,000
Nebraska	$766,965,400	$93,805,700	$1,885,777,300
Nevada	$1,980,420,500	$217,824,300	$2,079,082,900
New Hampshire	$415,928,500	$50,356,100	$1,088,044,700
New Jersey	$5,594,358,300	$621,022,700	$9,350,631,600
New Mexico	$2,026,725,000	$211,870,300	$4,739,079,800
New York	$15,055,383,800	$2,689,050,600	$43,834,093,100
North Carolina	N/A	N/A	$13,752,491,600
North Dakota	$382,999,100	$47,138,000	$668,863,900
Ohio	$7,113,678,100	$789,815,500	$15,926,150,200
Oklahoma	$2,561,933,600	$233,386,800	$5,139,232,800
Oregon	$4,551,561,600	$506,854,800	$6,573,075,500
Pennsylvania	$7,083,684,700	$787,076,100	$19,543,836,300
Rhode Island	$758,536,900	$88,602,700	$1,622,248,100
South Carolina	N/A	N/A	$6,652,683,100
South Dakota	$11,769,600	$960,000	$786,090,500
Tennessee	N/A	N/A	$8,607,066,600
Texas	N/A	N/A	$36,190,073,700

Utah	$1,045,833,800	$113,261,900	$2,424,306,500
Vermont	$292,646,900	$32,495,600	$1,021,937,000
Virginia	$6,211,485,600	$692,144,700	$8,036,045,800
Washington	$9,348,678,300	$1,016,797,100	$10,195,002,000
West Virginia	$1,283,189,500	$145,475,300	$3,009,628,700
Wisconsin	N/A	N/A	$7,714,619,100
Wyoming	N/A	N/A	$431,964,700

Source: KFF analysis of Medicaid spending data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES)

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EXHIBIT 3

NHA-MEDICAID - ADMINISTRATION
101-3158

PROGRAM DESCRIPTION

The Nevada Health Authority account includes funding for the administrative costs of staff and vendors for the agency, including those staff and vendors that are eligible for federal funds under Title XIX and Title XXI of the Social Security Act. The agency's mission is to improve access to quality and affordable health care in Nevada through new purchasing strategies and sound policies; to promote equal access to health care at an affordable cost to the taxpayers of Nevada; to restrain the growth of health care costs; and to review Medicaid and other state health care programs to maximize potential federal revenue. Statutory Authority: NRS 422, NRS 439B, Title XIX and Title XXI of the Social Security Act and Section 42 of the Code of Federal Regulations.

BASE

This request continues 349.51 positions and associated operating costs. One-time expenditures have been eliminated, and partial year costs have been annualized. Additionally, this requests to transfer the Medicaid - Administration, budget account 3158, from the Department of Human Services to Director's Office of the Nevada Health Authority.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	41,431,138	37,846,857	41,890,421	40,263,630	43,429,605	41,776,625
REVERSIONS	-7,399,832	0	0	0	0	0
BALANCE FORWARD FROM PREVIOUS YEAR	1,240,452	4,521,635	650,377	650,377	687,374	692,278
BALANCE FORWARD TO NEW YEAR	-4,521,635	0	0	0	0	0
FEDERAL FUNDS FROM PREVIOUS YEAR	-242,910	242,910	0	0	0	0
FEDERAL RECEIPTS	0	380,800	0	0	0	0
FED TITLE XXI RECEIPTS	2,744,256	5,476,561	4,691,080	4,449,043	2,809,467	2,567,424
FEDERAL HRSA ORAL HEALTH GRANT	314,010	326,497	319,447	319,454	332,207	332,214
FED TITLE XIX RECEIPTS	152,717,058	159,448,686	147,694,442	150,594,531	151,140,281	153,572,549
FED EICA CHAPTER I GRANT	5,542	0	0	0	0	0
SUPPORT ACT GRANT	126,498	0	0	0	0	0
FED SHARE, HEALTH SERVICE COST	1,351,002	1,293,307	1,150,029	1,649,424	652,927	1,649,424
FEDERAL GRANT- CMS SCHOOL BASED SERVICES	0	500,000	1,000,000	1,000,000	1,000,000	1,000,000
HEALTH COST CONTAINMENT FEE	1,560,144	1,377,363	1,024,744	1,238,213	714,639	1,238,215
AUDIT FEES	0	204,650	177,432	170,958	177,432	0
CPE AUDIT FEES	100,930	118,606	109,999	165,858	107,876	165,859
PRIOR YEAR REVENUE	97,048	0	0	0	0	0
COUNTY REIMBURSEMENTS	205,042	80,313	68,454	90,291	219,064	90,291
CIVIL PENALTIES	131,749	41,894	36,990	41,894	449,691	41,894
COST CONTAINMENT FINES	0	83,608	0	83,608	0	83,608
RECOVERIES	1,256,525	2,125,380	2,562,979	2,125,380	2,562,978	2,125,379
PRIVATE GRANT ARNOLD VENTURE	278,143	0	0	0	0	0
KATIE BECKETT PREMIUMS	392,663	0	0	0	0	0
HOSPITAL ASSESS FOR COUNTIES	24,817,046	22,400,926	22,400,926	24,817,046	22,400,926	24,817,046
TRANSFER IN FED ARPA	8,721,496	10,476,170	3,015,590	906,684	1,266,156	924,760

NHA-MEDICAID - ADMINISTRATION
101-3158

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TRANSFER FROM DHHS-OPIOID	155,308	743,912	127,502	483,197	130,231	484,238
TRANSFER FROM BA 3157 IGT	50,000	50,000	2,212,801	50,000	2,272,100	50,000
TRANSFER FROM BA 3160 LTC PROVIDER TAX	447,240	436,009	0	436,009	0	436,009
TRANSFER FROM BA 3243 HCBS	844,386	0	0	0	0	0
TRANSFER FROM BA 3177	60,756	2,174,232	204,637	2,144,581	210,498	2,148,727
TRANSFER FROM BA 3245	70,316	0	0	0	0	0
TOTAL RESOURCES:	**226,954,371**	**250,350,316**	**229,337,850**	**231,680,178**	**230,563,452**	**234,196,540**
EXPENDITURES:						
PERSONNEL SERVICES	28,598,040	33,368,083	39,724,480	40,796,175	40,481,914	41,585,209
OUT-OF-STATE TRAVEL	18,410	32,185	23,452	23,452	23,452	23,452
IN-STATE TRAVEL	52,521	155,981	145,867	145,867	145,867	145,867
OPERATING	8,438,406	14,206,099	13,159,205	14,266,106	13,185,018	14,327,562
EQUIPMENT	44,097	29,227	0	0	0	0
ARPA STUDIES PROF SVCS	487,279	262,720	0	0	0	0
AUDIT EXPENSE	0	204,650	177,432	170,958	177,432	0
FISCAL AGENT	49,638,402	50,535,840	54,713,801	54,713,801	57,139,744	57,139,744
PAYMENTS TO STATE AGENCIES	74,176,847	76,988,789	68,454,075	68,810,192	68,454,075	68,669,102
ALL PAYERS CLAIM DATA BASE	754,435	2,154,695	1,701,549	1,958,870	1,747,846	2,006,208
RECOUP AND RECOVERIES	4,421,542	4,250,759	5,125,957	5,125,957	5,125,957	5,125,957
PHARMACY BENEFIT MANAGER	5,728,257	5,809,240	5,809,240	5,809,240	5,809,240	5,809,240
ARPA FISCAL SUPPORT	0	80,976	0	0	0	0
ARPA MANAGED CARE DIR PAY INIT	813,340	2,099,868	1,427,322	0	292,817	0
MOBILE CRISIS INTERVENTION GRANT	5,543	0	0	0	0	0
UNMET FREECARE OBLIGATIONS	24,817,046	22,400,926	22,400,926	24,817,046	22,400,926	24,817,046
ELECTRONIC VISIT VERIFICATION	663,390	750,000	752,500	752,500	482,500	482,500
SUPPORT ACT GRANT	126,498	0	0	0	0	0
PASS THRU TO LOCAL GOVT	15,511,467	16,671,741	8,851,207	8,851,207	9,088,400	9,088,400
INFORMATION SERVICES	756,130	855,165	953,446	867,980	953,615	867,980
TRAINING	39,058	50,840	36,235	36,235	36,235	36,235
HEALTH CARE INFORMATION WEB SITE	550,308	673,500	1,005,211	349,378	741,363	257,673
HCBS-AMERICAN RESCUE PLAN ACT	2,031,146	0	0	0	0	0
ARPA TRIBAL OUTREACH	29,986	8,074	0	0	0	0
ARPA SYS IMPROVEMENT PROJECTS	370,000	1,013,665	0	0	0	0
ARPA ORAL HEALTH FOR KIDS	1,227,990	1,484,782	635,842	0	0	0
ARPA LTC WORKFORCE	21,715	93,286	0	0	0	0

NHA-MEDICAID - ADMINISTRATION
101-3158

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
DSNP GRANT PROJECT	278,142	192,359	0	0	0	0
ROSEMAN UNIVERSITY	5,108,778	4,891,222	0	0	0	0
ORAL HEALTH WORKFORCE ACTIVITY	241,299	123,774	3,407	3,414	3,407	3,414
ARPA RARE DISEASE PROVIDER	50,000	0	0	0	0	0
WAIVER SUPPORT	278,429	690,198	750,000	690,198	750,000	690,198
CMS SCHOOLS BASED SVCS EXPANSION	0	500,000	1,000,000	1,000,000	1,000,000	1,000,000
REPLACEMENT EQUIPMENT	359,531	385,215	0	0	0	0
SB494 - SUR ACCESS DATABASE	0	431,855	0	0	0	0
SB494 - CENTRAL CREDENTIALING	0	1,600,000	0	0	0	0
SB 163 - GENDER DYSPHORIA	2,464	0	0	0	0	0
CDC ADVANCE ORAL HEALTH GRANT	0	380,800	0	0	0	0
AB 389	110,000	474,103	0	0	0	0
AB7-ELECTRONIC HEALTH RECORDS	0	3,000,000	0	0	0	0
AB 208 - FAMILY CAREGIVING	1,036	0	0	0	0	0
AB 286 - DOULA SERVICES	2,184	0	0	0	0	0
SB 221-SPECIAL DISEASE CLINICS	14,560	0	0	0	0	0
SB 385 - DENTAL SERVICES	280	0	0	0	0	0
AB 155 - BIOMARKER TESTING	0	650,000	0	0	0	0
MONEY FOLLOWS PERSON PLNG GRANT	0	0	0	2	0	2
HEALTH INFORMATION EXCHANGE	0	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
HIWA	0	400,000	0	0	0	0
RESERVE FOR RESIDENT PROTECTION	0	650,377	687,374	692,278	724,322	321,429
PURCHASING ASSESSMENT	8,183	8,183	8,183	8,183	8,183	8,183
STATEWIDE COST ALLOCATION PLAN	78,428	84,776	84,776	84,776	84,776	84,776
AG COST ALLOCATION PLAN	693,909	706,363	706,363	706,363	706,363	706,363
RESERVE FOR REVERSION TO GENERAL FUND	405,295	0	0	0	0	0
TOTAL EXPENDITURES:	**226,954,371**	**250,350,316**	**229,337,850**	**231,680,178**	**230,563,452**	**234,196,540**
TOTAL POSITIONS:	**326.51**	**326.51**	**336.51**	**349.51**	**336.51**	**349.51**

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MAINTENANCE

M100 STATEWIDE INFLATION

This request funds rate changes for internal service funds such as the Attorney General, Fleet Services, information technology services, state-owned building rent, vehicle insurance, personnel assessments, and property and contents insurance.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	38,046	189,484	37,270	194,771
FED TITLE XXI RECEIPTS	0	0	144	4,242	144	4,247
FEDERAL HRSA ORAL HEALTH GRANT	0	0	91	676	91	677
FED TITLE XIX RECEIPTS	0	0	38,877	345,044	38,102	392,917
HEALTH COST CONTAINMENT FEE	0	0	201	7,834	201	7,844
CPE AUDIT FEES	0	0	50	1,959	50	1,962
TRANSFER IN FED ARPA	0	0	180	1,351	180	1,354
TRANSFER FROM DHHS-OPIOID	0	0	30	226	30	226
TRANSFER FROM BA 3177	0	0	45	1,576	45	1,578
TOTAL RESOURCES:	**0**	**0**	**77,664**	**552,392**	**76,113**	**605,576**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	9,846	77,408	9,846	77,408
IN-STATE TRAVEL	0	0	775	4,353	775	4,353
OPERATING	0	0	5,036	187,285	5,035	187,218
INFORMATION SERVICES	0	0	62,006	92,588	60,456	84,382
ORAL HEALTH WORKFORCE ACTIVITY	0	0	1	0	1	0
PURCHASING ASSESSMENT	0	0	0	-8,183	0	-8,183
AG COST ALLOCATION PLAN	0	0	0	198,941	0	260,398
TOTAL EXPENDITURES:	**0**	**0**	**77,664**	**552,392**	**76,113**	**605,576**

M300 FRINGE BENEFITS RATE ADJUSTMENT

This request funds changes to fringe benefits rates.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	9,757	570,837	9,757	476,490
FED TITLE XXI RECEIPTS	0	0	0	4,826	0	4,000

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
FEDERAL HRSA ORAL HEALTH GRANT	0	0	0	9,575	0	7,824
FED TITLE XIX RECEIPTS	0	0	9,758	656,729	9,758	548,379
TRANSFER IN FED ARPA	0	0	0	26,219	0	21,904
TRANSFER FROM DHHS-OPIOID	0	0	0	3,376	0	2,769
TRANSFER FROM BA 3177	0	0	0	24,309	0	20,157
TOTAL RESOURCES:	**0**	**0**	**19,515**	**1,295,871**	**19,515**	**1,081,523**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	19,515	1,295,871	19,515	1,081,523
TOTAL EXPENDITURES:	**0**	**0**	**19,515**	**1,295,871**	**19,515**	**1,081,523**

M501 MANDATES - Actuarially Sound Rates in Managed Care

The request continues funding for required actuary services for mainstream managed care program and adds funding for non-emergency medical transport services and a new specialized managed care program for certain children through the end of the biennium.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	620,800	230,815	1,241,600	416,615
FED TITLE XIX RECEIPTS	0	0	995,800	605,815	1,991,600	1,166,615
TRANSFER FROM BA 3177	0	0	375,000	375,000	750,000	750,000
TOTAL RESOURCES:	**0**	**0**	**1,991,600**	**1,211,630**	**3,983,200**	**2,333,230**
EXPENDITURES:						
OPERATING	0	0	1,991,600	1,211,630	3,983,200	2,333,230
TOTAL EXPENDITURES:	**0**	**0**	**1,991,600**	**1,211,630**	**3,983,200**	**2,333,230**

M503 MANDATES - HCBS Grievance and Incident Command

This request adds one Social Services Chief, one new Social Services Manager, one Social Services Specialist, one Health Care Coordinator, and one Administrative Assistant for new federal mandates for home and community-based waiver services programs.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	109,745	223,733	108,241	280,352

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
FED TITLE XIX RECEIPTS	0	0	109,745	223,732	108,242	280,351
TOTAL RESOURCES:	**0**	**0**	**219,490**	**447,465**	**216,483**	**560,703**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	195,052	381,695	200,850	517,000
IN-STATE TRAVEL	0	0	955	3,818	955	3,818
OPERATING	0	0	10,086	26,682	10,367	27,448
EQUIPMENT	0	0	5,314	13,285	0	0
INFORMATION SERVICES	0	0	6,624	19,066	2,852	9,518
TRAINING	0	0	1,459	2,919	1,459	2,919
TOTAL EXPENDITURES:	**0**	**0**	**219,490**	**447,465**	**216,483**	**560,703**
TOTAL POSITIONS:	**0.00**	**0.00**	**2.00**	**5.00**	**2.00**	**5.00**

M504 MANDATES - Juvenile Justice Coverage

This request adds two Health Care Coordinators to support new benefits in Medicaid for the juvenile justice population. This request is a companion to decision unit M504 in the Nevada Medicaid budget accounts 3243, Nevada Check-Up Program budget account 3178, and the Improved Health Care Quality budget account 3177.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	125,804	0	124,594	0
FED TITLE XIX RECEIPTS	0	0	125,804	83,235	124,594	103,991
TRANSFER FROM BA 3177	0	0	0	83,235	0	103,991
TOTAL RESOURCES:	**0**	**0**	**251,608**	**166,470**	**249,188**	**207,982**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	225,416	139,341	231,758	189,663
IN-STATE TRAVEL	0	0	1,910	1,910	1,910	1,910
OPERATING	0	0	11,176	11,110	11,500	11,434
EQUIPMENT	0	0	5,314	5,314	0	0
INFORMATION SERVICES	0	0	6,624	7,627	2,852	3,807
TRAINING	0	0	1,168	1,168	1,168	1,168
TOTAL EXPENDITURES:	**0**	**0**	**251,608**	**166,470**	**249,188**	**207,982**
TOTAL POSITIONS:	**0.00**	**0.00**	**2.00**	**2.00**	**2.00**	**2.00**

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M505 MANDATES - Federal Compliance Unit

This request adds one Social Services Program Specialist and one Legal Research Assistant to support federal compliance activities and appeals for Medicaid.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	131,690	86,414	130,849	108,504
FED TITLE XIX RECEIPTS	0	0	131,691	86,414	130,849	108,505
TOTAL RESOURCES:	**0**	**0**	**263,381**	**172,828**	**261,698**	**217,009**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	238,144	146,654	245,223	199,645
IN-STATE TRAVEL	0	0	955	955	955	955
OPERATING	0	0	11,176	11,110	11,500	11,434
EQUIPMENT	0	0	5,314	5,314	0	0
INFORMATION SERVICES	0	0	6,624	7,627	2,852	3,807
TRAINING	0	0	1,168	1,168	1,168	1,168
TOTAL EXPENDITURES:	**0**	**0**	**263,381**	**172,828**	**261,698**	**217,009**
TOTAL POSITIONS:	**0.00**	**0.00**	**2.00**	**2.00**	**2.00**	**2.00**

M506 MANDATES - Provider Screening and Enrollment

This request adds two Social Services Program Specialist positions for federal compliance with provider screening and enrollment requirements for Medicaid programs.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	132,168	86,891	131,326	108,982
FED TITLE XIX RECEIPTS	0	0	132,168	86,892	131,327	108,982
TOTAL RESOURCES:	**0**	**0**	**264,336**	**173,783**	**262,653**	**217,964**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	238,144	146,654	245,223	199,645
IN-STATE TRAVEL	0	0	1,910	1,910	1,910	1,910
OPERATING	0	0	11,176	11,110	11,500	11,434
EQUIPMENT	0	0	5,314	5,314	0	0
INFORMATION SERVICES	0	0	6,624	7,627	2,852	3,807
TRAINING	0	0	1,168	1,168	1,168	1,168

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**264,336**	**173,783**	**262,653**	**217,964**
TOTAL POSITIONS:	**0.00**	**0.00**	**2.00**	**2.00**	**2.00**	**2.00**

M507 MANDATES - IT Support

This request adds one IT Manager, one IT Professional, and one Management Analyst to address federal compliance needs due to the increased risk from cybersecurity attacks and ransomware for health care technology systems.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	120,144	89,052	115,103	102,627
FED TITLE XIX RECEIPTS	0	0	321,149	213,689	319,169	272,007
TOTAL RESOURCES:	**0**	**0**	**441,293**	**302,741**	**434,272**	**374,634**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	402,007	249,280	408,129	338,768
IN-STATE TRAVEL	0	0	2,864	3,818	2,864	3,818
OPERATING	0	0	16,763	22,135	17,249	22,782
EQUIPMENT	0	0	7,971	10,628	0	0
INFORMATION SERVICES	0	0	9,937	14,545	4,279	6,931
TRAINING	0	0	1,751	2,335	1,751	2,335
TOTAL EXPENDITURES:	**0**	**0**	**441,293**	**302,741**	**434,272**	**374,634**
TOTAL POSITIONS:	**0.00**	**0.00**	**3.00**	**3.00**	**3.00**	**3.00**

M510 MANDATES - MAC and BAC

This request adds one Administrative Assistant to provide support new federal requirements for state consumer advisory committees and funds required travel compensation for participation. This request is contingent upon passage and approval of enabling legislation.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	45,270	34,576	44,137	41,939
FED TITLE XIX RECEIPTS	0	0	45,274	34,577	44,138	41,941
TOTAL RESOURCES:	**0**	**0**	**90,544**	**69,153**	**88,275**	**83,880**

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
EXPENDITURES:						
PERSONNEL SERVICES	0	0	75,108	53,253	77,263	72,427
IN-STATE TRAVEL	0	0	477	477	477	477
OPERATING	0	0	8,697	8,662	8,816	8,781
EQUIPMENT	0	0	2,657	2,657	0	0
INFORMATION SERVICES	0	0	3,313	3,812	1,427	1,903
TRAINING	0	0	292	292	292	292
TOTAL EXPENDITURES:	**0**	**0**	**90,544**	**69,153**	**88,275**	**83,880**
TOTAL POSITIONS:	**0.00**	**0.00**	**1.00**	**1.00**	**1.00**	**1.00**

M512 MANDATES - EQRO

This request adds one Social Services Program Specialist and additional contractual costs to fund the federally required External Quality Review Organization contract for the expanded managed care program.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	1,011,435	360,212	1,026,872	254,291
FED TITLE XIX RECEIPTS	0	0	1,011,434	360,210	1,026,871	254,289
TOTAL RESOURCES:	**0**	**0**	**2,022,869**	**720,422**	**2,053,743**	**508,580**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	85,611	70,541	116,485	95,222
OPERATING	0	0	1,061,801	649,175	1,061,801	412,675
FISCAL AGENT	0	0	875,000	0	875,000	0
INFORMATION SERVICES	0	0	457	706	457	683
TOTAL EXPENDITURES:	**0**	**0**	**2,022,869**	**720,422**	**2,053,743**	**508,580**
TOTAL POSITIONS:	**0.00**	**0.00**	**1.00**	**1.00**	**1.00**	**1.00**

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ENHANCEMENT

E250 HEALTH & WELLNESS

This request funds an increase in the projected nursing facility supplemental payments from fiscal year 2025 to fiscal years 2026 and 2027 which are transferred from budget account 3160 Increasing Quality of Nursing Care. This decision unit is a companion to E252 in the Increasing Quality of Nursing Care budget account 3160.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
TRANSFER FROM BA 3160 LTC PROVIDER TAX	0	0	0	83,090	0	112,068
TOTAL RESOURCES:	**0**	**0**	**0**	**83,090**	**0**	**112,068**
EXPENDITURES:						
OPERATING	0	0	0	83,090	0	112,068
TOTAL EXPENDITURES:	**0**	**0**	**0**	**83,090**	**0**	**112,068**

E252 HEALTH & WELLNESS

This request funds the creation of a single Preferred Drug List (PDL) for Medicaid and a purchasing strategy for a single Pharmacy Benefits Manager (PBM) for Medicaid and other state coverage programs to support reduced costs on pharmaceuticals for covered Nevadans and the state budget. The funds will support additional staff and vendor costs necessary to implement and operate the new Medicaid single PDL and statewide PBM purchasing strategy under the Nevada Health Authority. This request is a companion to decision unit E252 in the Prescription Drug Rebate budget account 3245 and decision unit E254 in the Nevada Medicaid budget account 3243.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	187,308	234,865	303,958	357,576
TRANSFER FROM BA 3245	0	0	187,307	234,865	303,958	357,575
TOTAL RESOURCES:	**0**	**0**	**374,615**	**469,730**	**607,916**	**715,151**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	146,042	209,590	198,850	282,803
IN-STATE TRAVEL	0	0	1,431	2,864	1,910	3,818
OPERATING	0	0	209,146	219,423	402,166	416,239
EQUIPMENT	0	0	7,971	15,942	0	0
INFORMATION SERVICES	0	0	9,149	19,721	3,822	9,372
TRAINING	0	0	876	2,190	1,168	2,919
TOTAL EXPENDITURES:	**0**	**0**	**374,615**	**469,730**	**607,916**	**715,151**
TOTAL POSITIONS:	**0.00**	**0.00**	**2.00**	**3.00**	**2.00**	**3.00**

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E253 HEALTH & WELLNESS

This request adds one Social Services Program Specialist and necessary vendor resources to improve the development and oversight of contract(s), policies, and procedures for non-emergency medical transportation benefit in Medicaid.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	173,116	165,783	187,174	176,764
FED TITLE XIX RECEIPTS	0	0	173,117	165,782	187,175	176,763
TOTAL RESOURCES:	**0**	**0**	**346,233**	**331,565**	**374,349**	**353,527**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	85,611	70,541	116,485	95,222
IN-STATE TRAVEL	0	0	716	716	955	955
OPERATING	0	0	253,608	253,573	254,899	254,864
EQUIPMENT	0	0	2,657	2,657	0	0
INFORMATION SERVICES	0	0	3,202	3,639	1,427	1,903
TRAINING	0	0	439	439	583	583
TOTAL EXPENDITURES:	**0**	**0**	**346,233**	**331,565**	**374,349**	**353,527**
TOTAL POSITIONS:	**0.00**	**0.00**	**1.00**	**1.00**	**1.00**	**1.00**

E255 HEALTH & WELLNESS

This request continues funding for an existing Biostatistician, Management Analyst, and Administrative Assistant for the oral health program due to the expiration of federal grant funds. This request is a companion to decision unit E491.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	0	74,096	76,599
FED TITLE XIX RECEIPTS	0	0	0	0	215,317	221,956
TOTAL RESOURCES:	**0**	**0**	**0**	**0**	**289,413**	**298,555**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	0	282,445	290,764
IN-STATE TRAVEL	0	0	0	0	1,000	1,000
OPERATING	0	0	0	0	3,157	3,050
INFORMATION SERVICES	0	0	0	0	1,811	2,741
TRAINING	0	0	0	0	1,000	1,000

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**0**	**0**	**289,413**	**298,555**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**0.00**	**3.00**	**3.00**

E256 HEALTH & WELLNESS

This request funds the increase in contracts above the legislatively approved budget.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	45,437	0	45,522
FED TITLE XXI RECEIPTS	0	0	0	45,437	0	45,521
TOTAL RESOURCES:	**0**	**0**	**0**	**90,874**	**0**	**91,043**
EXPENDITURES:						
INFORMATION SERVICES	0	0	0	90,874	0	91,043
TOTAL EXPENDITURES:	**0**	**0**	**0**	**90,874**	**0**	**91,043**

E258 HEALTH & WELLNESS

This request funds costs for an expert vendor to support an effort to modernize and improve financing for mobile crisis services through Medicaid. This request is a companion to decision unit E258 in the Improved Health Care Quality budget accounts 3177, Nevada Medicaid 3243, and the Nevada Check-Up Program, budget account 3178.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	85,000	0	0	0
FED TITLE XIX RECEIPTS	0	0	85,000	87,500	0	0
TRANSFER FROM BA 3177	0	0	0	87,500	0	0
TOTAL RESOURCES:	**0**	**0**	**170,000**	**175,000**	**0**	**0**
EXPENDITURES:						
OPERATING	0	0	170,000	175,000	0	0
TOTAL EXPENDITURES:	**0**	**0**	**170,000**	**175,000**	**0**	**0**

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E262 HEALTH & WELLNESS

This request adds one Management Analyst to leverage federal Medicaid funds to support workforce initiatives, like Graduate Medical Education programs in the state. This request is a companion to decision unit E262 in the Prescription Drug Rebate budget account 3245 and the Nevada Medicaid budget account 3243.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	52,032	43,876	67,985	56,369
TRANSFER FROM BA 3245	0	0	52,033	43,875	67,985	56,368
TOTAL RESOURCES:	**0**	**0**	**104,065**	**87,751**	**135,970**	**112,737**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	92,830	76,112	126,257	102,581
IN-STATE TRAVEL	0	0	716	716	955	955
OPERATING	0	0	4,221	4,188	5,748	5,715
EQUIPMENT	0	0	2,657	2,657	0	0
INFORMATION SERVICES	0	0	3,202	3,639	1,427	1,903
TRAINING	0	0	439	439	1,583	1,583
TOTAL EXPENDITURES:	**0**	**0**	**104,065**	**87,751**	**135,970**	**112,737**
TOTAL POSITIONS:	**0.00**	**0.00**	**1.00**	**1.00**	**1.00**	**1.00**

E275 PUBLIC SAFETY & INFRASTRUCTURE

This request adds one Management Analyst and associated system costs to support the development of the state's Behaviorally Complex Care Program by offering participating skilled nursing facilities a new quality incentive payment to reward high performing facilities. This is a companion to E275 in budget account 3243 Nevada Medicaid and budget account 3177 Improved Health Care Quality.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	0	36,384	0	77,351
TRANSFER FROM BA 3177	0	0	0	36,384	0	77,352
TOTAL RESOURCES:	**0**	**0**	**0**	**72,768**	**0**	**154,703**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	63,531	0	129,701
OPERATING	0	0	0	2,821	0	5,716
EQUIPMENT	0	0	0	2,657	0	0
FISCAL AGENT	0	0	0	0	0	16,800

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
INFORMATION SERVICES	0	0	0	3,467	0	1,903
TRAINING	0	0	0	292	0	583
TOTAL EXPENDITURES:	**0**	**0**	**0**	**72,768**	**0**	**154,703**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E280 PUBLIC SAFETY & INFRASTRUCTURE

This request adds one Deputy Director, one Deputy Administrator position, one Personnel Officer, and one Public Information Officer to support the administration of the Nevada Health Authority in the Director's Office. This request is a companion to decision unit E811.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	280,014	0	278,457
FED TITLE XIX RECEIPTS	0	0	0	338,694	0	354,429
TRANSFER FROM BA 3216 HCQC	0	0	0	58,678	0	75,972
TOTAL RESOURCES:	**0**	**0**	**0**	**677,386**	**0**	**708,858**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	617,330	0	670,907
IN-STATE TRAVEL	0	0	0	2,864	0	2,864
OPERATING	0	0	0	22,168	0	25,137
EQUIPMENT	0	0	0	18,074	0	0
INFORMATION SERVICES	0	0	0	14,907	0	7,614
TRAINING	0	0	0	2,043	0	2,336
TOTAL EXPENDITURES:	**0**	**0**	**0**	**677,386**	**0**	**708,858**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**4.00**	**0.00**	**4.00**

E281 PUBLIC SAFETY & INFRASTRUCTURE

This request funds one new Administrative Services Officer to lead the purchasing and contracts unit for the Nevada Health Authority.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	432,612	0	322,220

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
FED TITLE XIX RECEIPTS	0	0	0	432,612	0	322,220
TRANSFER FROM BA 3245	0	0	0	750,000	0	500,000
TOTAL RESOURCES:	**0**	**0**	**0**	**1,615,224**	**0**	**1,144,440**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	99,759	0	135,104
OPERATING	0	0	0	1,505,007	0	1,006,850
EQUIPMENT	0	0	0	6,380	0	0
INFORMATION SERVICES	0	0	0	3,639	0	1,903
TRAINING	0	0	0	439	0	583
TOTAL EXPENDITURES:	**0**	**0**	**0**	**1,615,224**	**0**	**1,144,440**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E282 PUBLIC SAFETY & INFRASTRUCTURE

This request adds one agency General Counsel and one Deputy Director for the Nevada Health Authority's Purchasing and Compliance section. This request is a companion to decision unit E815.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	262,533	0	252,423
FED TITLE XIX RECEIPTS	0	0	0	262,533	0	252,423
TOTAL RESOURCES:	**0**	**0**	**0**	**525,066**	**0**	**504,846**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	493,793	0	489,660
IN-STATE TRAVEL	0	0	0	1,910	0	1,910
OPERATING	0	0	0	8,106	0	8,301
EQUIPMENT	0	0	0	12,760	0	0
INFORMATION SERVICES	0	0	0	7,329	0	3,807
TRAINING	0	0	0	1,168	0	1,168
TOTAL EXPENDITURES:	**0**	**0**	**0**	**525,066**	**0**	**504,846**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**2.00**	**0.00**	**2.00**

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E283 PUBLIC SAFETY & INFRASTRUCTURE
This request adds one Administrative Services Officer for the Medicaid section under the Nevada Health Authority to oversee the Provider Reimbursement Unit.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	67,904	0	76,402
FED TITLE XIX RECEIPTS	0	0	0	67,904	0	76,401
TOTAL RESOURCES:	**0**	**0**	**0**	**135,808**	**0**	**152,803**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	88,620	0	119,839
IN-STATE TRAVEL	0	0	0	2,149	0	2,864
OPERATING	0	0	0	16,497	0	22,617
EQUIPMENT	0	0	0	14,351	0	0
INFORMATION SERVICES	0	0	0	12,440	0	5,147
TRAINING	0	0	0	1,751	0	2,336
TOTAL EXPENDITURES:	**0**	**0**	**0**	**135,808**	**0**	**152,803**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E284 PUBLIC SAFETY & INFRASTRUCTURE
This request adds one Director of Project Management for the Nevada Health Authority to oversee the enterprise informational technology and innovation.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	33,971	0	42,867
FED TITLE XIX RECEIPTS	0	0	0	101,910	0	128,600
TOTAL RESOURCES:	**0**	**0**	**0**	**135,881**	**0**	**171,467**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	117,506	0	161,176
IN-STATE TRAVEL	0	0	0	955	0	955
OPERATING	0	0	0	6,645	0	6,850
EQUIPMENT	0	0	0	6,380	0	0
INFORMATION SERVICES	0	0	0	3,812	0	1,903
TRAINING	0	0	0	583	0	583

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**0**	**135,881**	**0**	**171,467**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E286 PUBLIC SAFETY & INFRASTRUCTURE
This request adds one Deputy Director to oversee the Consumer Health section of the Nevada Health Authority.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	125,958	0	120,886
FED TITLE XIX RECEIPTS	0	0	0	125,959	0	120,887
TOTAL RESOURCES:	**0**	**0**	**0**	**251,917**	**0**	**241,773**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	233,542	0	231,482
IN-STATE TRAVEL	0	0	0	955	0	955
OPERATING	0	0	0	6,645	0	6,850
EQUIPMENT	0	0	0	6,380	0	0
INFORMATION SERVICES	0	0	0	3,812	0	1,903
TRAINING	0	0	0	583	0	583
TOTAL EXPENDITURES:	**0**	**0**	**0**	**251,917**	**0**	**241,773**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E301 GOVERNMENT SUPPORT SERVICES
This request funds the necessary positions, technology, and vendor support to modernize and automate Medicaid enrollment through Nevada Health Link's online technology platform, while leveraging enhanced federal Medicaid funds to support this initiative. This request is a companion to decision unit E301 in the Prescription Drug Rebate budget account 3245.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	299,408	306,486	340,988	347,729
FED TITLE XIX RECEIPTS	0	0	29,889,013	29,611,278	29,963,560	29,601,361
TRANSFER FROM BA 3245	0	0	3,497,222	3,468,878	3,571,531	3,532,922
TOTAL RESOURCES:	**0**	**0**	**33,685,643**	**33,386,642**	**33,876,079**	**33,482,012**

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
EXPENDITURES:						
PERSONNEL SERVICES	0	0	1,486,100	1,181,430	1,990,031	1,589,742
IN-STATE TRAVEL	0	0	10,023	10,023	13,363	13,363
OPERATING	0	0	61,428	60,958	81,350	80,885
EQUIPMENT	0	0	59,536	59,536	0	0
INFORMATION SERVICES	0	0	44,825	50,964	19,963	26,650
MEDICAID MODERNIZATION	0	0	32,017,600	32,017,600	31,763,200	31,763,200
TRAINING	0	0	6,131	6,131	8,172	8,172
TOTAL EXPENDITURES:	**0**	**0**	**33,685,643**	**33,386,642**	**33,876,079**	**33,482,012**
TOTAL POSITIONS:	**0.00**	**0.00**	**14.00**	**14.00**	**14.00**	**14.00**

E303 GOVERNMENT SUPPORT SERVICES

This request adds one Training officer and increases category 30 Training, to expand staff expertise, improve professional development, and increase training for Nevada Health Authority staff. This request is a companion to decision unit E303 in the Prescription Drug Rebate budget account 3245.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	91,222	83,456	184,874	173,893
TRANSFER FROM BA 3245	0	0	91,221	83,456	184,874	173,892
TOTAL RESOURCES:	**0**	**0**	**182,443**	**166,912**	**369,748**	**347,785**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	89,211	73,278	121,274	98,870
IN-STATE TRAVEL	0	0	716	716	955	955
OPERATING	0	0	3,608	3,573	4,899	4,864
EQUIPMENT	0	0	2,657	2,657	0	0
INFORMATION SERVICES	0	0	3,202	3,639	1,427	1,903
TRAINING	0	0	83,049	83,049	241,193	241,193
TOTAL EXPENDITURES:	**0**	**0**	**182,443**	**166,912**	**369,748**	**347,785**
TOTAL POSITIONS:	**0.00**	**0.00**	**1.00**	**1.00**	**1.00**	**1.00**

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E309 GOVERNMENT SUPPORT SERVICES

This request adds a Medicaid Academic Partnership between Division of Health Care Financing and Policy and participating public universities. This request is a companion to decision unit E309 in the Intergovernmental Transfer Program budget account 3157.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	1,019,320	1,019,320	1,019,320	1,019,320
TRANSFER FROM BA 3157 IGT	0	0	339,773	339,773	339,773	339,773
TOTAL RESOURCES:	**0**	**0**	**1,359,093**	**1,359,093**	**1,359,093**	**1,359,093**
EXPENDITURES:						
PASS THRU TO LOCAL GOVT	0	0	1,359,093	1,359,093	1,359,093	1,359,093
TOTAL EXPENDITURES:	**0**	**0**	**1,359,093**	**1,359,093**	**1,359,093**	**1,359,093**

E312 GOVERNMENT SUPPORT SERVICES

This request funds a contracted state Dental Hygienist as required by NRS 439.279.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FED TITLE XIX RECEIPTS	0	0	0	169,769	0	168,487
TRANSFER FROM DHHS-OPIOID	0	0	0	56,590	0	56,162
TOTAL RESOURCES:	**0**	**0**	**0**	**226,359**	**0**	**224,649**
EXPENDITURES:						
OPERATING	0	0	0	226,359	0	224,649
TOTAL EXPENDITURES:	**0**	**0**	**0**	**226,359**	**0**	**224,649**

E491 EXPIRING GRANT/PROGRAM

This request eliminates funding beginning September 1, 2026, due to the expiration of federal funding under the Health Resources and Services Administration Oral Health Grant. This request is a companion to decision unit E255, Oral Health Program.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
FEDERAL HRSA ORAL HEALTH GRANT	0	0	-293,007	0	-307,464	-268,444

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL RESOURCES:	**0**	**0**	**-293,007**	**0**	**-307,464**	**-268,444**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	-291,280	0	-303,037	-263,235
OPERATING	0	0	-357	0	-2,690	-2,583
INFORMATION SERVICES	0	0	-1,370	0	-1,737	-2,626
TOTAL EXPENDITURES:	**0**	**0**	**-293,007**	**0**	**-307,464**	**-268,444**
TOTAL POSITIONS:	**0.00**	**0.00**	**-3.00**	**0.00**	**-3.00**	**-3.00**

E499 EXPIRING ARPA GRANT/PROGRAM

This request eliminates seven positions funded with American Rescue Plan Act funding due to the sunsetting of American Rescue Plan Act funds.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
TRANSFER IN FED ARPA	0	0	0	-934,254	0	-948,018
TOTAL RESOURCES:	**0**	**0**	**0**	**-934,254**	**0**	**-948,018**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	-928,720	0	-942,651
OPERATING	0	0	0	-586	0	-584
INFORMATION SERVICES	0	0	0	-4,948	0	-4,783
TOTAL EXPENDITURES:	**0**	**0**	**0**	**-934,254**	**0**	**-948,018**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**-7.00**	**0.00**	**-7.00**

E599 CONTINUING EXPIRING ARPA POSITIONS

This request continues the funding for a Budget Analyst, Business Process Analyst, IT professional, IT Technician, Management Analyst, Personnel Analyst, and a Pharmacist due to the expiration of federal American Rescue Plan Act funds.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	357,109	0	359,831
FED TITLE XIX RECEIPTS	0	0	0	670,340	0	671,757

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL RESOURCES:	**0**	**0**	**0**	**1,027,449**	**0**	**1,031,588**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	1,021,915	0	1,026,221
OPERATING	0	0	0	586	0	584
INFORMATION SERVICES	0	0	0	4,948	0	4,783
TOTAL EXPENDITURES:	**0**	**0**	**0**	**1,027,449**	**0**	**1,031,588**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**7.00**	**0.00**	**7.00**

E710 EQUIPMENT REPLACEMENT

This request funds replacement computer hardware and associated software per the Office of the Chief Information Officer's recommended replacement schedule.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	70,234	70,234	67,425	67,425
FED TITLE XIX RECEIPTS	0	0	70,234	70,234	67,426	67,426
TOTAL RESOURCES:	**0**	**0**	**140,468**	**140,468**	**134,851**	**134,851**
EXPENDITURES:						
INFORMATION SERVICES	0	0	140,468	140,468	134,851	134,851
TOTAL EXPENDITURES:	**0**	**0**	**140,468**	**140,468**	**134,851**	**134,851**

E720 NEW EQUIPMENT

This request funds critical new computer hardware and associated software needs identified to sustain Division Information Technology infrastructure.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	7,571	7,571	7,572	7,572
FED TITLE XIX RECEIPTS	0	0	7,572	7,572	7,571	7,571
TOTAL RESOURCES:	**0**	**0**	**15,143**	**15,143**	**15,143**	**15,143**
EXPENDITURES:						
INFORMATION SERVICES	0	0	15,143	15,143	15,143	15,143

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**15,143**	**15,143**	**15,143**	**15,143**

E808 CLASSIFIED POSITION CHANGES
This request reclassifies a student worker position to an Accounting Assistant 2.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	23,219	19,977	24,242	20,852
FED TITLE XXI RECEIPTS	0	0	1	0	0	0
FED TITLE XIX RECEIPTS	0	0	23,223	19,976	24,242	20,852
HEALTH COST CONTAINMENT FEE	0	0	2	0	0	0
CPE AUDIT FEES	0	0	1	0	0	0
TOTAL RESOURCES:	**0**	**0**	**46,446**	**39,953**	**48,484**	**41,704**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	46,164	39,566	48,202	41,328
OPERATING	0	0	58	41	58	41
INFORMATION SERVICES	0	0	224	346	224	335
TOTAL EXPENDITURES:	**0**	**0**	**46,446**	**39,953**	**48,484**	**41,704**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.49**	**0.49**	**0.49**	**0.49**

E810 CLASSIFIED POSITION CHANGES
This request reclassifies Social Services Chief 3 to a Health Bureau Chief to align with the expanded responsibilities assigned in the Purchasing and Compliance Division of the Nevada Health Authority for this position. This request is a companion to decision unit E283 in budget account 3158.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	4,986	0	5,233
FED TITLE XIX RECEIPTS	0	0	0	4,986	0	5,232
TOTAL RESOURCES:	**0**	**0**	**0**	**9,972**	**0**	**10,465**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	9,972	0	10,465

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**0**	**9,972**	**0**	**10,465**

E811 UNCLASSIFIED CHANGES

This request reclassifies one Division Administrator of Health Care Financing and Policy to Director of Nevada Health Authority Department. This is a companion to decision unit E280 in budget account 3158.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	9,320	0	9,314
FED TITLE XIX RECEIPTS	0	0	0	9,320	0	9,315
TOTAL RESOURCES:	**0**	**0**	**0**	**18,640**	**0**	**18,629**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	18,640	0	18,629
TOTAL EXPENDITURES:	**0**	**0**	**0**	**18,640**	**0**	**18,629**

E815 UNCLASSIFIED POSITION CHANGES

This request reclassifies one Agency Manager to a Deputy Administrator who will serve as the Medicaid Inspector General at the Nevada Health Authority. This request is a companion to decision unit E282.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	472	0	472
FED TITLE XIX RECEIPTS	0	0	0	473	0	472
TOTAL RESOURCES:	**0**	**0**	**0**	**945**	**0**	**944**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	945	0	944
TOTAL EXPENDITURES:	**0**	**0**	**0**	**945**	**0**	**944**

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E816 UNCLASSIFIED POSITION CHANGES

This request reclassifies one Deputy Administrator to a Deputy Director that will oversee the budget and fiscal activities of the Nevada Health Authority. This request is a companion to decision units E283.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	15,578	0	15,569
FED TITLE XIX RECEIPTS	0	0	0	15,579	0	15,570
TOTAL RESOURCES:	**0**	**0**	**0**	**31,157**	**0**	**31,139**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	31,157	0	31,139
TOTAL EXPENDITURES:	**0**	**0**	**0**	**31,157**	**0**	**31,139**

E900 TRANSFERS FROM WELFARE ADMIN TO HCFP

The request transfers six positions consisting of one Business Process Analyst, three Social Services Program Specialists, and two Information Technology Professionals from Welfare Administration, budget account 3228, to Health Care Financing & Policy, budget account 3158, to transfer oversight of Medicaid policy.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	216,170	0	220,807
UNIVERSAL ENERGY CHARGE-UEC	0	0	0	8,040	0	8,330
FED SNAP ADMINISTRATION 50/50	0	0	0	35,078	0	36,278
FED CHILD SUPPORT	0	0	0	25,968	0	26,899
FED SNAP EMPLOYMENT & TRAINING	0	0	0	6,112	0	6,331
FED TANF	0	0	0	181,061	0	181,750
FED LIHEA EAP	0	0	0	30,622	0	31,728
FED CHILD CARE DEVELOPMENT	0	0	0	37,881	0	39,258
TITLE XIX MEDICAID 50/75/90	0	0	0	198,159	0	202,186
TITLE XXI NV CHECKUP SCHIP FMAP	0	0	0	20,023	0	20,751
TOTAL RESOURCES:	**0**	**0**	**0**	**759,114**	**0**	**774,318**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	754,371	0	769,717
OPERATING	0	0	0	503	0	501
INFORMATION SERVICES	0	0	0	4,240	0	4,100

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**0**	**0**	**0**	**759,114**	**0**	**774,318**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**6.00**	**0.00**	**6.00**

E901 TRANSFERS FROM HOME & COMMUNITY TO HNA ADMIN

This request transfers three Social Service Program Specialist positions from Home and Community-Based Services, budget account 3266, to Nevada Health Authority, Medicaid Administration, budget account 3158 to conduct provider reviews.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	207,648	0	211,141
TITLE XIX - MEDICAID CASE MGMT	0	0	0	21,228	0	21,440
TITLE XIX - MEDICAID ADMIN	0	0	0	67,953	0	69,189
TOTAL RESOURCES:	**0**	**0**	**0**	**296,829**	**0**	**301,770**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	289,259	0	294,271
IN-STATE TRAVEL	0	0	0	1,836	0	1,836
OPERATING	0	0	0	1,540	0	1,539
INFORMATION SERVICES	0	0	0	4,194	0	4,124
TOTAL EXPENDITURES:	**0**	**0**	**0**	**296,829**	**0**	**301,770**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**

E902 TRANSFER FROM DESERT REG CNTR TO NHA ADMIN

This request transfers two Management Analysts and one Auditor from Desert Regional Center, budget account 3279, to Nevada Health Authority, Medicaid Administration, budget account 3158.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	262,043	0	266,292
ICF-MR CLIENT LIABILITY	0	0	0	1,632	0	1,426
TITLE XIX - MEDICAID CASE MGMT	0	0	0	51,924	0	44,980
TITLE XIX - COMMUNITY SERVICES	0	0	0	214	0	106
MEDICAID ADMIN CHARGES	0	0	0	37,021	0	36,747

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
COUNTY REIMBURSEMENTS	0	0	0	37	0	19
TOTAL RESOURCES:	**0**	**0**	**0**	**352,871**	**0**	**349,570**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	342,673	0	344,507
OPERATING	0	0	0	940	0	939
INFORMATION SERVICES	0	0	0	9,258	0	4,124
TOTAL EXPENDITURES:	**0**	**0**	**0**	**352,871**	**0**	**349,570**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**

E903 TRANSFER FROM NHA ADMIN TO SCIENCE INNOVATION TECH

This requests transfers one Management Analyst IV that administers the Graduate Medical Education (GME) grant in the Science Innovation and Technology, budget account 1003 to the Department of Health and Human Services, Division of Healthcare Financing and Policy, budget account 3158.

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	0	0	0	156,846	0	156,172
TOTAL RESOURCES:	**0**	**0**	**0**	**156,846**	**0**	**156,172**
EXPENDITURES:						
PERSONNEL SERVICES	0	0	0	155,135	0	154,484
OPERATING	0	0	0	314	0	314
INFORMATION SERVICES	0	0	0	1,397	0	1,374
TOTAL EXPENDITURES:	**0**	**0**	**0**	**156,846**	**0**	**156,172**
TOTAL POSITIONS:	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**

E999 UNFUNDED

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
UNFUNDED DECISION UNITS	0	0	27,788,392	0	12,591,156	0
TOTAL RESOURCES:	**0**	**0**	**27,788,392**	**0**	**12,591,156**	**0**

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SUMMARY

	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
RESOURCES:						
APPROPRIATION CONTROL	41,431,138	37,846,857	51,434,243	45,184,296	53,771,086	46,841,745
REVERSIONS	-7,399,832	0	0	0	0	0
BALANCE FORWARD FROM PREVIOUS YEAR	1,240,452	4,521,635	650,377	650,377	687,374	692,278
BALANCE FORWARD TO NEW YEAR	-4,521,635	0	0	0	0	0
FEDERAL FUNDS FROM PREVIOUS YEAR	-242,910	242,910	0	0	0	0
UNIVERSAL ENERGY CHARGE-UEC	0	0	0	8,040	0	8,330
FEDERAL RECEIPTS	0	380,800	0	0	0	0
FED TITLE XXI RECEIPTS	2,744,256	5,476,561	4,691,225	4,503,548	2,809,611	2,621,192
FEDERAL HRSA ORAL HEALTH GRANT	314,010	326,497	26,531	329,705	24,834	72,271
FED TITLE XIX RECEIPTS	152,717,058	159,448,686	202,475,566	186,871,190	193,603,040	190,756,757
FED EICA CHAPTER I GRANT	5,542	0	0	0	0	0
SUPPORT ACT GRANT	126,498	0	0	0	0	0
FED SNAP ADMINISTRATION 50/50	0	0	0	35,078	0	36,278
FED CHILD SUPPORT	0	0	0	25,968	0	26,899
FED SHARE, HEALTH SERVICE COST	1,351,002	1,293,307	1,150,029	1,649,424	652,927	1,649,424
FED SNAP EMPLOYMENT & TRAINING	0	0	0	6,112	0	6,331
FED TANF	0	0	0	181,061	0	181,750
FED LIHEA EAP	0	0	0	30,622	0	31,728
FED CHILD CARE DEVELOPMENT	0	0	0	37,881	0	39,258
FEDERAL GRANT- CMS SCHOOL BASED SERVICES	0	500,000	1,000,000	1,000,000	1,000,000	1,000,000
HEALTH COST CONTAINMENT FEE	1,560,144	1,377,363	1,024,947	1,246,047	714,840	1,246,059
AUDIT FEES	0	204,650	177,432	170,958	177,432	0
CPE AUDIT FEES	100,930	118,606	110,050	167,817	107,926	167,821
ICF-MR CLIENT LIABILITY	0	0	0	1,632	0	1,426
TITLE XIX - MEDICAID CASE MGMT	0	0	0	73,152	0	66,420
TITLE XIX - MEDICAID ADMIN	0	0	0	67,953	0	69,189
TITLE XIX - COMMUNITY SERVICES	0	0	0	214	0	106
MEDICAID ADMIN CHARGES	0	0	0	37,021	0	36,747
TITLE XIX MEDICAID 50/75/90	0	0	0	198,159	0	202,186
TITLE XXI NV CHECKUP SCHIP FMAP	0	0	0	20,023	0	20,751
PRIOR YEAR REVENUE	97,048	0	0	0	0	0
COUNTY REIMBURSEMENTS	205,042	80,313	68,454	90,328	219,064	90,310
CIVIL PENALTIES	131,749	41,894	36,990	41,894	449,691	41,894

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
COST CONTAINMENT FINES	0	83,608	0	83,608	0	83,608
RECOVERIES	1,256,525	2,125,380	2,562,979	2,125,380	2,562,978	2,125,379
PRIVATE GRANT ARNOLD VENTURE	278,143	0	0	0	0	0
KATIE BECKETT PREMIUMS	392,663	0	0	0	0	0
HOSPITAL ASSESS FOR COUNTIES	24,817,046	22,400,926	22,400,926	24,817,046	22,400,926	24,817,046
TRANSFER IN FED ARPA	8,721,496	10,476,170	2,110,521	0	342,854	0
TRANSFER FROM DHHS-OPIOID	155,308	743,912	2,019,375	543,389	477,983	543,395
TRANSFER FROM BA 3157 IGT	50,000	50,000	2,552,574	389,773	2,611,873	389,773
TRANSFER FROM BA 3216 HCQC	0	0	0	58,678	0	75,972
TRANSFER FROM BA 3160 LTC PROVIDER TAX	447,240	436,009	0	519,099	0	548,077
TRANSFER FROM BA 3243 HCBS	844,386	0	0	0	0	0
TRANSFER FROM BA 3177	60,756	2,174,232	579,682	2,752,585	960,543	3,101,805
TRANSFER FROM BA 3245	70,316	0	3,827,783	4,581,074	4,128,348	4,620,757
TOTAL RESOURCES:	**226,954,371**	**250,350,316**	**298,899,684**	**278,499,132**	**287,703,330**	**282,212,962**
EXPENDITURES:						
PERSONNEL SERVICES	28,598,040	33,368,083	43,754,388	48,416,817	45,571,124	50,240,180
OUT-OF-STATE TRAVEL	18,410	32,185	23,452	23,452	23,452	23,452
IN-STATE TRAVEL	52,521	155,981	171,941	188,812	177,716	195,538
OPERATING	8,438,406	14,206,099	17,891,296	19,002,396	20,172,608	19,539,404
EQUIPMENT	44,097	29,227	128,618	192,943	0	0
ARPA STUDIES PROF SVCS	487,279	262,720	0	0	0	0
AUDIT EXPENSE	0	204,650	177,432	170,958	177,432	0
FISCAL AGENT	49,638,402	50,535,840	55,588,801	54,713,801	58,014,744	57,156,544
PAYMENTS TO STATE AGENCIES	74,176,847	76,988,789	68,454,075	68,810,192	68,454,075	68,669,102
ALL PAYERS CLAIM DATA BASE	754,435	2,154,695	1,701,549	1,958,870	1,747,846	2,006,208
RECOUP AND RECOVERIES	4,421,542	4,250,759	5,125,957	5,125,957	5,125,957	5,125,957
PHARMACY BENEFIT MANAGER	5,728,257	5,809,240	5,809,240	5,809,240	5,809,240	5,809,240
ARPA FISCAL SUPPORT	0	80,976	0	0	0	0
ARPA MANAGED CARE DIR PAY INIT	813,340	2,099,868	1,427,322	0	292,817	0
MOBILE CRISIS INTERVENTION GRANT	5,543	0	0	0	0	0
UNMET FREECARE OBLIGATIONS	24,817,046	22,400,926	22,400,926	24,817,046	22,400,926	24,817,046
ELECTRONIC VISIT VERIFICATION	663,390	750,000	752,500	752,500	482,500	482,500
SUPPORT ACT GRANT	126,498	0	0	0	0	0
PASS THRU TO LOCAL GOVT	15,511,467	16,671,741	16,710,300	10,210,300	16,947,493	10,447,493
INFORMATION SERVICES	756,130	855,165	1,307,002	1,418,506	1,221,169	1,303,938

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
MEDICAID MODERNIZATION	0	0	32,017,600	32,017,600	31,763,200	31,763,200
NDOC EHR	0	0	18,352,529	0	2,915,600	0
TRAINING	39,058	50,840	137,385	144,392	300,442	308,907
HEALTH CARE INFORMATION WEB SITE	550,308	673,500	1,005,211	349,378	741,363	257,673
HCBS-AMERICAN RESCUE PLAN ACT	2,031,146	0	0	0	0	0
ARPA TRIBAL OUTREACH	29,986	8,074	0	0	0	0
ARPA SYS IMPROVEMENT PROJECTS	370,000	1,013,665	0	0	0	0
ARPA ORAL HEALTH FOR KIDS	1,227,990	1,484,782	635,842	0	0	0
ARPA LTC WORKFORCE	21,715	93,286	0	0	0	0
DSNP GRANT PROJECT	278,142	192,359	0	0	0	0
ROSEMAN UNIVERSITY	5,108,778	4,891,222	0	0	0	0
ORAL HEALTH WORKFORCE ACTIVITY	241,299	123,774	3,408	3,414	3,408	3,414
ARPA RARE DISEASE PROVIDER	50,000	0	0	0	0	0
WAIVER SUPPORT	278,429	690,198	750,000	690,198	750,000	690,198
CMS SCHOOLS BASED SVCS EXPANSION	0	500,000	1,000,000	1,000,000	1,000,000	1,000,000
ADMINISTRATIVE HEARINGS	0	0	1,086,214	0	1,086,574	0
REPLACEMENT EQUIPMENT	359,531	385,215	0	0	0	0
SB494 - SUR ACCESS DATABASE	0	431,855	0	0	0	0
SB494 - CENTRAL CREDENTIALING	0	1,600,000	0	0	0	0
SB 163 - GENDER DYSPHORIA	2,464	0	0	0	0	0
CDC ADVANCE ORAL HEALTH GRANT	0	380,800	0	0	0	0
AB 389	110,000	474,103	0	0	0	0
AB7-ELECTRONIC HEALTH RECORDS	0	3,000,000	0	0	0	0
AB 208 - FAMILY CAREGIVING	1,036	0	0	0	0	0
AB 286 - DOULA SERVICES	2,184	0	0	0	0	0
SB 221-SPECIAL DISEASE CLINICS	14,560	0	0	0	0	0
SB 385 - DENTAL SERVICES	280	0	0	0	0	0
AB 155 - BIOMARKER TESTING	0	650,000	0	0	0	0
MONEY FOLLOWS PERSON PLNG GRANT	0	0	0	2	0	2
HEALTH INFORMATION EXCHANGE	0	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
HIWA	0	400,000	0	0	0	0
RESERVE FOR RESIDENT PROTECTION	0	650,377	687,374	692,278	724,322	321,429
PURCHASING ASSESSMENT	8,183	8,183	8,183	0	8,183	0
STATEWIDE COST ALLOCATION PLAN	78,428	84,776	84,776	84,776	84,776	84,776
AG COST ALLOCATION PLAN	693,909	706,363	706,363	905,304	706,363	966,761
RESERVE FOR REVERSION TO GENERAL FUND	405,295	0	0	0	0	0

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	2023-2024 ACTUAL	2024-2025 WORK PROGRAM	2025-2026 AGENCY REQUEST	2025-2026 GOVERNOR RECOMMENDS	2026-2027 AGENCY REQUEST	2026-2027 GOVERNOR RECOMMENDS
TOTAL EXPENDITURES:	**226,954,371**	**250,350,316**	**298,899,684**	**278,499,132**	**287,703,330**	**282,212,962**
PERCENT CHANGE:		**10.31%**	**19.39%**	**11.24%**	**-3.75%**	**1.33%**
TOTAL POSITIONS:	**326.51**	**326.51**	**366.00**	**410.00**	**369.00**	**410.00**

EXHIBIT 4

Assembly Bill No. 591–Committee on Ways and Means

CHAPTER.....

AN ACT relating to state financial administration; making appropriations from the State General Fund and the State Highway Fund for the support of the civil government of the State of Nevada for the 2025-2027 biennium; providing for the use of the money so appropriated; making various other changes relating to the financial administration of the State; and providing other matters properly relating thereto.

EXPLANATION – Matter in bolded italics is new; matter between brackets [omitted material] is material to be omitted.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The sums set forth in sections 2 to 34, inclusive, of this act are hereby appropriated from the State General Fund for the purposes expressed in those sections and for the support of the government of the State of Nevada for Fiscal Year 2025-2026 and Fiscal Year 2026-2027.

	2025-2026	2026-2027
Sec. 2. The Office of the Governor.		
For the support of the:		
Office of the Governor	$6,086,691	$6,129,359
Office for New Americans	538,177	548,960
Office of Finance	6,946,980	7,338,591
Office of Finance – Special Appropriations	275,000	250,000
Division of Internal Audits	2,713,860	2,715,844
CORE.NV	4,417,619	4,410,215
Governor's Mansion	407,110	405,851
Agency for Nuclear Projects	1,520,464	1,516,594
Office of Energy	100	100
Office of Science, Innovation and Technology	4,469,267	4,486,360
Office of Federal Assistance	931,814	929,726
Office of Emergency Management	1,801,768	1,847,207

	2025-2026	2026-2027
Homeland Security	$31,971	$35,063
Nevada Office of Cyber Defense Coordination	610,209	606,195

Sec. 3. The Office of Lieutenant Governor.

For the support of the Office of the Lieutenant Governor $1,138,358 $1,144,102

Sec. 4. The Office of Attorney General.

For the support of the:

Attorney General Administration	$4,641,854	$4,004,696
Special Litigation Account	1,208,655	1,208,655
Medicaid Fraud Control Unit	283,887	693,868
Crime Prevention	313,005	305,009
Office of the Extradition Coordinator	1,676,123	1,679,909
Consumer's Advocate	900,314	882,351
Advisory Council for Prosecuting Attorneys	200,929	234,150
Grants Unit	109,645	117,390
Victims of Domestic Violence	258,254	254,782
Investigations Unit	3,263,601	3,260,362

Sec. 5. The Office of Secretary of State.

For the support of the:

Office of the Secretary of State	$25,319,804	$26,361,219
Help America Vote Act	1,369,246	1,399,240

Sec. 6. The Office of State Treasurer.

For the support of the:

Office of the State Treasurer	$728,058	$1,375,783
Nevada Employee Savings Trust Administration	731,244	783,288

Sec. 7. The Office of State Controller.

For the support of the Office of the State Controller $7,868,693 $8,148,374

	2025-2026	2026-2027
Sec. 8. Department of Administration.		
For the support of the:		
National Judicial College and National Council of Juvenile and Family Court Judges	$352,500	$352,500
Director's Office	46,694	46,417
State Public Works Division - Marlette Lake	100	100
State Public Works Division - Facility Condition and Analysis	517,391	514,633
State Library	3,689,104	3,708,904
Archives and Public Records	2,656,033	2,654,782
Merit Award Board	8,000	0
Sec. 9. Department of Taxation.		
For the support of the Department of Taxation	$49,606,489	$50,752,402
Sec. 10. Legislative Fund.		
For the support of the:		
Legislative Commission	$550,000	$470,000
Audit Division	9,972,736	10,040,964
Administrative Division	57,406,542	56,821,098
Legal Division	16,972,533	17,851,963
Research Division	8,639,133	8,690,907
Fiscal Analysis Division	6,203,169	6,150,566
Interim Legislative Operations	2,378,575	2,406,460
Sec. 11. Supreme Court of Nevada.		
For the support of the:		
Specialty Courts	$6,992,837	$7,348,654
Supreme Court of Nevada	2,880,532	2,903,731
Supreme Court Law Library	1,961,064	2,005,504
Senior Justice and Senior Judge Program	1,545,898	1,545,898
State Judicial Elected Officials	27,137,860	31,926,365
Court of Appeals	439,925	457,895

	2025-2026	2026-2027
Judicial Department Staff Salaries	$30,081,655	$30,063,463
Administrative Office of the Courts	5,226,178	5,028,707

Sec. 12. Commission on Judicial Discipline.

For the support of the Commission on Judicial Discipline	$1,520,532	$1,503,129

Sec. 13. Office of Economic Development in the Office of the Governor.

For the support of the:

Office of Economic Development	$9,316,413	$9,363,531
Rural Community Development	265,616	262,429
Workforce Innovations for a New Nevada Account	2,005,000	2,005,000
Nevada Main Street Program	341,669	341,669
Procurement Outreach Program	332,631	332,640
Knowledge Account	2,500,000	2,500,000

Sec. 14. Department of Tourism and Cultural Affairs.

For the support of the:

Museums and History Administration	$160,359	$160,625
Nevada Historical Society, Reno	261,227	196,361
Nevada State Museum Carson City	426,993	432,908
Nevada State Museum Las Vegas	433,098	419,382
Lost City Museum	125,702	123,291
Nevada State Railroad Museums	338,299	364,433
Nevada Arts Council	1,142,306	1,167,333
Nevada Humanities	200,000	200,000

Sec. 15. Department of Education.

For the support of the:

Office of the Superintendent	$3,517,887	$3,615,594

	2025-2026	2026-2027
Parental Involvement and Family Engagement	$206,630	$222,173
Office of Early Learning and Development	55,472,586	73,161,810
Literacy Programs	932,910	855,989
Student and School Support	1,434,337	1,428,865
Standards and Instructional Support	4,417,646	4,414,297
District Support Services	2,279,322	2,340,607
Career and Technical Education	1,500,775	1,491,626
Continuing Education	858,286	851,201
Individuals with Disabilities Education Act	777,408	833,362
Assessments and Accountability	15,690,289	15,752,361
Educator Effectiveness	830,103	823,004
Data Systems Management	4,033,668	4,028,182
Safe and Respectful Learning	1,985,600	2,021,214
Account for Alternative Schools	178,013	188,908

Sec. 16. Nevada System of Higher Education.

For the support of the:

System Administration	$8,623,352	$8,606,893
System Computing Center	20,666,545	20,600,234
University Press	554,873	552,400
Special Projects	2,512,557	2,507,585
Business Center North	2,807,626	2,791,883
Business Center South	2,326,864	2,311,557
University of Nevada, Reno	179,729,463	178,640,909
UNR – Intercollegiate Athletics	5,718,902	5,718,917
UNR – Statewide Programs	10,386,322	10,353,179
Agricultural Experiment Station	7,229,132	7,192,232

	2025-2026	2026-2027
Cooperative Extension Service	$4,974,948	$4,945,036
UNR – School of Medicine	44,062,675	43,929,486
Health Laboratory and Research	2,210,917	2,200,687
University of Nevada, Las Vegas	278,369,269	274,255,918
UNLV – School of Medicine	55,979,322	55,540,125
UNLV – Intercollegiate Athletics	8,664,978	8,651,793
UNLV – Statewide Programs	6,189,655	6,176,170
UNLV Law School	13,378,506	12,979,367
UNLV Dental School	13,700,757	13,251,566
Great Basin College	18,447,536	18,406,398
Nevada State University	37,356,896	36,092,310
Desert Research Institute	11,095,689	11,061,202
College of Southern Nevada	127,608,809	124,740,751
Western Nevada College	21,280,177	21,273,246
Truckee Meadows Community College	49,293,623	48,439,039
Silver State Opportunity Grant Program	5,000,000	5,000,000
Prison Education Program	453,522	451,934
Western Interstate Commission for Higher Education:		
Administration	433,959	441,258
Loans and Stipends	1,019,715	1,079,104

Sec. 17. Department of Human Services.

For the support of the:

Human Services Administration	$3,663,872	$3,867,948
Grants Management Unit	43,828	44,691
Aging and Disability Services Division:		
Administration	3,317,444	2,835,208
Autism Treatment Assistance Program	8,399,600	9,078,215

	2025-2026	2026-2027
Home- and Community-Based Services	$23,676,884	$23,993,362
Early Intervention Services	44,254,663	44,671,495
Consumer Health Assistance	1,113,277	1,146,188
Nevada Commission for Persons Who Are Deaf and Hard of Hearing	34,282	34,282
Desert Regional Center	157,326,317	159,090,450
Sierra Regional Center	53,291,830	54,300,507
Rural Regional Center	21,515,700	21,752,842
Family Preservation Program	2,644,673	2,644,185
FOCIS and MFP	637,144	652,836
Planning, Advocacy and Community Grants	8,827,116	8,924,274
Adult Protective Services and Long-Term Care	16,410,878	16,745,273
State Independent Living Council	164,551	171,387
Division of Child and Family Services:		
Community Juvenile Justice Services	3,322,626	3,339,674
Information Services	5,175,496	5,222,385
Children, Youth and Family Administration	8,709,768	8,779,793
Nevada Youth Training Center	10,669,819	10,802,139
Caliente Youth Center	10,485,450	10,534,978
Rural Child Welfare	13,960,457	14,284,511
Youth Alternative Placement	3,057,866	3,198,940
Youth Parole Services	4,529,103	4,541,066

	2025-2026	2026-2027
Northern Nevada Child and Adolescent Services	$6,652,464	$6,867,439
Clark County Child Welfare	73,146,380	73,520,211
Washoe County Child Welfare	20,434,184	20,434,878
Southern Nevada Child and Adolescent Services	25,307,188	25,721,922
Summit View Youth Center	10,214,994	10,309,027
Family Support Program	2,417,037	2,952,757
Victims of Crime	4,660,241	4,720,309
Division of Public and Behavioral Health:		
Public Health:		
Office of Health Administration	756,828	1,694,047
Maternal, Child and Adolescent Health Services	925,311	961,600
Community Health Services	1,738,327	1,985,901
Emergency Medical Services	1,268,110	1,259,222
Immunization Program	1,511,886	1,586,221
Health Investigations and Epidemiology	577,639	634,360
Chronic Disease	568,829	568,829
Public Health Preparedness Program	347,292	366,330
Family Planning	2,676,849	2,694,747
Public Health Improvements	7,500,000	7,500,000

	2025-2026	2026-2027
Behavioral Health:		
Southern Nevada Adult Mental Health Services	$130,636,893	$131,932,743
Northern Nevada Adult Mental Health Services	28,103,572	28,621,632
Lake's Crossing Center	18,805,805	19,184,297
Rural Clinics	16,812,806	17,000,795
Behavioral Health Prevention and Treatment	6,481,894	6,917,849
Problem Gambling	2,088,293	2,125,559
Division of Social Services:		
Welfare Administration	22,012,553	21,819,673
Welfare Field Services	67,227,025	68,678,971
Assistance to Aged and Blind	12,445,616	13,042,413
Temporary Assistance for Needy Families	24,607,810	24,607,810
Child Assistance and Development	2,580,421	2,580,421

Sec. 18. Nevada Health Authority.

For the support of the:

Nevada Medicaid	$1,175,394,320	$1,273,173,048
Medicaid Administration	44,781,939	46,929,619
Public Option	2,608,025	2,625,248
Nevada Check-Up Program	22,959,208	24,663,168
Developmental Disabilities	163,866	161,595
Data Analytics	1,239,525	1,264,282
Patient Protection Commission	431,561	432,264
Health Care Facilities Regulation	338,153	338,618
Account for the Graduate Medical Education Grant Program	8,530,000	0

	2025-2026	2026-2027
Sec. 19. Office of the Military.		
For the support of the:		
Office of the Military	$8,639,942	$9,049,281
National Guard Benefits	72,000	72,000
Sec. 20. Department of Veterans Services.		
For the support of the:		
Department of Veterans Services	$4,755,313	$4,617,100
Northern Nevada Veterans Home Account	438,360	438,360
Sec. 21. Department of Corrections.		
For the support of the:		
Office of the Director	$41,002,003	$43,387,588
Prison Medical Care	70,115,282	72,037,324
Correctional Programs	15,397,961	15,639,430
Southern Nevada Correctional Center	180,085	180,085
Southern Desert Correctional Center	45,142,948	47,278,436
Nevada State Prison	156,984	156,984
Northern Nevada Correctional Center	41,752,291	42,525,981
Warm Springs Correctional Center	736,360	740,431
Ely State Prison	31,382,032	32,266,262
Lovelock Correctional Center	39,194,346	40,260,878
Florence McClure Women's Correctional Center	27,818,121	28,254,226
Stewart Conservation Camp	2,833,680	2,851,641
Ely Conservation Camp	60,015	60,015
Humboldt Conservation Camp	128,054	118,920
Three Lakes Valley Conservation Camp	4,058,803	4,134,668
Jean Conservation Camp	2,638,482	2,679,085
Pioche Conservation Camp	2,949,603	2,995,463

	2025-2026	2026-2027
Carlin Conservation Camp	$2,225,523	$2,269,437
Wells Conservation Camp	36,349	21,793
Tonopah Conservation Camp	96,339	75,379
Northern Nevada Transitional Housing	1,209,788	1,207,936
High Desert State Prison	95,552,528	97,391,730
Casa Grande Transitional Housing	5,325,891	5,375,639
Training Academy	13,954,058	14,705,941
Prison Industry	250,000	0
Prison Ranch	350,000	0

Sec. 22. Department of Business and Industry.

For the support of the:

Business and Industry Administration	$1,121,828	$1,092,454
Office of Business and Planning	464,592	468,226
Real Estate Administration	3,040,911	2,802,205
Office of Labor Commissioner	3,647,750	4,007,295
New Markets Performance Guarantee Account	144,955	147,376
Office of Nevada Boards, Commissions and Councils Standards	324,029	0

Sec. 23. State Department of Agriculture.

For the support of the:

Administrative Services	$229,179	$288,920
Plant Health and Quarantine Services	641,955	648,916
Veterinary Medical Services	1,529,431	1,545,739
Predatory Animal and Rodent Control	1,086,966	1,105,544
Nutrition Education Programs	807,656	808,592
Livestock Enforcement	526,790	534,432

	2025-2026	2026-2027
Commodity Foods Distribution	$104,970	$104,989

Sec. 24. State Department of Conservation and Natural Resources.

For the support of the:

Conservation and Natural Resources Administration	$881,139	$815,110
Division of State Parks	15,101,699	15,650,026
Nevada Tahoe Regional Planning Agency	1,881	1,881
Out-of-State Fire Suppression Account	100	100
Division of Forestry	13,865,765	14,062,597
Forest Fire Suppression	6,650,010	6,682,897
Forestry Conservation Camps	9,778,741	9,984,869
Division of Water Resources	12,236,893	12,575,388
Division of State Lands	2,604,573	2,543,075
Division of Natural Heritage	307,183	305,952
Division of Outdoor Recreation	785,888	796,240
Conservation Districts Program	824,836	834,162
Office of Historic Preservation	851,099	858,925
Comstock Historic District	332,532	340,887

Sec. 25. Tahoe Regional Planning Agency.

For the support of the Tahoe Regional Planning Agency	$2,783,479	$2,783,479

Sec. 26. Department of Wildlife.

For the support of the:

Law Enforcement	$44,984	$42,256
Fisheries Management	151,209	151,209
Game Management	74,341	74,341
Biodiversity Division	577,679	577,320
Conservation Education	231,928	232,216

	2025-2026	2026-2027
Sec. 27. Department of Employment, Training and Rehabilitation.		
For the support of the:		
Nevada Equal Rights Commission	$2,482,882	$2,424,466
Bureau of Vocational Rehabilitation	6,236,993	6,673,956
Bureau of Services to Persons Who Are Blind or Visually Impaired	812,889	834,159
Commission on Postsecondary Education	697,555	702,144
Nevada P20 Workforce Reporting	860,951	859,856
Governor's Office of Workforce Innovation	230,242	250,906
Sec. 28. Department of Motor Vehicles.		
For the support of the Division of Customer Services	$35,590	$35,590
Sec. 29. Department of Public Safety.		
For the support of the:		
Training Division	$1,262,678	$1,270,296
Justice Grant	215,224	208,299
Nevada Highway Patrol Division	88,077	87,953
Dignitary Protection	2,609,342	2,635,994
Investigation Division	10,795,125	10,834,836
State Board of Parole Commissioners	4,385,235	4,399,423
Division of Parole and Probation	81,652,316	83,853,032
Central Repository for Nevada Records of Criminal History	11,362,358	9,236,114
Child Volunteer Background Checks	15,086	15,086
State Fire Marshal Division	100	100

	2025-2026	2026-2027
Sec. 30. Commission on Ethics.		
For the support of the Commission on Ethics	$449,725	$387,182
Sec. 31. Department of Indigent Defense Services.		
For the support of the:		
Department of Indigent Defense Services	$12,948,021	$12,978,924
Office of the State Public Defender	2,443,847	2,376,171
Sec. 32. Department of Sentencing Policy.		
For the support of the Department of Sentencing Policy	$995,410	$1,009,974
Sec. 33. Peace Officers' Standards and Training Commission.		
For the support of the Peace Officers' Standards and Training Commission	$2,905,013	$3,041,756
Sec. 34. Department of Native American Affairs.		
For the support of the:		
Nevada Indian Commission	$987,461	$1,007,566
Stewart Indian School Living Legacy	227,619	230,418

Sec. 35. The following sums are hereby appropriated from the State Highway Fund for the purposes expressed in this section for Fiscal Year 2025-2026 and Fiscal Year 2026-2027:

Department of Motor Vehicles:		
Office of the Director	$4,142,300	$4,318,318
Fiscal Operations Division	12,887,604	12,889,873
Hearings Office	1,726,459	1,742,291
Division of Information Technology	11,508,102	10,558,236
Division of Customer Services	25,767,571	25,540,339
Division of Compliance Enforcement	9,846,890	9,946,374
Division of Research and Project Management	3,703,032	3,711,645
Motor Carrier Division	3,063,361	3,052,829
Department Transformation Effort	9,512,217	11,189,570

	2025-2026	2026-2027
Department of Public Safety:		
Training Division	$1,337,739	$1,345,675
Nevada Highway Patrol Division	106,037,375	108,589,658
Highway Safety Plan and Administration	435,395	437,359
Investigation Division	742,628	766,052
State Emergency Response Commission	331,454	328,563
Highway Safety Grants Account	54,081	54,104
Department of Business and Industry:		
Nevada Transportation Authority	$6,177,021	$6,191,225
Legislative Fund:		
Legislative Counsel Bureau	$5,000	$5,000
The Office of the Governor:		
CORE.NV	$1,036,232	$1,034,495

Sec. 36. 1. Except as otherwise provided in subsection 3, the sums appropriated by this act must be:

(a) Expended in accordance with the allotment, transfer, work program and budget provisions of NRS 353.150 to 353.246, inclusive; and

(b) Work-programmed for the two separate fiscal years of the 2025-2027 biennium, as required by NRS 353.215. Work programs may be revised with the approval of the Governor upon the recommendation of the Director of the Office of Finance in the Office of the Governor and in accordance with the provisions of the State Budget Act.

2. Transfers to and from salary allotments, travel allotments, operating expense allotments, equipment allotments and other allotments must be allowed and made in accordance with the provisions of NRS 353.215 to 353.225, inclusive, and after separate consideration of the merits of each request.

3. Pursuant to law, sums appropriated for the support of the Supreme Court of Nevada, the Legislative Fund and the Tahoe Regional Planning Agency are excluded from the allotment, transfer, work program and budget provisions of NRS 353.150 to 353.246, inclusive.

4. Transfers of appropriations between fiscal years that are authorized in this act must be completed on or before September 18, 2026.

5. Amounts of appropriations from the State General Fund may only be transferred to budget accounts that are included in sections 2 to 34, inclusive, of this act.

Sec. 37. The sums appropriated to the following budget accounts are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor:

1. Forest Fire Suppression;
2. National Guard Benefits;
3. Maternal, Child and Adolescent Health Services;
4. Immunization Program;
5. Welfare Administration;
6. Welfare Field Services;
7. Temporary Assistance for Needy Families;
8. Assistance to Aged and Blind;
9. Child Assistance and Development;
10. Nevada Medicaid;
11. Medicaid Administration;
12. Nevada Check-Up Program;
13. Rural Child Welfare;
14. Special Litigation Account;
15. Office of the Extradition Coordinator;
16. Clark County Child Welfare;
17. Washoe County Child Welfare;
18. Child Volunteer Background Checks;
19. Agency for Nuclear Projects;
20. Assessments and Accountability;
21. Problem Gambling;
22. Department Transformation Effort; and
23. Victims of Crime.

Sec. 38. Of the amounts appropriated by sections 2 to 34, inclusive, of this act, the amounts appropriated in both Fiscal Year 2025-2026 and Fiscal Year 2026-2027 to fund deferred maintenance and extraordinary maintenance projects approved within agency budgets are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027 and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. Any amount so transferred must be used to complete

the deferred maintenance and extraordinary maintenance projects as approved by the Legislature.

Sec. 39. Of the amounts appropriated to the Office of Finance in the Office of the Governor by section 2 of this act for the Special Appropriations budget account, a total of $25,000 in Fiscal Year 2025-2026 is intended to support Civil Air Patrol operations and is available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the same budget account from Fiscal Year 2025-2026 to Fiscal Year 2026-2027. Any amount so transferred must be used to pay for Civil Air Patrol operations as approved by the Legislature.

Sec. 40. Of the amounts appropriated to the Office of Science, Innovation and Technology in the Office of the Governor by section 2 of this act, $1,000,000 in Fiscal Year 2025-2026 and $1,000,000 in Fiscal Year 2026-2027 to fund the development and improvement of broadband for schools and libraries, are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. Any amount so transferred must be used to pay for the development and improvement of broadband for schools and libraries as approved by the Legislature.

Sec. 41. Of the amounts appropriated to the Commission on Ethics by section 30 of this act, $79,679 in Fiscal Year 2025-2026 and $21,450 in Fiscal Year 2026-2027 for the implementation of a new electronic case management system, are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. Any amount so transferred must be used to pay for the implementation of the Commission's electronic case management system as approved by the Legislature.

Sec. 42. Any money remaining in the Workforce Innovations for a New Nevada Account created by NRS 231.151 at the end of Fiscal Year 2025-2026 does not revert to the State General Fund and must be carried forward to Fiscal Year 2026-2027. Any money remaining in the Account at the end of Fiscal Year 2026-2027 must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

Sec. 43. Of the amounts appropriated to the Merit Award Board by section 8 of this act, $3,000 is intended to administer the Merit Award Program and $5,000 is intended for program awards, and both amounts are available for both Fiscal Year 2025-2026 and

Fiscal Year 2026-2027, and any unspent balance may be carried forward from Fiscal Year 2025-2026 to Fiscal Year 2026-2027 with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 44. Of the amounts appropriated to the Supreme Court of Nevada by section 11 of this act:

1. Except as otherwise provided in subsections 2 and 7 to 11, inclusive, the sums appropriated for the Supreme Court of Nevada, Administrative Office of the Courts, Court of Appeals, Senior Justice and Senior Judge Program and Supreme Court Law Library budget accounts may be transferred between fiscal years and between those budget accounts with the approval of the Chief Justice of the Supreme Court and is limited to operating budgets only. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The Supreme Court of Nevada shall report quarterly to the Interim Finance Committee regarding any such transfers between fiscal years and budget accounts.

2. The provisions of subsection 1 do not apply to the sums appropriated for the Specialty Courts, State Judicial Elected Officials and Judicial Department Staff Salaries budget accounts.

3. The Supreme Court of Nevada shall not request from the Interim Finance Committee additional money from the Contingency Account created by NRS 353.266 or a supplemental appropriation for the Judicial Department Staff Salaries budget account.

4. The Supreme Court of Nevada shall report quarterly to the Interim Finance Committee information regarding all salary adjustments and the establishment of new positions.

5. The Supreme Court of Nevada shall include individual position data in the computerized budgeting system utilized by the Budget Division of the Office of Finance in the Office of the Governor in future budget submittals, including, without limitation, working titles, annual salaries, and all position attributes required to allow for the budgeting system to calculate salaries and benefits as well as cost-of-living adjustments and benefit rate changes, as applicable.

6. The Supreme Court of Nevada shall include recommendations for increases in the total funding level of base salaries approved by the Legislature, excluding fringe benefits, with the total funding level based on the salary of all positions at the

Employee/Employer Paid Retirement rate in enhancement decision units in future budget submittals.

7. The amounts of $248,172 in Fiscal Year 2025-2026 and $101,956 in Fiscal Year 2026-2027 to fund comprehensive training and education are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the Administrative Office of the Courts budget account from one fiscal year to the other. Any amount so transferred must be used for comprehensive training and education as approved by the Legislature. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The unexpended balance of the amount transferred pursuant to this subsection must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

8. The amounts of $82,000 in Fiscal Year 2025-2026 and $86,100 in Fiscal Year 2026-2027 for contract staffing to maintain legacy information technology systems are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the Administrative Office of the Courts budget account from one fiscal year to the other. Any amount so transferred must be used for contract staffing to maintain legacy information technology systems as approved by the Legislature. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The unexpended balance of the amount transferred pursuant to this subsection must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

9. The amounts of $175,930 in Fiscal Year 2025-2026 and $175,930 in Fiscal Year 2026-2027 for the support and continued development of an electronic portal for the Guardianship Program are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the Administrative Office of the Courts budget account from one fiscal year to the other. Any amount so transferred must be used for the support and continued development of an electronic portal for the Guardianship Program as approved by the Legislature. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The

unexpended balance of the amount transferred pursuant to this subsection must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

10. The amounts of $596,561 in Fiscal Year 2025-2026 and $496,561 in Fiscal Year 2026-2027 to operate the Supreme Court's Technology Unit independent of the Governor's Technology Office are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the Administrative Office of the Courts budget account from one fiscal year to the other. Any amount so transferred must be used to operate the Supreme Court's Technology Unit independent of the Governor's Technology Office as approved by the Legislature. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The unexpended balance of the amount transferred pursuant to this subsection must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

11. The amounts of $22,447 in Fiscal Year 2025-2026 and $16,950 in Fiscal Year 2026-2027 to expand the Court Interpreter Program are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the Administrative Office of the Courts budget account from one fiscal year to the other. Any amount so transferred must be used to expand the Court Interpreter Program as approved by the Legislature. Notwithstanding the provisions of subsection 4 of NRS 353.220, the approval of the Interim Finance Committee is not required for any request for the revision of a work program to transfer money pursuant to this subsection. The unexpended balance of the amount transferred pursuant to this subsection must not be committed for expenditure after June 30, 2027, and must be reverted to the State General Fund on or before September 17, 2027.

Sec. 45. Of the amounts appropriated to the Department of Motor Vehicles by section 35 of this act for the Fiscal Operations Division budget account, $2,000,000 in Fiscal Year 2025-2026 and $2,000,000 in Fiscal Year 2026-2027 to fund credit card fees are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. The appropriated amounts approved to fund credit card fees pursuant to

this section may only be used for those expenses, and any amount so transferred must be used to pay credit card fees as approved by the Legislature.

Sec. 46. Any money remaining in the Account for the Office of Science, Innovation and Technology created by NRS 223.630 for the Graduate Medical Education Grant Program at the end of Fiscal Year 2024-2025 does not revert to the State General Fund, and must be transferred to the Account for the Graduate Medical Education Grant Program created by NRS 223.631 on or before September 19, 2025. Any balance in the Account for the Graduate Medical Education Grant Program and any portion of appropriations made to the Account remaining at the end of Fiscal Year 2025-2026 and Fiscal Year 2026-2027, respectively, must be carried forward.

Sec. 47. Notwithstanding the provisions of paragraph (a) and (b) of subsection 1 of NRS 353.288, the State Controller shall not make a transfer required by paragraph (a) or (b) of subsection 1 of NRS 353.288 during Fiscal Year 2025-2026 and Fiscal Year 2026-2027 from the State General Fund to the Account to Stabilize the Operation of the Government created by NRS 353.288.

Sec. 48. Any remaining balance of the sums appropriated to the Prison Industry and Prison Ranch budget accounts by section 21 of this act do not revert to the State General Fund.

Sec. 49. Any remaining balance of the $1,000,000 appropriation from the State General Fund approved by the 2015 Legislature for sagebrush habitat improvement projects does not revert to the State General Fund.

Sec. 50. Of the amounts appropriated to the State Department of Conservation and Natural Resources by section 24 of this act for the Conservation and Natural Resources Administration budget account, $50,000 in Fiscal Year 2025-2026 and $50,000 in Fiscal Year 2026-2027 to fund contract services to update the Conservation Credit System Manual and Nevada's Scientific Methods Document and Habitat Quantification Tool, are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. Any amount so transferred must be used to pay for contract services to update the Conservation Credit System Manual and Nevada's Scientific Methods Document and Habitat Quantification Tool as approved by the Legislature.

Sec. 51. Any money remaining in the Knowledge Account created by NRS 231.1592 and the Account for the Nevada Main

Street Program created by NRS 231.1536 at the end of Fiscal Year 2024-2025 and any remaining portion of any appropriations made to those Accounts for the 2023-2025 biennium do not revert to the State General Fund. The balance in those Accounts and any portion of appropriations remaining at the end of Fiscal Year 2024-2025 must be carried forward to Fiscal Year 2025-2026. Any balance in those Accounts and any portion of appropriations made to those Accounts remaining at the end of Fiscal Year 2025-2026 and Fiscal Year 2026-2027, respectively, must be carried forward.

Sec. 52. 1. Of the sums appropriated by section 16 of this act, any amounts used to match documented research grants received by the Nevada System of Higher Education which are not committed for expenditure by June 30 of each fiscal year of the 2025-2027 biennium may be carried forward for a maximum of 2 fiscal years, after which time any unexpended amounts must be reverted to the State General Fund.

2. All money appropriated by section 16 of this act, other than the amounts described in subsection 1 to match documented research grants, is subject to the provisions of section 81 of this act.

Sec. 53. The sums appropriated by this act to any division, bureau, agency or section of any department of the State Government for the support of salaries and payroll costs may be transferred to any other division, bureau, agency or section of the same department for the support of salaries and payroll costs with the approval of the Interim Finance Committee upon the recommendation of the Governor. Such transfers are limited only to those activities which are supported by appropriations from the State General Fund or the State Highway Fund.

Sec. 54. 1. The sums appropriated to the Legislative Fund by section 10 of this act for the support of the Legislative Commission, the divisions of the Legislative Counsel Bureau and Interim Legislative Operations are available for both Fiscal Year 2025-2026 and Fiscal Year 2026-2027, and may be transferred among the various budget accounts of the Legislative Commission, the divisions of the Legislative Counsel Bureau and Interim Legislative Operations and from one fiscal year to the other with the approval of the Legislative Commission upon the recommendation of the Director of the Legislative Counsel Bureau.

2. The sums appropriated for the support of salaries and payroll costs must be applied pursuant to the budget approved by the Legislature.

Sec. 55. The sums appropriated to the Division of Social Services of the Department of Human Services by section 17 of this

act may be transferred among the various budget accounts of the Division of Social Services with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 56. The sums appropriated to the Nevada Health Authority by section 18 of this act for the Nevada Medicaid and the Nevada Check-Up Program budget accounts may be transferred between those budget accounts with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 57. The sums appropriated to the Division of Child and Family Services of the Department of Human Services by section 17 of this act for the Summit View Youth Center, Caliente Youth Center and the Nevada Youth Training Center budget accounts may be transferred among those budget accounts with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 58. The sums appropriated to the Division of Child and Family Services of the Department of Human Services by section 17 of this act for the Northern Nevada Child and Adolescent Services and Southern Nevada Child and Adolescent Services budget accounts may be transferred between those budget accounts with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 59. The sums appropriated to the Division of Public and Behavioral Health of the Department of Human Services by section 17 of this act for the Southern Nevada Adult Mental Health Services, Northern Nevada Adult Mental Health Services and Lake's Crossing Center budget accounts may be transferred among those budget accounts with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 60. 1. The Department of Human Services may, with the approval of the Interim Finance Committee upon the recommendation of the Governor, transfer from the various divisions of the Department to an account which is hereby created within the State General Fund any excess money available to the divisions as a result of savings from not providing health and related services, including, without limitation, savings recognized by using a different source of funding to pay the providers of services if the persons previously served by a division no longer require the provision of services from the division.

2. Any money transferred to the account created by subsection 1, to the extent approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and authorized by the State Plan for Medicaid, must:

(a) Be transferred by the Department to the Nevada Health Authority to be used to pay administrative and related costs and the State's share of the cost for participation in the private hospital collaborative upper payment limit program. Any remaining money to pay the State's share of the cost for participation in the private hospital collaborative upper payment limit program must be transferred not later than September 30 of the following fiscal year for the benefit of the upper payment limit program.

(b) After being used to satisfy the requirements of paragraph (a), be:

(1) Reserved for reversion to the State General Fund and reverted to the State General Fund at the end of each fiscal year of the 2025-2027 biennium; or

(2) Transferred to the Fund for a Healthy Nevada created by NRS 439.620 at the end of each fiscal year of the 2025-2027 biennium.

Sec. 61. The sums appropriated to the Aging and Disability Services Division of the Department of Human Services by section 17 of this act for the Desert Regional Center, Sierra Regional Center and Rural Regional Center budget accounts may be transferred among those budget accounts for residential support, family support and respite and jobs and day training services with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 62. The sums appropriated to the Nevada Health Authority by section 18 of this act for the Nevada Medicaid and Nevada Check-Up Program budget accounts may be transferred to the Medicaid Administration budget account with the approval of the Interim Finance Committee upon recommendation of the Governor. Money may only be transferred to the Medicaid Administration budget account pursuant to this section for personnel and administrative costs necessary for implementing the provisions of NRS 422.401 to 422.406, inclusive, in Fiscal Year 2025-2026 and Fiscal Year 2026-2027 upon submittal of an analysis demonstrating savings in the Nevada Medicaid and Nevada Check-Up Program budget accounts resulting from the provisions of NRS 422.401 to 422.406, inclusive.

Sec. 63. The sums appropriated to the Nevada System of Higher Education by section 16 of this act may be transferred among the various budget accounts of the Nevada System of Higher Education included in the Executive Budget with the approval of the Interim Finance Committee upon the recommendation of the Governor.

Sec. 64. 1. Except as otherwise provided in subsections 2 and 3, the sums appropriated to the Department of Corrections by section 21 of this act may be transferred among the various budget accounts of the Department of Corrections in the same manner and within the same limits as allowed for revisions of work programs in NRS 353.220.

2. The provisions of subsection 1 do not apply to appropriations to the Department for deferred maintenance and extraordinary maintenance projects transferred pursuant to section 38 of this act.

3. The provisions of subsection 1 do not apply to the sums appropriated for the Training Academy budget account.

Sec. 65. Notwithstanding the provisions of paragraph (b) of subsection 2 of NRS 695K.300, the amounts appropriated by section 18 of this act are made directly to the Public Option budget account under the Nevada Health Authority for the operation of the Public Option.

Sec. 66. It is the intent of the Legislature that the amounts appropriated by section 18 of this act to the Nevada Health Authority for the Nevada Medicaid and the Nevada Check-Up Program budget accounts must be expended in such a manner as to continue the current service delivery model for prescription drugs in which persons enrolled in Medicaid and Check-Up managed care programs receive prescription drugs through a Medicaid managed care organization in the 2025-2027 biennium.

Sec. 67. The total sums appropriated by section 17 of this act for the Temporary Assistance for Needy Families and Child Assistance and Development budget accounts of the Division of Social Services of the Department of Human Services and by section 18 of this act to the Nevada Medicaid and Nevada Check-Up Program budget accounts of the Nevada Health Authority are limits. The Nevada Health Authority or the Division of Social Services shall not request additional money for these budget accounts, except for:

1. Increased State costs in Fiscal Year 2025-2026 and Fiscal Year 2026-2027 in the event that federal financial participation rates are less than the amounts approved by the Legislature effective on October 1, 2025;

2. Costs related to additional services or populations which are mandated by the Federal Government on or after October 1, 2025, and which are not specifically funded in the Nevada Medicaid budget account in Fiscal Year 2025-2026 and Fiscal Year 2026-2027;

3. Costs related to the Medicaid county match and waiver populations that exceed the 8-cent county reimbursement cap established pursuant to NRS 428.285;

4. Increased State costs in Fiscal Year 2025-2026 and Fiscal Year 2026-2027, in the event that the annual allocation of federal Temporary Assistance for Needy Families block grant funds is lower than the amounts approved by the Legislature for either fiscal year;

5. Increased State costs in Fiscal Year 2025-2026 and Fiscal Year 2026-2027 due to federal changes in the payment structure of Nevada Medicaid or the Nevada Check-Up Program; or

6. Increased State costs in Fiscal Year 2025-2026 and Fiscal Year 2026-2027 due to higher than budgeted prescription drug costs for fee-for-service participants.

Sec. 68. Except as otherwise provided in this section, the sums appropriated to the Division of Child and Family Services of the Department of Human Services by section 17 of this act for the Clark County Child Welfare and Washoe County Child Welfare budget accounts for the purpose of providing respite and block grant allocations to agencies which provide child welfare services in a county whose population is 100,000 or more, are limits. The Division shall not request additional sums for these budget accounts, except that the Division may request additional sums for the adoption assistance programs described in NRS 432B.219.

Sec. 69. Of the amounts appropriated to the Aging and Disability Services Division of the Department of Human Services by section 17 of this act for the Home- and Community-Based Services budget account to fund the rates paid to providers of personal care services for the Community Options Program for the Elderly and the Personal Care Services Program, not less than $16 of the $25 per hour reimbursement rate received by providers must be paid as an hourly wage to direct care workers. The hourly wage of $16 must be paid as direct compensation and may not be decreased by health insurance or any other employee benefit costs.

Sec. 70. Of the amounts appropriated to the Nevada Health Authority by section 18 of this act for the Nevada Medicaid budget account to fund the rates paid to providers of personal care services, not less than $16 of the $25 per hour reimbursement rate received by providers must be paid as an hourly wage to direct care workers. The hourly wage of $16 must be paid as direct compensation and may not be decreased by health insurance or any other employee benefit costs.

Sec. 71. In addition to the requirements of NRS 353.225, for Fiscal Year 2025-2026 and Fiscal Year 2026-2027, the Board of Regents of the University of Nevada shall comply with any request by the Governor to set aside money from the appropriations made by this act in any specified amount.

Sec. 72. 1. If the Director of the State Department of Conservation and Natural Resources determines in Fiscal Year 2025-2026 or Fiscal Year 2026-2027 that, because of delays in the receipt of revenue for services billed to the Federal Government, local governments and other state governments, the amount of current claims for expenses incurred in the suppression of fires or response to emergencies exceeds the amount of money available to pay such claims within 30 days, he or she may request from the Director of the Office of Finance in the Office of the Governor a temporary advance from the State General Fund to pay authorized expenses.

2. The Director of the Office of Finance in the Office of the Governor shall provide written notification to the State Controller and to the Senate and Assembly Fiscal Analysts of the Fiscal Analysis Division of the Legislative Counsel Bureau if he or she approves a request made pursuant to subsection 1. The State Controller shall draw his or her warrant upon receipt of such a notification.

3. An advance from the State General Fund:

(a) May be approved by the Director of the Office of Finance in the Office of the Governor only for expenses incurred in the suppression of fires or response to emergencies charged to the Forest Fire Suppression or Out-of-State Fire Suppression Account budget accounts of the Division of Forestry of the State Department of Conservation and Natural Resources. Before approving the advance, the Director shall verify that billings for reimbursement have been sent to the agencies of the Federal Government, local governments or other state governments responsible for reimbursing the Division of Forestry for costs incurred in activities relating to the suppression of fires or response to emergencies.

(b) Is limited to the total due from outstanding billings for reimbursable expenses incurred in the suppression of fires or response to emergencies as approved for payment to the State by agencies of the Federal Government, local governments and other state governments.

4. Any money which is temporarily advanced from the State General Fund to the Forest Fire Suppression budget account or Out-of-State Fire Suppression Account budget account pursuant to

this section must be repaid on or before the last business day in August immediately following the end of the fiscal year in which the temporary advance was approved.

Sec. 73. 1. If the Governor orders the Nevada National Guard into active service as described in NRS 412.122 for an emergency, as defined in subsection 1 of NRS 353.263, in Fiscal Year 2025-2026 or Fiscal Year 2026-2027 and the Adjutant General of the Office of the Military determines expenditures will be required, the Adjutant General may request from the Director of the Office of Finance in the Office of the Governor a temporary advance from the State General Fund for the payment of authorized expenses.

2. The Director of the Office of Finance in the Office of the Governor shall provide written notification to the State Controller and to the Senate and Assembly Fiscal Analysts of the Fiscal Analysis Division of the Legislative Counsel Bureau of the approval of a request made pursuant to subsection 1. The State Controller shall draw his or her warrant upon receipt of the approval by the Director of the Office of Finance in the Office of the Governor.

3. An advance from the State General Fund:

(a) Must be approved by the Director of the Office of Finance in the Office of the Governor for expenses incurred as a result of activation of the Nevada National Guard.

(b) Is limited to $50,000 per activation as described in subsection 1.

4. Any money which is temporarily advanced from the State General Fund to a budget account pursuant to subsection 2 must be repaid as soon as possible, and the repayment must be made from the Emergency Account created by NRS 353.263.

Sec. 74. The amounts appropriated by section 6 of this act to the Office of the State Treasurer for costs related to the administration of the Nevada Employee Savings Trust Program established pursuant to chapter 353D of NRS are a loan and must be repaid as soon as the Office has received sufficient money for the operation of the Program.

Sec. 75. The amounts appropriated by section 2 of this act to the Nevada Office of Cyber Defense Coordination are a loan. Commencing on July 1, 2027, the Office of the Governor shall use revenues from intergovernmental transfers to repay the loan in annual installments to the State Treasurer for deposit in the State General Fund. Each annual installment must be 25 percent of the loan and the loan must be fully repaid not later than the end of Fiscal Year 2030-2031.

Sec. 76. There is hereby appropriated from the State General Fund to the Public Employees' Retirement Board the sum of $103,477 for Fiscal Year 2025-2026 and $105,182 for Fiscal Year 2026-2027 for the administration of the Legislators' Retirement System.

Sec. 77. There is hereby appropriated from the State General Fund to the Legislative Fund created by NRS 218A.150 the sum of $16,365,429 for the costs of the 83rd Legislative Session.

Sec. 78. There is hereby appropriated from the State General Fund to the Legislative Fund created by NRS 218A.150 the sum of $8,118,404 for the costs of information technology projects and equipment and for dues and registration costs for national organizations.

Sec. 79. 1. During the 2025-2027 biennium, the Legislative Auditor shall conduct an audit of the Aging and Disability Services Division's Early Intervention Services Program, including, without limitation, an analysis of the Program's state and community providers' records related to services provided and billing practices, including, without limitation, reimbursements from Medicaid and private insurance, an evaluation of the claims submitted for reimbursement and an assessment of the adequacy of the Program's internal controls.

2. The Legislative Auditor shall present a final written report of the audit conducted pursuant to subsection 1 to the Audit Subcommittee of the Legislative Commission not later than January 31, 2027.

Sec. 80. Section 44 of chapter 209, Statutes of Nevada 2023, at page 1248, is hereby amended to read as follows:

Sec. 44. *1.* Of the amounts appropriated to the State Department of Conservation and Natural Resources by section 23 of this act for the Division of State Lands budget account, $840,284 in Fiscal Year 2023-2024 and $63,000 in Fiscal Year 2024-2025 to replace the Division's land management system, are available for both Fiscal Year 2023-2024 and Fiscal Year 2024-2025, and may be transferred within the same budget account from one fiscal year to the other with the approval of the Interim Finance Committee upon the recommendation of the Governor. Any amount so transferred must be used to pay for replacement of the Division's land management system as approved by the Legislature.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after

June 30, 2026, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 18, 2026, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 18, 2026.

Sec. 81. 1. Except as otherwise provided in this section and sections 46, 48, 51, 52 and 76 of this act, any balances of the appropriations made by this act for Fiscal Year 2025-2026 and Fiscal Year 2026-2027 must not be committed for expenditure after June 30 of each fiscal year, respectively, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 18, 2026, and September 17, 2027, respectively, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred and, except as otherwise provided in subsection 2, must be reverted to the fund from which it was appropriated on or before September 18, 2026, and September 17, 2027, respectively.

2. Any balance of the appropriations made to the Legislative Fund by sections 10, 77 and 78 of this act does not revert to the State General Fund but constitutes a balance carried forward.

Sec. 82. The State Controller shall provide for the payment of claims legally obligated in each fiscal year of the 2025-2027 biennium on behalf of state agencies until the last business day of the August immediately following the end of each fiscal year. The State Controller shall process any transactions requested by the Director of the Office of Finance in the Office of the Governor from the previous fiscal year until the third Friday in September immediately following the end of the fiscal year.

Sec. 83. The State Controller shall transfer among the appropriate budget accounts and funds the amounts necessary to carry out the budget approved by the Legislature, and the amounts so transferred shall be deemed appropriated.

Sec. 84. The State Controller shall pay the annual salaries of the Governor, the Lieutenant Governor, the Secretary of State, the State Treasurer, the State Controller and the Attorney General in biweekly installments for each day worked up to and including the

date of payment. The payment of a portion of the annual salaries of these officers at the end of a calendar year for the purpose of reconciling the amount of the salary paid during that calendar year with the amount of the salary set forth in statute for that office must not be made if it will result in the issuance of a separate check.

Sec. 85. 1. If projections of the ending balance of the State General Fund fall below the amount estimated by the 83rd Session of the Nevada Legislature for Fiscal Year 2025-2026 or Fiscal Year 2026-2027, the Chief of the Budget Division of the Office of Finance in the Office of the Governor shall report this information to the State Board of Examiners.

2. If the State Board of Examiners determines that the ending balance of the State General Fund is projected to be less than $175,000,000 for Fiscal Year 2025-2026 or Fiscal Year 2026-2027, the Governor, pursuant to NRS 353.225, may direct the Chief of the Budget Division of the Office of Finance in the Office of the Governor to require the State Controller or the head of each department, institution or agency to set aside a reserve of not more than 15 percent of the total amount of operating expenses or other appropriations and money otherwise available to the department, institution or agency.

3. A reserve must not be set aside pursuant to this section unless:

(a) The Governor, on behalf of the State Board of Examiners, submits a report to the Legislature or, if the Legislature is not in session, to the Interim Finance Committee, stating the reasons why a reserve is needed and indicating each department, institution or agency that will be required to set aside a reserve; and

(b) The Legislature or Interim Finance Committee approves the setting aside of the reserve.

Sec. 86. If the State of Nevada is required to make payment to the United States Treasury under the provisions of Public Law 101-453, the Cash Management Improvement Act of 1990, the State Controller, upon approval of the State Board of Examiners, may make such payments from the interest earnings of the State General Fund or interest earnings in other funds when interest on federal money has been deposited in those funds.

Sec. 87. Notwithstanding the provisions of paragraph (a) of subsection 2 of NRS 422.27497, the Director of the Nevada Health Authority shall establish rates of reimbursement which are provided on a fee-for-service basis for applied behavior analysis services, as defined in NRS 422.27497, for the Nevada Medicaid and Nevada Check-Up Program budget accounts as approved by the Legislature.

Sec. 88. 1. Notwithstanding the provisions of section 81 of this act, the remaining balance of any money appropriated by this act to a nonreversionary account does not revert to the State General Fund at the end of a fiscal year and must be carried forward to the next fiscal year.

2. As used in this section, "nonreversionary account" means an account created in the Nevada Revised Statutes in which the money does not revert to the State General Fund at the end of a fiscal year and must be carried forward.

Sec. 89. If the name of an officer or agency has been changed or the responsibilities of an officer or agency have been transferred pursuant to the provisions of another act enacted by the 83rd Session of the Legislature and approved by the Governor and the change in name or transfer of duties is not indicated in this act, any reference to that officer or agency in this act shall be deemed to refer to the officer or agency the name of which or duties of which have been changed or transferred by the other act.

Sec. 90. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after May 18, 2025.

Sec. 91. 1. This section and sections 46, 47, 49, 51, 77 to 80, inclusive, 89 and 90 of this act become effective upon passage and approval.

2. Sections 1 to 45, inclusive, 48, 50, 52 to 76, inclusive, and 81 to 88, inclusive, of this act become effective on July 1, 2025.

20 —— 25

EXHIBIT 5

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Federal and State Share of Medicaid Spending

Search State Health Facts Data

Timeframe: FY 2024

TABLE

Location	Federal
Nevada	73.0%

NOTES

Notes

Medicaid expenditures do not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was approximately $909 billion in FY 2024.

Sources

Estimates based on data downloaded from CMS (Form 64), as of September 2025.

Definitions

Federal Fiscal Year: Federal Fiscal Year: Unless otherwise noted, years preceded by "FY" refer to the Federal Fiscal Year, which runs from October 1 through September 30. FY 2024 refers to the period from October 1, 2023 through September 30, 2024.

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EXHIBIT 15

DECLARATION OF GREGORY WOODS

I, Gregory Woods, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of New Jersey. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director, of information and records gathered by the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and Department staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Assistant Commissioner for DMAHS and Director for the New Jersey State Medicaid program and Children's Health Insurance Program (CHIP) (known together in New Jersey as NJ FamilyCare).

3. DHS, through DMAHS, is the single state agency responsible for administering NJ FamilyCare. NJ FamilyCare provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. NJ FamilyCare's coverage includes medical, dental, mental health and substance use treatment, and home and community-based services. NJ FamilyCare's mission is to provide high-quality health coverage to people who qualify for the program.

4. NJ FamilyCare insures approximately 1.8 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those living with disabilities, experiencing homelessness, or who have serious or complex medical conditions.

5. New Jersey administers the NJ FamilyCare program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. NJ FamilyCare receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP). In State Fiscal Year 2025, FFP provided approximately 61% of New Jersey's Medicaid and CHIP expenditures and New Jersey paid for 39% of those expenditures.

Medicaid Expansion in New Jersey

6. On January 1, 2014, New Jersey implemented Medicaid expansion under the Patient Protection and Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the ACA Expansion group. The FFP for those covered under the Affordable Care Act Medicaid expansion is 90%.

7. Enrollees in the ACA Expansion group receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the ACA Expansion group requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of May 2026, approximately 30% of NJ FamilyCare members are enrolled in the ACA Expansion group. For the State Fiscal Year 2025, approximately $5.7 billion or 35% of NJ FamilyCare's federal Medicaid and CHIP benefit funding comes from the FFP for the ACA Expansion group.

CMS's Pre-IFR Guidance to New Jersey

9. I and my staff at NJ FamilyCare have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work / community engagement requirements for adults covered under the ACA Expansion group (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, NJ FamilyCare does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy to States through a range of webinars, calls, workgroups, and forums. This is consistent with long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, New Jersey has relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

12. States likewise relied on the guidance shared by CMS on various calls and forums concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated in a December 4, 2025 slide deck that it emailed to states that it intended to "use a definition … similar to that described in regulations at 42 C.F.R. § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Exhibit 1 (CMS Slide Deck) at 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider

documentation, or completion of a screening tool." Exhibit 1 at 11, 17 ("medical frailty status … available through claims data" or "medical screener").

13. Not until shortly before the issuance of the Interim Final Rule in June 2026 did CMS give any indication that it may require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

14. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Exhibit 1 at 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

15. In March 2026, CMS communicated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation to confirm ongoing medical frailty in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, even without extensive claims history, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

16. In May 2026, CMS presented to states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

17. On or about Wednesday, May 13, 2026, CMS informed states that preliminary policy decisions conveyed in previous calls had subsequently changed, though those policy decisions were not specified.

CMS Issues the Interim Final Rule

18. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirements. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for NJ FamilyCare to implement before January 1, 2027. Furthermore, these provisions are expected to cause significant harm to members and NJ FamilyCare once implemented. These provisions include the following:

Medically Frail Definition

19. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement." 42 C.F.R. § 435.554(c)(5)(i).

20. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(V), 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in Section 71119, *as codified at* 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in

order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

21. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as early May 2026.

22. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exclusion in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition(s), utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

23. Since the IFR's release, CMS has told states that it is considering releasing further guidance or supporting documentation on the medical frailty exclusion. However, this additional documentation has not yet been provided.

Self-Attestation

24. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was

unavailable, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework, one that changes again after the first year of implementation and will be harmful for members and difficult to implement.

25. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 C.F.R. § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 C.F.R. § 435.554(c)(3)(i)(C)).

26. Under Section 1902 of the Social Security Act and 42 C.F.R. § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

27. A renewal cycle lasts at most 12 months (or when Section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

28. Under 42 C.F.R. § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid

agencies cannot require an individual to reverify citizenship under 42 C.F.R. § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation of medical frailty. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

29. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

30. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exclusion or exception from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period, and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase needless disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fail as a meaningful work incentive or program integrity measure.

Data Feed Integration

31. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as

"information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 C.F.R. § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment.

Renewal Process

32. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

33. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 C.F.R. § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify exclusion or exception from or compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6), 42 U.S.C. § 1396a(xx)(6). This disenrollment must happen no later than the month following the month in

which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "[s]tates must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412 (June 3, 2026).

34. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period during which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members and is inconsistent with existing practice to evaluate eligibility factors like income using the most recent available data. The modified structure for renewals will also likely result in undoing some of the progress that DMAHS has made in improving the *ex parte* renewal process and outcomes over the last several years, representing substantial reductions in administrative and member burden for eligible NJ FamilyCare members.

Short-term Hardship Exceptions

35. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* Social Security Act Section 1902(xx)(3)(B), 42 U.S.C. § 1396a(xx)(3)(B).

36. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

37. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive, and possibly even apply for, necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system. This structure prevents Expansion Adult members experiencing short-term hardship events like a hospitalization from receiving coverage to reduce the financial burden of that care.

Relevant available data

38. Several of the timelines set out in the IFR do not comport with the extended timeframe allowed to providers to submit claims to insurers. Under NJ FamilyCare, providers have 180 days to submit initial claims to Managed Care Organizations (MCOs) and 12 months to submit initial claims covered by Fee for Service (FFS). For medical frailty determinations that are supposed to be made regarding the preceding year, NJ FamilyCare may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

NJ FamilyCare's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

39. Following the enactment of H.R. 1, DMAHS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice initiation deadline and January 1, 2027 implementation date, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, DHS began work to prepare to comply with community engagement requirements.

40. Beginning in July 2025 and continuing until the release of the IFR, DMAHS based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, DMAHS has already done the following:

- Conducted analysis of the statutory text to assess changes needed to NJ FamilyCare policies, procedures, systems, communications, financing, and other components of Medicaid and CHIP operations
- Estimated the impact of H.R. 1 on funding for NJ FamilyCare and enrolled providers
- Made budget requests to address reductions in FFP required by H.R. 1, and made available funding in the current State Fiscal Year (ending June 30, 2026) to move forward urgent operational work to prepare for community engagement and other requirements
- Completed substantial systems planning, including establishing a new community engagement engine to evaluate exclusion or exception from or compliance with community engagement requirements, with more work still required
- Drafted changes to NJ FamilyCare application, renewal and other notification materials to reflect changes required by H.R. 1
- Supported Eligibility Determining Agencies in hiring, staff to complete new systems, eligibility and other work required by H.R. 1
- Made multiple amendments to DMAHS's contract with its Health Benefits Coordinator (HBC) vendor, which supports eligibility determinations for a majority of Expansion Adult members

- Hired professional services support to conduct project management, policy analysis and other planning support to implement H.R. 1 requirements
- Conducted substantial public outreach about H.R. 1 requirements, including launching a public-facing website, a self-service tool intended to help individuals evaluate how the community engagement requirements will affect them, and mailing letters to every household with at least one Expansion Adult member notifying them that eligibility changes are coming
- With respect to implementing the medically frail exclusion in particular, DMAHS has worked extensively with clinical, data analytics, and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Exhibit 1 at 11; *see also id.* at 17 ("medical frailty status … available through claims data").

41. DMAHS faces several urgent deadlines with respect to implementing community engagement requirements. NJ FamilyCare must apply community engagement requirements to applications and renewals as of January 1, 2027. To achieve that target, DMAHS began developing a community engagement engine in the last quarter of 2025 that must be integrated with two existing eligibility determination systems used by the County Social Service Agencies and the HBC vendor. Although NJ FamilyCare is using an agile, iterative project methodology to streamline development, meeting the January 1, 2027 deadline required substantially finalizing policy requirements by May 1, 2026, a date that has already passed. As a result, the January 1, 2027 deadline is no longer achievable without a change to scope, schedule, or resources. Absent

intervention, NJ FamilyCare will either miss the January 1, 2027 deadline outright or be forced to implement live with insufficient testing, materially increasing the risk that eligible compliant, excluded, or excepted individuals are erroneously denied or terminated from coverage. This compressed timeline is a direct consequence of the interval between the issuance of final implementation guidance and the statutory deadline and the fact that the IFR differed substantially from CMS's prior guidance.

42. Moreover, NJ FamilyCare is required by H.R. 1 to issue notices beginning by the end of August 2026 addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, DMAHS needs to finalize the information to be provided in those notices in mid-August.

43. Nevertheless, DMAHS still lacks clarity on several crucial issues from the IFR. While the IFR says that DMAHS will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how DMAHS should determine this. Prior to the IFR, DMAHS had been developing a diagnosis-code-based approach to identifying medical frailty, work that was already underway, including the clinical review needed to designate which diagnosis codes qualify. The IFR's impairment standard would require substantially modifying this approach: a qualifying diagnosis code alone is no longer sufficient to establish medical frailty, and DMAHS must now also evaluate and document whether that condition specifically impairs the individual's ability to meet the 80-hour community engagement requirement. Furthermore, while CMS has said more subregulatory guidance may be provided, DMAHS must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only DMAHS, but also the messages that DMAHS

can provide to stakeholders, members, providers, or other organizations that serve members: if DMAHS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate others about how to demonstrate exclusion or exception from or compliance with this requirement, nor can DMAHS begin to modify the *ex parte* process.

44. The shift from a diagnosis-only standard to an impairment-based standard also has a direct, compounding effect on system design: an automated, *ex parte* determination based on diagnosis code alone could previously be made entirely within the eligibility system, without requiring any new information from the member or their provider. An impairment-based determination may not be able to be made this way. If DMAHS pursues an automated approach to determining impairment, it must still account for the fact that impairment may not be static (a provider attestation confirming impairment may need to be re-verified on a recurring basis every six months) to remain valid, since the system must be able to demonstrate, on an ongoing and auditable basis, that the member continues to be impaired. This may introduce a new category of system functionality—a recurring clinical documentation collection, tracking, and expiration process that did not previously exist in the eligibility system's design. In order to modify the proposed definition of and verification process for medical frailty in New Jersey, DMAHS and partners will need to align on new business requirements, agree on those business requirements with clinical leadership, and then complete a substantial technical build and test process. Any recurring documentation requirement needs to be built, tested, and kept synchronized across DMAHS's full eligibility systems environment, not just the system performing the determination, which substantially increases both the technical scope and the testing burden of this change relative

to the diagnosis-code-only approach DMAHS had originally begun building. DMAHS expects that this process will take multiple months.

45. Finally, the IFR does not clarify which data sources DMAHS is required to have integrated as of January 1, 2027, and which can be integrated later. DMAHS requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

46. Of note, the consequences for DMAHS from building its systems inconsistently with CMS's incomplete and as-yet unissued medical frailty guidance are significantly heightened. If DMAHS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for New Jersey and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

47. The purpose of the ACA was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

48. Independent analysis conducted before the IFR was released suggest that between 155,000 and 304,000 fewer individuals will have NJ FamilyCare coverage in 2028 as a result of the community engagement and six-month redetermination requirements (a provision of H.R. 1

that requires ACA Expansion group members' eligibility to be reevaluated every six months). This represents between 29% and 56% of the total Adult Expansion population enrolled in NJ FamilyCare in September 2025. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, even the "low mitigation" scenario included in this analysis, representing decisions by states to impose stricter requirements and narrower exclusions and exceptions, may underestimate the impact to members. Matthew Buettgens et al., Urban Institute, *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and SixMonth Redeterminations* (Mar. 25, 2026), https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work.

49. Indeed, DMAHS expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frailty. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. NJ FamilyCare members may think they do not qualify as "medically frail," given the added complexity, and NJ FamilyCare may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people DMAHS can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many

renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms and abilities from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

50. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to NJ FamilyCare sicker and it may ultimately be costlier for the State to treat and manage their conditions due to the loss of health coverage and resulting lack of treatment in the intervening time. This type of "churn" in Medicaid enrollment both raises costs for NJ FamilyCare and decreases quality of care for members.

51. DMAHS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In DMAHS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DMAHS expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

52. DMAHS also expects the "once per enrollment period" limitation on medical frailty self-attestations, which takes effect January 1, 2028, to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second, distinct medically frail condition within the same enrollment period: having already used their one self-attestation for the first condition, these members would be unable to self-attest to the second and would instead need to meet a higher verification standard,

even though their underlying circumstances changed through no fault of their own. Implementing this "once per enrollment period" limitation would require DMAHS and partners to conduct systems discovery, validate the approach against existing eligibility logic, and complete a technical build and test process. This change would need to be coordinated across multiple technology systems and likely represents a multi-month effort. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in NJ FamilyCare) go into remission from cancer but subsequently develop congestive heart failure or major depressive disorder. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on congestive heart failure or major depressive disorder and thus could lose coverage for this diagnosis.

53. DMAHS is statutorily required to provide notice to members regarding the changes occasioned by the IFR starting by August 31, 2026. 42 U.S.C. § 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, DMAHS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

54. DMAHS has spent years conducting outreach and building relationships with its members. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on New Jersey

Burdens on NJ FamilyCare

55. Because CMS had never before imposed community engagement requirements across eligibility categories, NJ FamilyCare's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. As a result, DMAHS requires substantial additional resources to conduct the additional verifications required to establish eligibility for Expansion Adults starting January 1, 2027. DMAHS has spent at least $7.5 million in State Fiscal Year 2026 on project management, policy analysis, and other implementation support to ensure timely, compliant implementation of H.R. 1 changes, including community engagement. In addition, DMAHS projects spending at least an additional $35 million to comply with H.R. 1 requirements, including new resources required to support eligibility systems, operations, project management and other work on community engagement. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DMAHS to rapidly change its operational approach and systems development. In addition to analyzing, developing, and implementing new ways to evaluate medical frailty, DMAHS may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. The expanded requirements to establish medical frailty will also increase the ongoing workload for eligibility staff at initial application as well as at renewal. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, DMAHS expects it will be required to respond to more calls, process more documents, and handle more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, NJ FamilyCare will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

56. DMAHS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, DMAHS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on New Jersey

57. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on NJ FamilyCare, but on New Jersey more generally. As noted above, NJ FamilyCare members will likely face increased denials and terminations—and, due to the "significant impairment" requirement for medical frailty, many of those terminations could be of some of NJ FamilyCare's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the ACA Expansion group. New Jersey's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers—in particular rural, community, and safety net hospitals as well as community health centers—that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals who are disenrolled from NJ FamilyCare will likely lose access to primary, behavioral health, and preventive care—and care necessary to treat their statutorily recognized medical conditions—resulting in more individuals seeking high-cost emergency care. In addition, the lack of preventative care may result in increased transmission

of communicable diseases and more strain on NJ FamilyCare and public health systems more broadly. Most importantly, DMAHS expects poorer health outcomes across New Jersey, as fewer people will be able to access appropriate care and manage chronic conditions.

58. In addition, DMAHS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations on medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exclusions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 27th day of June 2026.

Gregory Woods

Gregory Woods
Assistant Commissioner and Medicaid Director
New Jersey Department of Human Services

Implementing Section 71119 of the Working Families Tax Cut Legislation

Key Requirements and Preliminary Policy Direction from CMS

November 19, 2025

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Medicaid WORKS!

Background and Vision for Community Engagement

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Background

- Pub. L. No. 119-21, referred to by CMS as the "Working Families Tax Cut" (WFTC) legislation, introduced community engagement (C-E) requirements for certain applicable adults as a condition of their Medicaid eligibility.[1]

- Key Facts:
  - This new requirement applies in any state and the District of Columbia that provides coverage to the adult expansion group under the state plan or similar adult group through certain 1115 demonstrations.
  - U.S. territories, regardless of whether they adopted the adult group, are not required to implement community engagement.
  - States must implement C-E requirements by January 1, 2027, and may elect to implement earlier.
  - C-E requirements may not be waived under section 1115 demonstration authority.

1. Section 71119 of WFTC legislation amended Section 1902 of the Social Security Act (the Act) to add subsection (xx) - Community Engagement Requirement For Applicable Individuals.

Pre-decisional and iterative. The preliminary information presented in this deck is for exclusive use by states and vendors to inform planned implementation of Medicaid community engagement requirements. All policies and requirements are subject to change.

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Important Considerations

- Information presented in this slide deck **represents CMS' preliminary policy, systems, and operational considerations** as of mid-November 2025 related to implementation of Section 71119 of the WFTC legislation.
- CMS is developing formal guidance that will be released on a rolling basis in 2025-2026. By June 1, 2026, **CMS will also publish an Interim Final Rule** outlining requirements and expectations for all states.
- While states and vendors are strongly encouraged to review this deck to inform planning, please note that **all information described here is preliminary and subject to change**.
- The information summarizing Section 71119 in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutory language that it is based upon. We encourage readers to refer to the applicable statutory language for complete information.
- Please contact CMS for additional guidance and direction: MedicaidWorks@cms.hhs.gov.

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CMS Vision for C-E Implementation

1. **Connect Members to Work and Community.** Community engagement has potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation, build confidence, and achieve prosperity.

2. Start on time by **retaining state flexibility.** Balance the benefits of flexibility with the potential costs of options, including systems and operational costs.

3. **Promote alignment.** Anywhere possible, align new policies with existing statutory and regulatory requirements, including existing requirements for Medicaid, SNAP, TANF, IRS, and the Marketplace. This will help defray operational costs and streamline business flows.

4. **Protect taxpayers.** Ensure program integrity by ensuring that state determinations and policy decisions are easily auditable.

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Definition of Applicable Individual

- Applicable individuals must demonstrate compliance with community engagement requirements as a condition of Medicaid eligibility.
- Applicable individuals are generally those:
  - Eligible for or enrolled under the state plan **in the adult group** described in §1902(a)(10)(A)(i)(VIII) of the Act; or
  - Eligible to enroll or is enrolled in a section **1115 demonstration that provides minimum essential coverage (MEC),** and who are at least 19 and under 65 years of age, not pregnant, not entitled to or enrolled for benefits under Medicare Part A or Part B, and not otherwise eligible to enroll under the state Medicaid plan.
- Individuals enrolled in the parent/caretaker relative group under the state plan are *not* included as an applicable population, regardless of the age of their dependent(s).

Community engagement requirements do not apply to individuals enrolled in an 1115 demonstration if the only coverage available to these individuals is not MEC (e.g., family planning-only services). Requirements do apply in states with 1115 demonstrations for partial expansions that provide MEC. CMS continues to evaluate which section 1115 demonstration populations fall into the definition of an applicable individual.

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Mandatory Exceptions & Exclusions

Individuals are excepted from demonstrating C-E for a month if for any part of a month the individual was: **under the age of 19**; entitled to or enrolled in **Medicare Part A** or enrolled in **Medicare Part B**; described in a **mandatory categorically needy eligibility group.** An additional exception applies to an individual who was an **inmate of a public institution at any point during the three-month period** ending on the first day of a month in which the individual is otherwise subject to the C-E requirement.

Individuals in any of the specified groups below are excluded from C-E requirements:

1. **Former foster care children** defined in §1902(a)(10)(A)(i)(IX);
2. Most **American Indians and Alaska Natives**;
3. A **parent, guardian, caretaker relative or family caregiver** of a dependent child under the age of 14 or a disabled individual;
4. **Veterans** with a total disability rating as defined under 38 U.S.C. §1155;
5. Individuals who are **medically frail** or otherwise have special medical needs (as defined by the Secretary);
6. Individuals who are **already compliant with TANF work requirements**;
7. Members of households that **receive SNAP benefits who are not exempt from SNAP work requirements** for able-bodied adults without dependents at 7 USCS § 2015(o)(2);
8. Participants in certain **drug addiction or alcoholic treatment and rehabilitation programs**;
9. **Inmates of a public institution**; and
10. **Pregnant women** or individuals entitled to **postpartum medical assistance**.

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Key Definitions: Family Caregiver Exclusion

- The RAISE Act defines family caregiver as "an adult family member or other individual who has a *significant relationship* with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."

- CMS expects to limit application of the family caregiver exclusion to individuals who provide care to:
  1. an individual living in their household;
  2. a relative (to be further defined); or
  3. another individual for whom the applicable individual provides a minimum number of hours of caregiving per month

  Additional guidance is forthcoming.

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Key Definitions: Medical Frailty Exclusion

- CMS intends to require states to use a definition of medical frailty similar to that described in regulations at 42 CFR § 440.315(f). This regulatory definition includes certain individuals described in the community engagement statute (e.g., those with serious and complex medical conditions or who have a disabling mental disorder). (See slide 36 for comparison.)
  - CMS does not intend to provide states with flexibility to add other types of individuals to the definition of medical frailty, beyond those listed in the statute.
- CMS will expect states to implement an auditable approach to verify medical frailty, in alignment with certain guardrails.
  - E.g., medical claims data review or provider documentation, or completion of a screening tool. States may require new applicants without any claims history to complete a screening tool to verify medical frailty, but CMS expects to require states to confirm that determination via claims data/documentation within 6 months post enrollment.
- CMS will expect states to distinguish between conditions justifying a medical frailty exclusion that are permanent (to be reverified at least every 12 months) vs. temporary (to be reverified at least at every renewal).
- Additional details and guardrails forthcoming.

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SNAP and TANF

The WFTC legislation treats exemptions for TANF and SNAP participants differently.

- An individual must be excluded from demonstrating the Medicaid community engagement requirements if the individual:

    1. is ***compliant*** with any work requirements applied by the individual's state **TANF** program; or
    2. is a member of a household that receives SNAP benefits and is ***not exempt*** from **SNAP** work requirements under such Act for able-bodied adults without dependents at 7 USC § 2015(o)(2).

- States will need to know if an individual in a household receiving SNAP is subject to or exempt from SNAP work requirements. Medicaid agencies will also need to identify when this status changes.
- If someone fails to meet SNAP work requirements, or has another change that affects SNAP eligibility, this will affect their SNAP eligibility, and the Medicaid agency should be made aware of changes to SNAP eligibility to process the potential Medicaid change in circumstance.
- As part of CMS' plan to collect data from states specific to C-E, CMS may ask states to separately report the number of applicable individuals who are excepted from Medicaid community engagement because they must meet work requirements in SNAP or TANF.

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Demonstrating and Verifying C-E Compliance & Exceptions/ Exclusions

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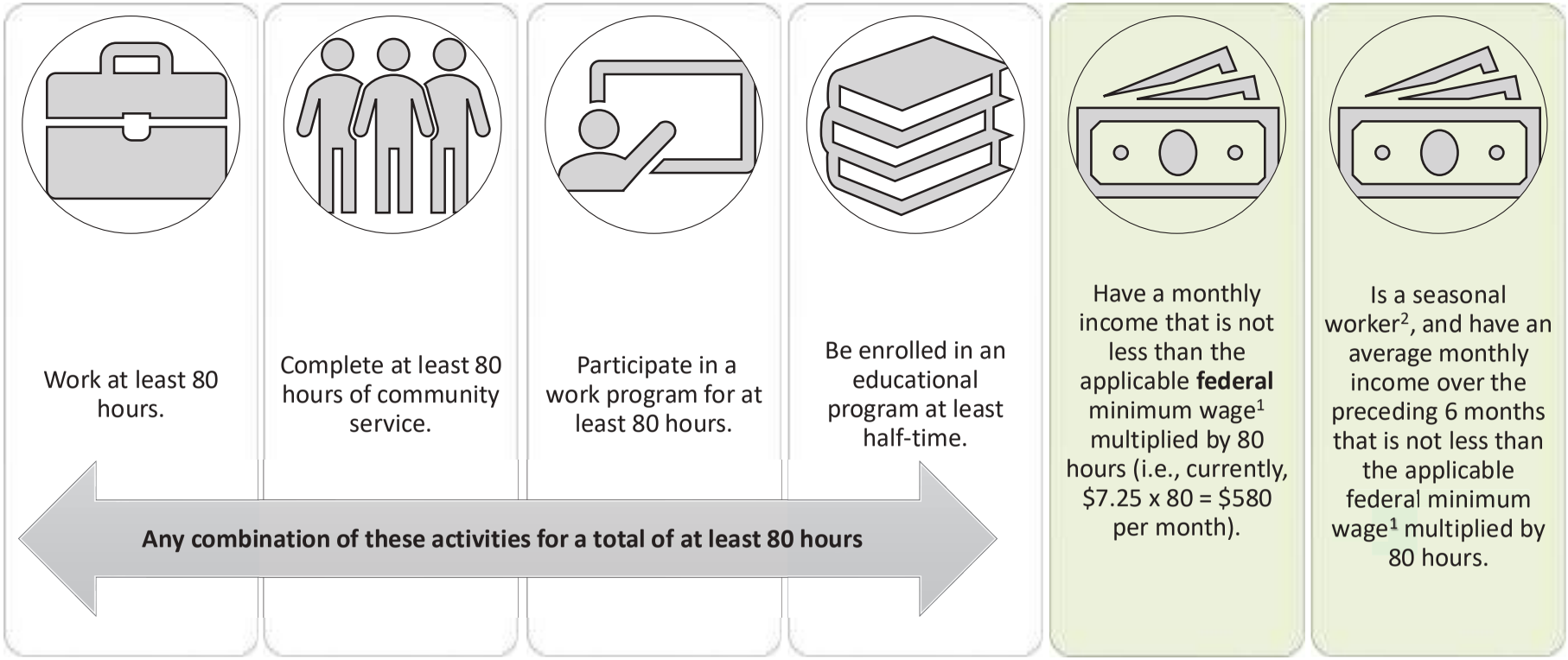
Community Engagement Compliance

To meet C-E requirements in a given month, applicable individuals must do one or more of the following, if they are neither excepted nor excluded:



Section 1902(xx)(2) of the Act.

1. Federal minimum wage is defined by section 6 of the Fair Labor Standards Act of 1938, 29 U.S.C. § 206(a)(1)(C).
2. A seasonal worker is described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986.

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Verification of C-E Compliance

States must establish processes and attempt to use reliable information, including reliable data sources (e.g., payroll, encounter data, data in state eligibility systems/case record) to establish whether an individual met the community engagement requirement, without requiring, where possible, the applicable individual to submit additional information.

Generally, the existing **Medicaid statutory and regulatory framework** for eligibility verification applies to verification of community engagement compliance, including requirements for agencies to:

- Use available electronic data sources before requesting documentation or additional information from individuals *(see 42 CFR 435.948(b)).*
- Minimize requests for information to the minimum needed to verify compliance or exceptions *(42 CFR 435.952(c))*
- Permit individuals to provide any necessary documentation through all modalities (online, mail, phone, etc.) (*42 CFR 435.907(a)).*
- Accept information from the applicant/beneficiary, adult in the applicable individual's household, authorized representative, or individual acting responsibly for the adult *(42 CFR 435.907(a)).*

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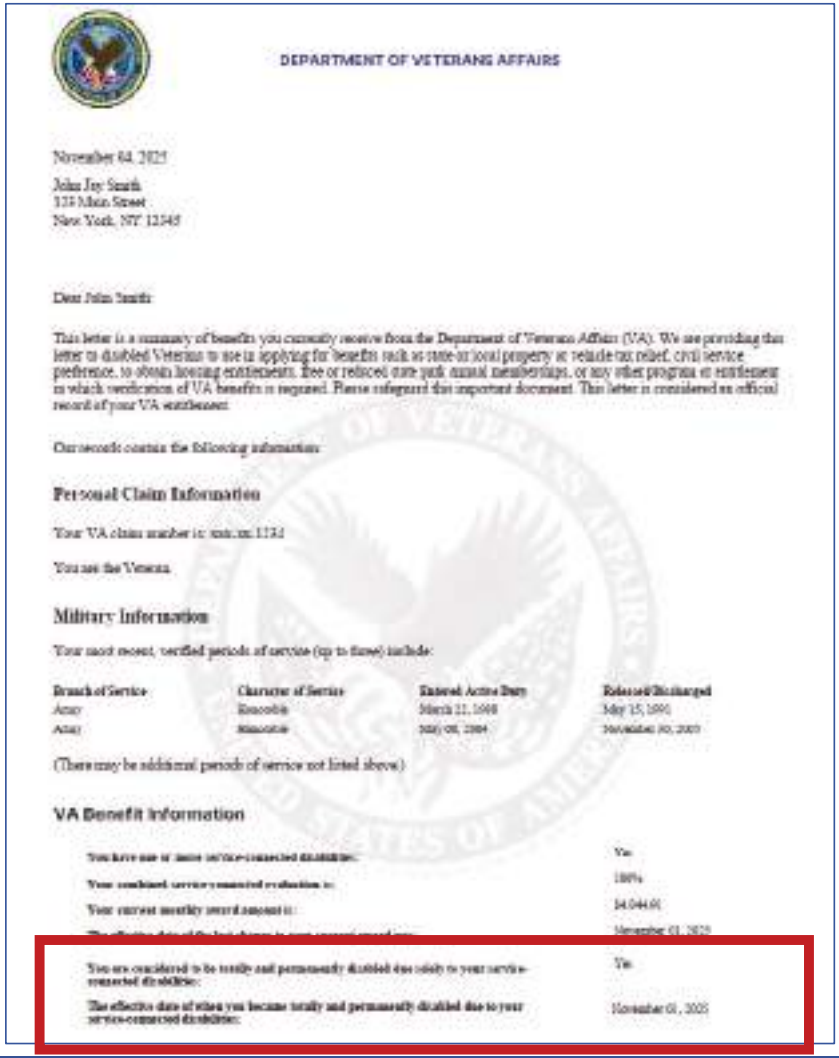
Verifying Exceptions & Exclusions

- CMS expects states to use available data, including from the individual case record or reliable sources, to verify an applicant's or beneficiary's status as excepted or excluded from community engagement requirements.
- States must not request documentation from individuals to verify a mandatory exception where reliable data is available (e.g., from claims data or the beneficiary record).
- To ensure program integrity, CMS intends to require that states maximize use of data sources and other auditable information to verify exclusions and exceptions and to limit states' use of self-declaration to the greatest extent possible.



DEPARTMENT OF VETERANS AFFAIRS

November 04, 2025

John Jay Smith
123 Main Street
New York, NY 12345

Dear John Smith:

This letter is a summary of benefits you currently receive from the Department of Veterans Affairs (VA). We are providing this letter to disabled Veterans to use in applying for benefits such as state or local property tax relief, civil service preference, to obtain housing entitlements, free or reduced state park annual memberships, or any other programs or entitlement in which verification of VA benefits is required. Please safeguard this important document. This letter is considered an official record of your VA entitlement.

Our records contain the following information:

Personal Claim Information

Your VA claim number is: xxx-xx-1234

You are the Veteran.

Military Information

Your most recent, verified periods of service (up to three) include:

Branch of Service	Character of Service	Entered Active Duty	Released/Discharged
Army	Honorable	March 21, 1988	May 15, 1991
Army	Honorable	July 08, 2004	November 30, 2007

(There may be additional periods of service not listed above.)

VA Benefit Information

You have one or more service-connected disabilities:	Yes
Your combined service-connected evaluation is:	100%
Your current monthly award amount is:	$4,044.91
The effective date of this award is your current award date:	November 01, 2025
You are considered to be totally and permanently disabled due solely to your service-connected disabilities:	Yes
The effective date of when you became totally and permanently disabled due to your service-connected disabilities:	November 01, 2025

Sample VA Benefit Summary Letter (or VA Award Letter) documenting individual's total disability. Available for download by all veterans on VA.gov.

Potential Sources for Verification of Exceptions & Exclusions

	Exclusion/Exception	Verification Source & Process
Information already collected and stored in states' eligibility systems	Former Foster Care Status	**Information in application.** Collected at application and available in state eligibility system or from IV-E agency.
	American Indian/Alaska Native	**Information in application.** Collected at application and available in state eligibility system. Exclusion aligns with exceptions required for cost-sharing provision of WFTC legislation, so states will need this information for multiple purposes.
	Pregnant/Postpartum Status	**Information in application.** Collected at application or post-enrollment. States must accept reports of pregnancy, under penalty of perjury, unless the state has information that is not reasonably compatible with the information provided (see 435.956(e)).
For enrolled benes, must start with available data. If no data exists, then move to other verification approaches as applicable **Additional guidance forthcoming.**	Medical Frailty Status	Available through **claims data** for enrolled Medicaid beneficiaries. If no claims, use other verification approaches. CMS expects to require that states use at least a medical **screener** at application or for individuals newly declaring medical frailty.
	Participant in Drug/Alcohol Addiction Treatment/Rehab	Available through **claims data** for enrolled Medicaid beneficiaries. If no claims, provider documentation or a screener could be used to the extent permissible under federal law and regulations.

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Potential Sources for Verification of Exceptions & Exclusions

	Exclusion/Exception	Verification Source & Process
Available through state interfaces or other state systems	TANF Compliance or SNAP Enrollment	**Information exists.** May be obtained through integrated **state eligibility system** or via interface and data sharing agreement between agencies.
	Inmate of a Public Institution Within Prior 3 months	**Information exists.** May be accessible using methods developed under CAA 2023, Section 5121 Medicaid provisions and/or 1115 reentry policies, which outline how states can obtain information on timing of an inmate's release.
No data source. Standard documentation exists	Veteran with Total Disability	**New to Medicaid**. Veterans can provide a VA Benefit Summary Letter (see slide 16). This is a downloadable letter on VA.gov.
No data source or standard documentation	Family Caregiver Status	**New to Medicaid** for caregivers of individuals not enrolled in Medicaid. Additional guidance forthcoming.

Note: Additional details forthcoming

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Implementation Timing

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Implementation Timing

- States must implement new community engagement requirements by **January 1, 2027.** Outreach to existing beneficiaries would begin no later than September 2026.
- States **may adopt C-E earlier** than the effective date via the state plan or 1115 authority.
  - If a state elects to begin outreach for community engagement prior to August 2026, CMS may allow a "hold harmless period" (up to 4 months) where states may choose whether to disenroll non-compliant individuals as they test systems. States must be in full compliance by January 1, 2027.
- CMS **may not waive** the requirements under section 1115 demonstration authority.

Outreach

- States must conduct outreach to applicable individuals enrolled in Medicaid before they implement community engagement requirements and periodically thereafter. Outreach requirements cannot be waived by starting early.
- States must conduct outreach to applicable individuals between 4 and 6 months prior to the first day that individuals must comply with the requirements, depending on whether a state elects a 1-, 2-, or 3-month review period (i.e., the number of consecutive months a state requires individuals to demonstrate community engagement at application).
- CMS anticipates requiring that all states conduct periodic outreach to applicable individuals at least once every 6 months after implementation.

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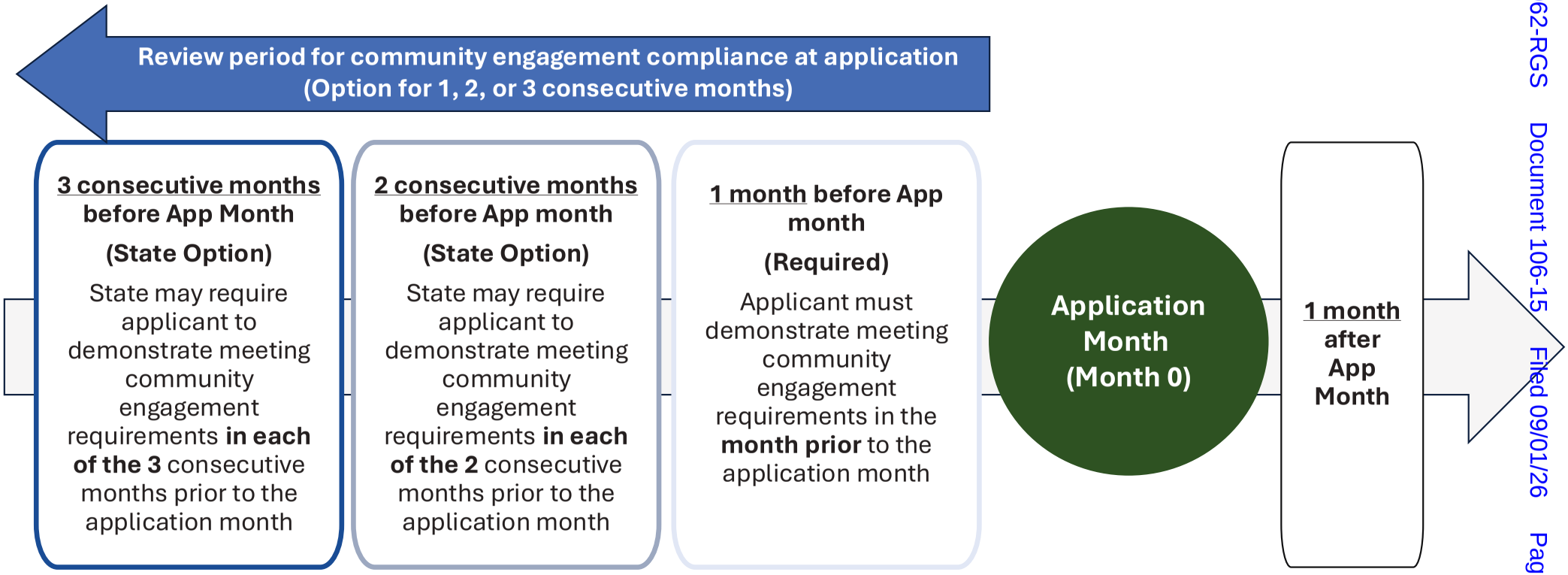
State Review Period for Community Engagement Compliance at Application



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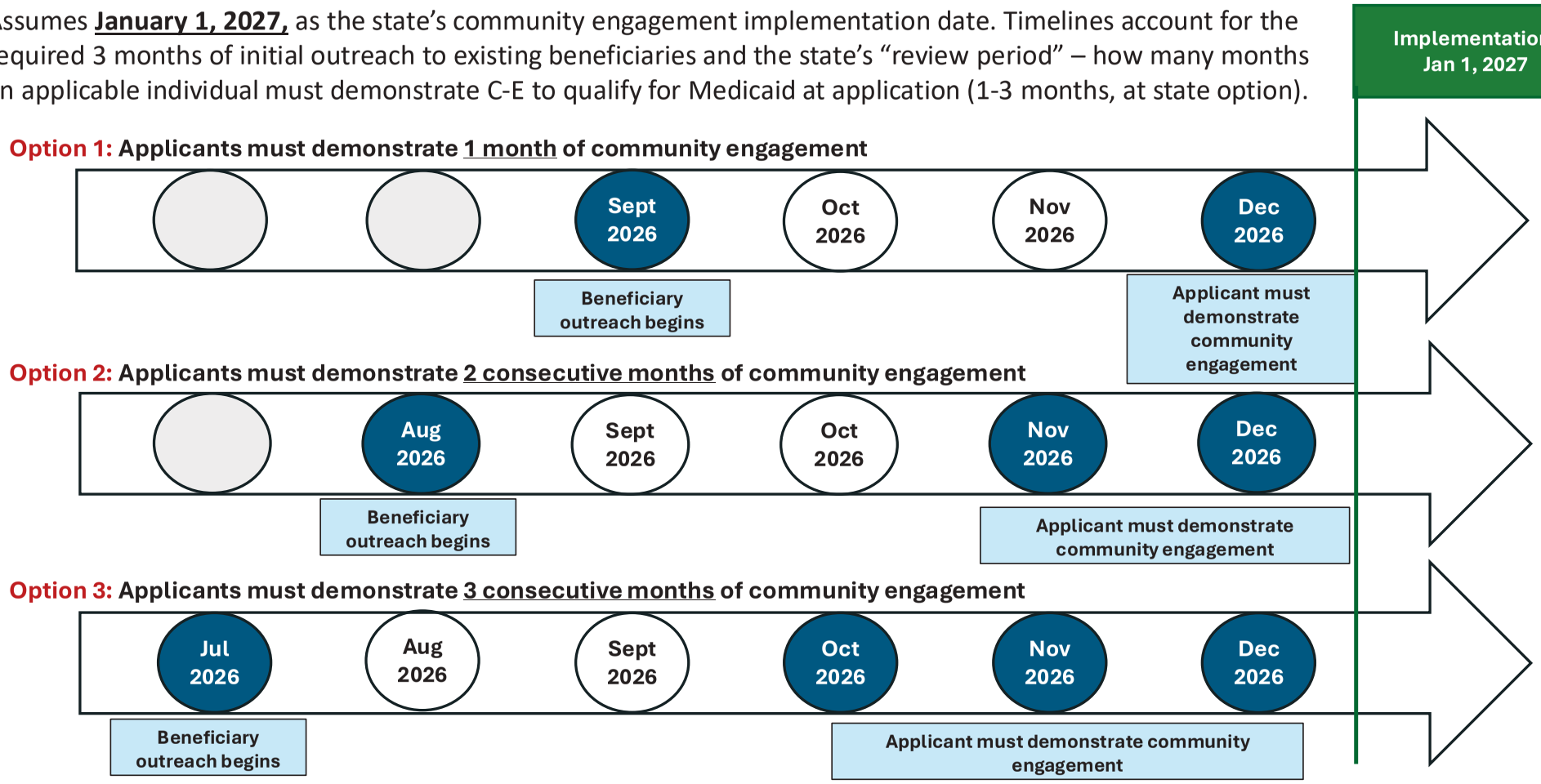
State Options for Initial Beneficiary Outreach & Compliance Review Periods at Application

Assumes **January 1, 2027,** as the state's community engagement implementation date. Timelines account for the required 3 months of initial outreach to existing beneficiaries and the state's "review period" – how many months an applicable individual must demonstrate C-E to qualify for Medicaid at application (1-3 months, at state option).



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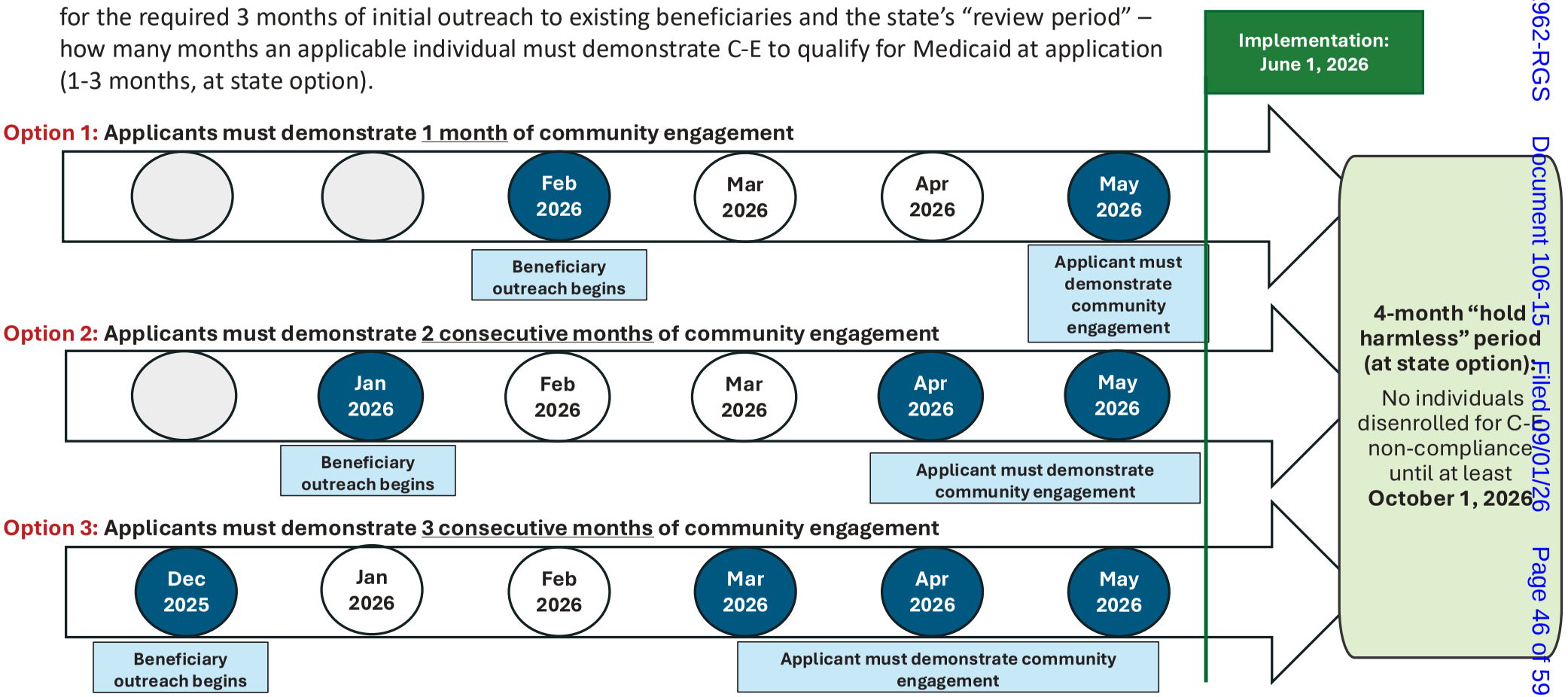
Early Starters: State Options for Initial Beneficiary Outreach & Compliance Review Periods at Application

Assumes **June 1, 2026,** as the state's community engagement implementation date. Timelines account for the required 3 months of initial outreach to existing beneficiaries and the state's "review period" – how many months an applicable individual must demonstrate C-E to qualify for Medicaid at application (1-3 months, at state option).



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Implementing Community Engagement: Developing a Minimum Viable Product

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Systems and Operational Requirements for Full C-E Implementation

Full implementation of C-E includes multiple, interdependent elements that extend beyond system updates. States will need to address policy, process, and operational capacity to meet compliance. The following is meant as an example only and is not an exhaustive list.

System Development

- **Procure new vendor(s)** and/or update existing vendor contracts.
- **Update applications and renewal forms** to capture and validate C-E-related information.
- Integrate **new data sources** and update E&E systems workflows to identify and verify applicable individuals at application and renewal.
- Modify existing functionality to enable data **monitoring and reporting** of compliance, exceptions, and disenrollments.
- **Update eligibility rules engines data exchanges, and notices** to reflect C-E compliance determinations.
- Update all **consumer and worker portals** to include new C-E related elements.

Process and Policy Changes

- Determine the **initial beneficiary outreach & compliance review periods**.
- Define **verification procedures**
- Establish **auditable procedures** for verifying compliance, exclusions, and short-term exceptions.
- **Revise paper applications and renewal forms** to include community engagement-related questions.
- Update **call center scripts** and Interactive Voice Response messaging.
- **Update eligibility manuals**, make necessary **state regulatory** and other administrative directive changes.
- Pursue necessary **state legislative changes.**

Operational Updates and Training

- **Train eligibility workers**, call center staff, and contractors on new business processes and systems logic.
- Develop **updated communication/ outreach and notice templates** that include C-E requirements and rights.
- **Update state monitoring** / compliance processes.
- **Update managed care contracts**, inter-agency agreements or other contracts.

Optional Enhancements Improvements

- Further **expand data sources** over time to improve verification accuracy (e.g., for workforce programs and volunteer activities).
- Establish data-driven**, closed-loop referral pathways** connecting beneficiaries to employment, education, and community-based resources.
- **Integrate referrals with case management systems** and external partners to document outcomes and verify participation.

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Potential C-E Systems Workflow – Initial Application

Individual Completes and Submits Application

Individuals must be able to submit applications through the following modalities:
(1) Online,
(2) Telephone,
(3) Mail, and
(4) In-person.

Update applications, customer and worker portals to include questions that screen for compliance with and exclusions from C-E.

State Receives & Processes Application

States' systems intake applications through manual and/or automated processes.

States identify if the individual is in the applicable population.

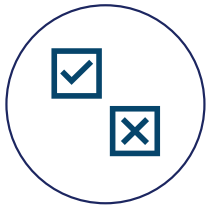
Update eligibility logic, state systems, and worker training to identify applicable population subject to C-E and route them through appropriate determination process.

State Verifies C-E Compliance or Exemption

Use reliable information, including information obtained through reliable data sources, to verify compliance with or exemption from C-E.

Request additional documentation, as applicable.

Add data sources and update processes and eligibility logic to verify individuals' compliance with or exemption from C-E.



State Makes Determination

Determine eligibility. If no satisfactory showing (i.e., compliance or exception) is made after appropriate notices, the state must redetermine eligibility on other bases.

States must provide individuals a minimum of 30 calendar days from the notice of non-compliance to demonstrate compliance or an exception.

Update rules engine and eligibility determination logic.

State Provides Notice

If the individual is determined eligible, the state sends notice and enrolls them.

If ineligible on all bases, the state must deny eligibility with appropriate notices and fair hearing rights, and transfer the account to the appropriate program, including the Marketplace, if potentially eligible.**

Update rules engine and eligibility determination logic. Update account transfer logic to send accts to the Marketplace.

*States must conduct outreach to applicable individuals between 4 and 6 months prior to the first day that individuals must comply with the requirements.
** Individuals determined ineligible for Medicaid for non-compliance with C-E requirements are not eligible for financial assistance to obtain Marketplace coverage.

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Potential C-E Systems Workflow – Renewal

State Identifies the Renewal Cohort

Identify the cohort of individuals enrolled in Medicaid for whom a renewal must be initiated and whether those individuals are in the applicable population. Renewals will occur every 6 months for most applicable individuals.

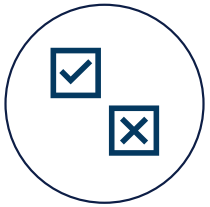
Update eligibility logic, state systems, and worker training to identify applicable population subject to C-E and route them through appropriate redetermination process.

State Verifies C-E Compliance or Exemption

Use reliable information, including information obtained through data sources, to verify income and other eligibility criteria compliance with or exception from C-E.

Request additional documentation, if applicable.

Add data sources and update processes and eligibility logic to verify individuals' compliance with or exemption from C-E.



State Makes Determination

State rules engine determines whether the individual is eligible.

If no satisfactory showing (i.e., compliance or exception) is made after appropriate notices with appeal rights, the state must redetermine eligibility on other bases.

Note: States must provide individuals a minimum of 30 calendar days from the notice of non-compliance to demonstrate compliance or an exception.

Update rules engine and eligibility determination logic.

State Provides Notice

If individual is determined eligible, the state sends notice and renews eligibility. Notice includes reminder of C-E and other obligations.*

If an individual is determined ineligible on all bases, and after a minimum 30-day period to demonstrate compliance, the state must provide appropriate notices and appeal rights, deny eligibility, and transfer the account to the appropriate program, including the Marketplace, if applicable**.

Update rules engine and eligibility determination logic. Update notice and outreach materials.

* States must conduct periodic outreach to applicable individuals.

** Individuals determined ineligible for Medicaid for non-compliance with C-E requirements are not eligible for financial assistance to obtain Marketplace coverage.

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Minimum Viable Product for Initial State Implementation

- CMS is outlining requirements of a **minimum viable product (MVP)** for all states to achieve.

- States will be expected to implement basic systems and operational requirements of the statute in first year (**the MVP**) as they work to expand use of data sources and enhance systems to support increased reliance on data sources in years 2 and 3.

- CMS is exploring data sources for states to verify educational status and will also use the additional time in years 2 and 3 to identify and include more data sources in the federal data Hub and elsewhere.

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Vision of Systems Development From Year 1 to Year 2+

Minimum Viable Product (Year 1 2027)

- Implement all core systems functionality (updates to eligibility determination logic, eligibility worker and customer portal, etc.).
- For Verification of Qualifying Activities:
  - Work Hours & Education: Primary use of electronic **data sources or auditable documents.**
  - Community Service & Job Program Enrollment**:** Auditable individual declaration allowed in year 1, under penalty of perjury; states are encouraged to use data or documents if available.
  - Mandatory Exceptions & Exclusions**:** Validation using data from data sources; MMIS/eligibility system, auditable individual declaration under penalty of perjury, etc. (see slides 17-18 for more detail).

Enhanced Functionality for Verification (Year 2+ 2028)

- Maximum reliance on data.
- Primary use of data sources for all qualifying activities, including work, education, job programs, and community service.
- Fixes and improvements over year 1 functionality.

January 2027> MVP; January 2028> and beyond Further Improvements

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Additional Policy Areas

CMS intends to provide states flexibility in certain areas, which include but are not limited to, the following:

- Verification Frequency: States have flexibility in determining frequency of compliance with qualifying activities and exceptions that are subject to change, within the statutory framework.
    - *Note*: Consistent with 42 CFR 435.916(d)(1) (in effect as of 2023), states must promptly act on all information received from a beneficiary that may affect eligibility.

- Approaches to Outreach: CMS will not prescribe additional required forms of individual outreach beyond those specified in statute but will provide examples states may consider – e.g., text, emails, calls, in person. Managed care plans are considered a potential modality for individual outreach.

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CMS' Compliance and Monitoring Strategy

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CMS' Proposed Approach to Assessing Readiness

CMS will establish a consistent, transparent systems and operational readiness assessment framework to evaluate state progress toward MVP implementation and guide technical assistance (TA) and compliance decisions.

Systems Readiness Assessment Framework:

- Will be based upon monthly State Officer state meetings, the review of systems projects status reports, and demonstrations.
- TA to states, as needed, will be provided through engagement with partner organizations (i.e., S-TAG monthly workgroup, state cohort meetings, NAMD CIO Affinity Group meetings).

Operational Readiness Assessment Framework:

- Will consider factors such as budget requests, procurement, staffing, training, development of outreach materials and inter-agency agreements, and coordination with managed care plans.
- CMS will meet with states on a regular cadence to assess progress, including via quarterly deep-dive sessions with states to address emerging issues.

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Monitoring and Compliance

- CMS will expect regular data reporting from states on community engagement.
  - CMS is reviewing existing CMS data sources to assess where those data may need to be updated or enhanced.
  - Expect forthcoming guidance about potential updates to Performance Indicator and Eligibility Processing data sets and T-MSIS data quality priorities.

- States that fail to meet expected timelines or compliance deadlines may be placed on a corrective action plan and may be subject to compliance action under Section 1904 of the Act (withholding of federal matching funds).

- CMS also plans to outline any new processes and procedures for ensuring compliance in the IFR for states that do not comply with the community engagement requirements.

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Forthcoming Guidance and Next Steps

- WFTC Legislation Overview Center Informational Bulletin (CIB) and Accompanying Slide Deck (available on www.Medicaid.gov/medicaidreforms)
- Interim Final Rule – no later than June 2026
- Resuming Friday NAMD/CMCS Eligibility Workgroup Calls
- MedicaidWorks@cms.hhs.gov

Appendix: Medical Frailty – Comparison of Statutory & Regulatory Definitions

Medically frail definition for an Alternative Benefit Plan:

42 CFR 440.315(f): The State's definition of individuals who are medically frail or otherwise have special medical needs must at least include all of the following:

- Individuals described in § 438.50(d)(3) of this chapter,
- **Individuals with disabling mental disorders** (including children with serious emotional disturbances and adults with serious mental illness),
- **Individuals with** chronic **substance use disorders,**
- **individuals with serious and complex medical conditions,**
- **Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, [and]**
- Individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

C-E medically frail definition in statute includes **bolded** bullets above and "an individual—(aa)who is blind or disabled (as defined in section 1614);"

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EXHIBIT 16

DECLARATION OF ALANNA DANCIS

I, Alanna Dancis, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of New Mexico. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Acting Medicaid Director for New Mexico of information and records gathered by the New Mexico Health Care Authority (HCA) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Acting Director for the New Mexico State Medicaid program and Children's Health Insurance Program, collectively referred to as Medicaid.

3. HCA is the single state agency responsible for administering the New Mexico Medicaid Program. The New Mexico Medicaid Program provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. The New Mexico Medicaid Program's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. The New Mexico Medicaid Program's mission is to provide high-quality health care and safety-net services.

4. The New Mexico Medicaid Program insures approximately 813,057 thousand people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. New Mexico administers the Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115

Demonstration Project. the New Mexico Medicaid Program receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 77.9% of the New Mexico Medicaid Program's expenditures on eligible enrollees.

Medicaid Expansion in New Mexico

6. On January 1, 2014, New Mexico implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the New Adult Eligibility Group (i.e. the VIII Group) program, hereafter referred to as Medicaid Expansion.

7. Enrollees in Medicaid Expansion receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Medicaid Expansion requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of June 26th, 2026, approximately 228,709 (28.1%) of the New Mexico Medicaid Program members are enrolled in Medicaid Expansion. For the current state fiscal year 2026, approximately $3.6 billion of $9.3 billion (38.3%) of the New Mexico Medicaid Program's federal Medicaid funding comes from the FFP for Medicaid Expansion members.

CMS's Pre-IFR Guidance to New Mexico

9. I and my staff at the New Mexico Medicaid Program have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work

or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, the New Mexico Medicaid Program does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, New Mexico relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a

regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for the New Mexico Medicaid Program to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and the New Mexico Medicaid Program once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June

9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely --on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct,

a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance"

with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis

added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not take account of the fact that providers have [12 months] to submit claims data. For determinations that are supposed to be made regarding the preceding year, the New Mexico Medicaid Program may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

The New Mexico Medicaid Program's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, the New Mexico Medicaid Program recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, [immediately] after H.R. 1 was passed in July 2025, the New Mexico Medicaid Program began work to prepare to comply with community engagement requirements.

41. Beginning in November 2025 and continuing until the release of the IFR, the New Mexico Medicaid Program based its policy and system determination on the statutory language

and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, the New Mexico Medicaid Program has already done the following:

- Established HR1 Leadership Structure
    - Executive Steering Committee
    - Cross Functional Workgroups
    - Developed Reporting and Reporting Structures
- Conducted Procurement and Additional Contracting for:
    - Policy analysis of PL119-21 for Medicaid and SNAP
    - Modular Systems Impact Analysis
    - Project Management and Systems Integration Support
- Conducted Procurement and Additional Contracting for Necessary Changes to the:
    - Eligibility and Enrollment Solution
    - Medicaid Managed Information System
    - Systems Integration Platform
    - Unified Portal
    - Consolidated Customer Support Center
    - Intelligent Document Processing Solution
    - Developed new mythologies to assist with additional eligibility determinations
- Hired additional 78 staff to support the Income Support Division and 32 additional staff to support the Medicaid Assistance Division and provided equipment

- Conducted detailed design and discovery sessions on each of the Community Engagement Features, involving multiple vendors and staff from multiple agencies from March through June
- Engaged with CMS State Representatives to advise on identified questions associated with the policy and posed
- Engaged with multiple Communications partners to educate New Mexicans of the impending changes
    - Press Releases
    - Articles
    - Social Media
    - Traditional Mailings
    - Webinars
    - In person workshops
- Revised training and developed actional materials for social service workers to support clients.
    - ASPEN CRs for the 5 non-CE-related systems work
    - HR1 Non-CE Change Request : #1 Limit Retroactive Medicaid
    - HR1 Non-CE Change Request : #2 Immigrant Medicaid
    - HR1 Non-CE Change Request : #3 Six Month Certification – MAGI Adult
    - HR1 Non-CE Change Request : #4 Agency Action from Updated Address

- HR1 Non-CE Change Request : #5 Quarterly SSA Death Master File Match
- Engaged workgroup and professional stakeholders to establish a Medically Frail Screener

42. With respect to implementing the medically frail exclusion in particular, the New Mexico Medicaid Program has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data".

43. the New Mexico Medicaid Program faces several urgent deadlines with respect to implementing community engagement requirements. the New Mexico Medicaid Program must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, the New Mexico Medicaid Program must substantially finalize eligibility system requirements by June 26, 2026, in order to enable full system deployment, with appropriate testing, in July 2026. After August 31, 2026, the New Mexico Medicaid Program will only have limited ability to make further system changes for use by January 1, 2027. Moreover, the New Mexico Medicaid Program is required by H.R. 1 to issue notices by August 31, 2026, addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, the New Mexico Medicaid Program needs to send information by July 15, 2026, to allow the vendor program into the eligibility system.

44. Nevertheless, the New Mexico Medicaid Program still lacks clarity on several crucial issues from the IFR. While the IFR says that the New Mexico Medicaid Program will need

to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how the New Mexico Medicaid Program should determine this. While CMS has said more subregulatory guidance will be provided, the New Mexico Medicaid Program must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only the New Mexico Medicaid Program, but also the messages that the New Mexico Medicaid Program can provide its members: if the New Mexico Medicaid Program does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources the New Mexico Medicaid Program is required to have integrated as of January 1, 2027, and which can be integrated later. the New Mexico Medicaid Program requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

45. Of note, the consequences for the New Mexico Medicaid Program from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If the New Mexico Medicaid Program is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for New Mexico and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

46. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

47. New Mexico studies conducted before the IFR was released suggest that (1) at least 38.9% of the New Mexico Medicaid Program's Medicaid Expansion members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires Medicaid Expansion members' eligibility to be reevaluated every six months), and (2) New Mexico uninsured rates will increase by up to 13.6%. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

48. Indeed, the New Mexico Medicaid Program expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. the New Mexico Medicaid Program members may think they do not qualify as "medically frail," given the added complexity, and the New Mexico Medicaid Program may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also

likely decrease the number of people the New Mexico Medicaid Program can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

49. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to the New Mexico Medicaid Program sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for the New Mexico Medicaid Program and decreases quality of care for members.

50. The New Mexico Medicaid Program expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In the New Mexico Medicaid Program's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, the New Mexico Medicaid Program expects that more members who are actually eligible will be disenrolled simply because they are be unable to demonstrate their eligibility.

51. The New Mexico Medicaid Program also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and

then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in the New Mexico Medicaid Program) develop cognitive dysfunction or depression that would not be immediately identifiable in the New Mexico Claims System. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the development of cognitive dysfunction or depression and thus could lose coverage if they could not obtain documentation for this diagnosis.

52. The New Mexico Medicaid Program is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, the New Mexico Medicaid Program is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

53. The New Mexico Medicaid Program has spent years conducting outreach and building relationships with enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on New Mexico

Burdens on the New Mexico Medicaid Program

54. Because CMS had never before imposed community engagement requirements across eligibility categories, the New Mexico Medicaid Program's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the

numerous eligibility factors necessary to evaluate community engagement. The state of New Mexico has currently requested $60,537,385 in both state and federal funds to cover the cost of system implementations, communications, staffing, and administrative costs for these changes.

55. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require the New Mexico Medicaid Program to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, the New Mexico Medicaid Program may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, the New Mexico Medicaid Program expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, the New Mexico Medicaid Program will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

56. The New Mexico Medicaid Program also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, the New Mexico Medicaid Program expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on New Mexico

57. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on the New Mexico Medicaid Program, but on New Mexico more generally. As noted above, the New Mexico Medicaid Program members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of the New Mexico Medicaid Program's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the Medicaid Expansion. New Mexico's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from the New Mexico Medicaid Program will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on HCA. Most importantly, the New Mexico Medicaid Program expects poorer health outcomes across the New Mexico, as fewer people will be able to access appropriate care and manage chronic conditions.

58. In addition, the New Mexico Medicaid Program expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to

devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Alanna Dancis
Acting Medicaid Director

EXHIBIT 17

DECLARATION OF JAMES V. McDONALD, M.D., M.P.H.

I, **JAMES V. McDONALD, M.D., M.P.H.**, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

Professional and Agency Background

1. I am familiar with the information in the statements set forth below either through personal knowledge, consultation with New York State Department of Health ("DOH" or "Department") staff, or from my review of relevant documents and information. I submit this Declaration in support of the State's Motion for a Preliminary Injunction.

2. I am the Commissioner of New York State Department Health, and I have been in this role since 2023. In this role, I am responsible for the policy direction, day-to-day strategy, operations, and management for DOH. Prior to this role, I held multiple positions at the Rhode Island Department of Health between 2012 and 2023, including Interim Director of Health, Chief Administrative Officer of the Board of Medical Licensure and Discipline, Medical Director for the COVID Unit, as well as Medical Director for the Division of Health Care Quality and Safety and the Drug Overdose Prevention Program. I earned my Doctor of Medicine (M.D.) from Loyola Stritch School of Medicine in Chicago, Illinois and completed my pediatric residency with the United States Navy and my residency in General Preventive Medicine and Public Health with State University of New York. I earned my Master of Public Health from the University of North Carolina at Chapel Hill.

3. DOH is the single state agency responsible for administering the New York State Medicaid Program, which provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost.

4. The New York State Medicaid Program insures approximately 6.4 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. On January 1, 2014, New York State implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level.

6. As of May 2026, approximately 1.9 million, or nearly 30 percent, of New York State Medicaid members fit these criteria. For the prior state fiscal year 2026, approximately $17.5 billion or nearly 32 percent of DOH's federal Medicaid funding comes from the FFP for these Medicaid expansion adults.

The Interim Final Rule

7. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the novel work or community engagement requirement imposed under Section 7119 of H.R.1 for adults covered under the Medicaid expansion provision of the ACA (the "community engagement requirements").

8. Among other things, the IFR added a new requirement that a "medically frail" individual must also be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements 42 CFR § 435.554(c)(5)(i).

Human Costs of the IFR's Community Engagement Requirements

9. DOH studies conducted of H.R. 1 before the IFR was released suggest that (1) at least 25 percent (approximately 475,000) of DOH's Medicaid expansion adults will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires members' eligibility to be reevaluated every six months), and (2) New York State uninsured rates will increase up to 45% (i.e., the number of uninsured individuals will increase from approximately 1,000,000 before H.R. 1 to as high as 1,450,000 after H.R. 1). Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail, these studies likely underestimate the impact to members.

IFR's Significant Impairment Requirement

10. The IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

11. DOH expects the "significant impairment" requirement could result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely decrease the number of people the New York State Medicaid Program can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process may require not just a diagnosis code, but also other information on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for

many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew.

12. Members with conditions that meet the statutory categories of medical frailty, but who lose coverage due to inability to document "significant impairment" may return to the New York State Medicaid Program sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for the New York State Medicaid Program and decreases quality of care for members.

Administrative, Operational, and Financial Burdens on New York State

13. DOH faces several urgent deadlines with respect to implementing community engagement requirements. DOH must apply community engagement requirements to applications and renewals initiated on January 1, 2027. To do this, DOH must substantially finalize eligibility system requirements by July 2, 2026, to enable full system deployment, with appropriate testing, in Fall 2026. After July 2, 2026, DOH will only have limited ability to make further system changes for use by January 1, 2027. Moreover, DOH is required by H.R. 1 to issue notices before September 2026 informing individuals of the community engagement requirements in at least two different modalities. . In order to issue those notices in a timely fashion, DOH needs to begin to send these notices in July 2026, to ensure the full population receives timely notice.

14. With respect to the medical frailty exclusion, the "significant impairment" requirement– plus the uncertainty of how to implement it – may require DOH to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, DOH may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and

denied coverage or disenrolled because of this requirement, DOH expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, DOH will also incur the cost of educating its members, staff, and other stakeholders including advocacy agencies, community-based organizations and the provider community, about what the requirement means and how it can be met.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

James V. McDonald, M.D., M.P.H.
Commissioner
New York State Department of Health

EXHIBIT 18

DECLARATION OF SARAH GREGOSKY

I, Sarah Gregosky, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of North Carolina. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Assistant Secretary and Deputy Medicaid Director of North Carolina Medicaid, of information and records gathered by the North Carolina Department of Health and Human Services ("NC DHHS") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Assistant Secretary and Deputy Medicaid Director for the North Carolina State Medicaid program ("NC Medicaid").

3. NC DHHS is the single state agency responsible for administering NC Medicaid. NC Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. NC Medicaid's coverage includes medical, pharmacy, dental, mental health and substance use treatment, long-term services and supports, and long-term care. NC Medicaid's mission is to strengthen access to quality health care for all North Carolinians.

4. NC Medicaid insures more than three million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. North Carolina administers the NC Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans, Section 1115 Demonstration Project, and waivers. NC Medicaid receives federal Medicaid funding, known as "Federal Financial Participation" ("FFP"), which covers an average of 68% of NC Medicaid's expenditures on eligible enrollees.

Medicaid Expansion in North Carolina

6. On December 1, 2023, North Carolina implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through North Carolina's Medicaid expansion program.

7. Enrollees in NC Medicaid's expansion program receive full, comprehensive benefits that include medical, pharmacy, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Eligibility for NC Medicaid's expansion program requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of May 1, 2026, 727,341 (approximately 23%) of NC Medicaid's members are enrolled in the expansion program. For the current state fiscal year 2026, approximately $6.8 billion, equal to about 27% of NC Medicaid's federal Medicaid funding, comes from the FFP for NC Medicaid's expansion program members.

CMS's Pre-Interim Final Rule (IFR) Guidance to North Carolina

9. I and my staff at NC Medicaid have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel community

engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, Title XIX of the Social Security Act never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, NC Medicaid does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, the Centers for Medicare and Medicaid Services ("CMS") has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroup calls to provide guidance and conduct question-and-answer sessions with states on implementing community engagement ("Workgroup Calls"). These Workgroup Calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, CMS continues to hold Workgroup Calls.

12. These Workgroup Calls, usually occurring after rule making, are part of a historical practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, NC Medicaid relied on CMS guidance provided during these Workgroup Calls, and the accompanying slide decks and other materials, to determine how to comply with new community engagement requirements in H.R. 1; implement operational, system, and process changes; and, ultimately, avoid financial penalties for noncompliance. Other states also relied on this guidance.

13. H.R. 1 excludes medically frail individuals. Guidance from CMS during Workgroup Calls indicated that it intended to "use a definition … similar to that described in

regulations at 42 CFR § 440.315(f),” which is a regulation whose language closely resembles the H.R. 1 language. CMS also stated that it expected to allow verification of medical frailty through “medical claims data review or provider documentation, or completion of a screening tool.”

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require “medically frail” individuals to have a significant impairment in order to be excluded from community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. During a November 2025 Workgroup Call, CMS signaled that only limited use of self-attestation would be permitted to verify medical frailty. Several months later CMS indicated that self-attestation would be an acceptable verification method when data was not available.

16. In the March 27, 2026, Workgroup Call, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation “*to confirm ongoing medical frailty”* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, which may include several “renewal cycles” or redetermination periods, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during Workgroup Call, CMS shared a slide deck that included a definition of the medical frail exclusion. These slides did not mention any requirement

that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS released the IFR, which was published in the Federal Register on June 3, 2026 (91 FR 33,348), relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for NC Medicaid to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and NC Medicaid once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. The phrase "significantly impairs" only exists in the text of H.R. 1 Section 71119 in the context of inability to perform one or more activities of daily living; not in the context of inability to comply with community engagement requirements. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual be medically frail, the IFR adds a new element of

requiring that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this new, required element.

22. Additionally, the "significant impairment" element was not mentioned in the context of an individual's ability to comply with community engagement requirements in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medically frail exclusion in general. Instead, the IFR requires that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. In a Workgroup Call since the IFR's release, CMS informed states that it is developing more guidance on the medically frail exclusion. However, as of date of June 26, 2026, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. The IFR uses a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR. Because self-attestations to medical frailty will be limited to once per period of enrollment, which includes multiple renewal periods or "renewal cycles", this new concept operates to hinder states' operational efficiencies, to put medically at-risk members in danger of losing Medicaid coverage, and to treat patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid. Exceeding 12 months conflicts with long standing law and regulation.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations when evaluating exclusion from community engagement requirements. The IFR's analysis, absent other evidence to demonstrate medical frailty, is based on whether the individual has previously submitted a self-attestation during the current period of enrollment. This distinction on when self-attestation can be used increases the operational complexity states face in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once disenrolled and use self-attestation again at the start of a new period of enrollment. As such,

the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs, and increase administrative burden on the State and our county Departments of Social Services (entities who make eligibility determinations in North Carolina) in implementing the rule. Simultaneously, it fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). Particularly, to determine whether an individual is medically frail, the IFR would require North Carolina to build systems and complex algorithms to incorporate data sources and the co-occurrence of multiple data elements for each factor of medical frailty, even though such factors are numerous, vary depending on medical condition, and often relate to areas that Medicaid agencies have never assessed before to assess eligibility, such as medical diagnoses and healthcare services as it relates to an individual's ability to comply with the community engagement requirements. It is not possible for North Carolina to build the systems and complex algorithms necessary to determine compliance with the community engagement requirements or eligibility for exemptions or exclusions to the requirements based on all of the new, additional requirements being imposed under the IFR by January 1, 2027.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). CMS acknowledges in the IFR that most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services.

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not account for the fact that providers have 12 months to submit claims. For determinations that are supposed to be made regarding the preceding year, NC Medicaid may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

NC Medicaid's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, NC Medicaid recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the

July 1, 2026, notice deadline and January 1, 2027, implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1 (North Carolina has an earlier deadline to notice beneficiaries than required by H.R. 1 so as to comply with State law requirements.). Therefore, after H.R. 1 was passed in July 2025, NC Medicaid promptly began work to prepare to comply with community engagement requirements.

41. Beginning in August 2025 and continuing until the release of the IFR, NC Medicaid based its policy and system determination on the statutory language and the guidance provided by CMS, as detailed above. Based on this guidance, NC Medicaid has already done the following:

- Initiated internal workgroups with NC DHHS staff to develop work plan, policy and technology requirements, and external stakeholder engagement approach. To date, NC Medicaid has held 18 cross functional workgroup meetings, in addition to 33 weekly program leadership meetings and 31 communications and engagement meetings.
- Initiated internal workgroups with NC DHHS staff to develop medical frailty approach. To date, NC Medicaid has held 19 medical frailty workgroup meetings with clinical leadership and data subject matter experts.
- Initiated workgroups with Managed Care Health Plan staff to review work plans, policy and technology requirements, and external stakeholder engagement approach. To date, NC Medicaid has held 12 meetings with Managed Care Health Plan staff.
- Initiated workgroups with eligibility and enrollment system (NCFAST) to review and implement policy and statutory requirements. To date, NC Medicaid has held

68 meetings with NCFAST staff and an additional 29 meetings with NC DHHS leadership to ensure cross program alignment with other economic service programs managed within NCFAST.

- Developed budget estimates to implement and operationalize community engagement requirements and sought state and federal budgetary authority to support the requirements.
- Developed stakeholder engagement materials and began stakeholder engagement, including website content, call scripting, and training presentations. To date, NC Medicaid has met with 63 external stakeholder groups, including community partner organizations and county Departments of Social Services staff.
- Analyzed existing eligibility policies to confirm necessary updates to support community engagement and began necessary updates.
- Began updating paper and electronic application aligned with community engagement requirements.
- Drafted and began mailing member notification letters to Medicaid expansion beneficiaries regarding upcoming eligibility policy changes. Initiated proactive communication to beneficiaries, including text, email and phone outreach about upcoming eligibility changes to Medicaid expansion beneficiaries.
- Initiated design and development of new data sources to support automation of community engagement requirements, including education data, work program data, NC Medicaid claims and encounter data, NC Health Information Exchange electronic medical record data, and veteran's disability rating data.

- Initiated design and development of existing data sources to support automation of community engagement requirements, including wage data, incarceration data, and managed care eligibility data.

42. With respect to implementing the medically frail exclusion in particular, NC Medicaid has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims and encounter data available through NC Medicaid data warehouse and electronic health record data available through NC Health Information Exchange, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation."

43. NC Medicaid faces several urgent deadlines with respect to implementing community engagement requirements. NC Medicaid must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, NC Medicaid must substantially finalize eligibility system requirements by September 2026, in order to enable full system deployment, with appropriate testing, in September 2026. After September 2026, NC Medicaid will only have limited ability to make further system changes for use by January 1, 2027. NC Medicaid has already passed the deadline to build the systems and complex algorithms to incorporate multiple data sources or data elements as contemplated by the IFR to begin determining medical frailty exclusions effective January 1, 2027. Moreover, NC Medicaid is required by H.R. 1 to issue notices addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, NC Medicaid needs to send information by no later than July 1, 2026, due to additional State law look-back provisions for determining compliance with the community engagement requirements. Additionally, N.C. Gen. Stat. § 108A-54.2 requires NC Medicaid to engage in a public notice and comment process to promulgate and implement new

medical coverage policies necessary to implement H.R. 1, including the IFR. In order to comply with that State law and meet the implementation deadlines in H.R. 1, NC Medicaid needs to publish the new medical coverage policies for public comment by August 2026.

44. NC Medicaid still lacks clarity on several crucial issues from the IFR. While the IFR says that NC Medicaid will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how NC Medicaid should determine this. While CMS has said more guidance will be provided, NC Medicaid must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only NC Medicaid internal processes, but also the clarity of communications that NC Medicaid can provide its members. If NC Medicaid does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources NC Medicaid is required to have integrated as of January 1, 2027, and which can be integrated later. NC Medicaid requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

45. If NC Medicaid cannot configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106 in addition to the expense of bringing the systems into compliance. In other words, while financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for North Carolina and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

46. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

47. National estimates for North Carolina conducted before the IFR was released estimate that at least 30% of NC Medicaid's Expansion program members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (H.R. 1 requires NC Medicaid expansion program members' eligibility to be reevaluated every six months). Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 for the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these national estimates likely underestimate the impact to members.

48. Indeed, NC Medicaid expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. NC Medicaid members may think they do not qualify as "medically frail," given the added complexity, and NC Medicaid may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people NC Medicaid can automatically verify as medically frail, because, under the IFR, the *ex parte* verification

process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

49. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to NC Medicaid sicker and costlier due to the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for NC Medicaid and decreases quality of care for members.

50. NC Medicaid expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In NC Medicaid's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, NC Medicaid expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

51. NC Medicaid also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still

enrolled in NC Medicaid) develop a substance use disorder. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the newly developed substance use disorder and thus could lose coverage if they could not obtain documentation for this diagnosis.

52. NC Medicaid is required by State law to provide notice to members regarding the changes occasioned by the IFR on or before July 1, 2026. At present, NC Medicaid is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice does not have the clarity required to communicate to members how they can comply with the new requirements.

53. NC Medicaid has spent years conducting outreach and building relationships with NC Medicaid enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on NC Medicaid

Burdens on NC Medicaid

54. Because CMS had never before imposed community engagement requirements across eligibility categories, NC Medicaid's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. North Carolina anticipated system costs and staffing needs to be approximately $29.9 million in start-up costs and an additional $44.4 million annual operational funding to support implementation prior to the release of the IFR. NC Medicaid anticipates that the additional requirements under the IFR will result in increased costs to

implement system changes and will increase resources required to support ongoing operations, above prior estimates.

55. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require NC Medicaid to rapidly redirect its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, NC Medicaid may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, NC Medicaid expects more calls, more documents to process, additional manual processing by county caseworkers that may increase processing errors, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, NC Medicaid will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

56. NC Medicaid also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, NC Medicaid expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require yet more additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on North Carolina

57. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on NC Medicaid, but on North Carolina more generally. As noted above, NC Medicaid members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of NC Medicaid's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in NC Medicaid's expansion program. As the uninsured rate increases, there will be a greater financial strain on providers—in particular rural, community, and safety net hospitals as well as community health centers—that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from NC Medicaid will likely lose access to primary and preventive care—and care necessary to treat their statutorily recognized medical conditions—resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on NC DHHS. Most importantly, NC Medicaid expects poorer health outcomes across North Carolina, as fewer people will be able to access appropriate care and manage chronic conditions.

58. Lastly, NC Medicaid expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

/s/ Sarah Gregosky
Sarah Gregosky, MSPH
Assistant Secretary and Deputy Medicaid Director
NC Department of Health and Human Services,
Division of Health Benefits (NC Medicaid)

EXHIBIT 19

DECLARATION OF VIVIAN LEVY

I, Vivian Levy, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Oregon. I am over the age of 18 and have personal knowledge, as well as knowledge based on my review, in my capacity as Interim State Medicaid Director, of information and records gathered by the Oregon Health Authority and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Interim Medicaid Director for the Oregon State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Oregon as the Oregon Medicaid Program). As Interim Medicaid Director, I am responsible for the administration of the state's full benefit Medicaid program. Since graduating from Portland State University with a master's degree in Public Administration, I have spent over 16 years with the Oregon Medicaid Program. During this time, I have served in leadership roles across Medicaid policy, operations, outreach, and technology including as Deputy Medicaid Director, and now Interim Medicaid Director effective June 2026.

3. The Oregon Health Authority (OHA) is the single state agency responsible for administering the Oregon Medicaid Program.

4. The Oregon Medicaid Program provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. The Oregon Medicaid Program's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. The

Oregon Medicaid Program's mission is to increase access to health care for low-income Oregonians, improve the health of Oregonians by improving quality of care and access to preventive services, and contain the cost of health care.

5. The Oregon Medicaid Program insures approximately 1.4 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

6. Oregon administers the Oregon Medicaid Program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. The Oregon Medicaid Program receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers a percentage of the Oregon Medicaid Program's expenditures on eligible enrollees.

Medicaid Expansion in Oregon

7. On January 1, 2014, Oregon implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level.

8. Enrollees in Oregon's Medicaid expansion population receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the Medicaid expansion population requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

9. As of April 2026, approximately 565,694 (44.3%) of the Oregon Medicaid Program members are enrolled as part of the Medicaid expansion population, also referred to as the MAGI adult eligibility group. For the current state fiscal year 2026, approximately $4.7 billion, or 52%, of the Oregon Medicaid Program's federal Medicaid funding comes from the FFP for the MAGI adult eligibility group.

10. My staff at the Oregon Medicaid Program and I have been closely following enactment and implementation of H.R. 1, especially including Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

11. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, the Oregon Medicaid Program does not have in place systems by which to verify work, volunteer, or other community engagement activities.

12. Since November 2025, CMS has been providing guidance on community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

13. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal

Medicaid law. In the absence of regulations, Oregon relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

14. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025, CMS Slide Deck at 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

15. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

16. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025, CMS Slide Deck at 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

17. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-

attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

18. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

19. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon, and was subject to change.

20. In response to this and concerns that CMS would change its policy direction related to community engagement, Oregon Governor Tina Kotek sent a letter to CMS on May 29, 2026, conveying Oregon's concerns with limiting the definition of medically frail and the use of self-attestation. This letter is attached as Exhibit 1.

CMS Issues the Interim Final Rule

21. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for the Oregon Medicaid Program to design by August 31, 2026, and implement before January 1, 2027, and are expected

to cause significant harm to members and the Oregon Medicaid Program once implemented. These provisions include the following:

Medically Frail Definition

22. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

23. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) (codified at 42 U.S.C. § 1396a(xx)(A)(ii)(II)(V)). In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

24. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

25. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because

doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided, nor has a timeline been shared for when it will be provided. During the June 5, 2026, call CMS hosted for states, CMS acknowledged that states will need this additional guidance in order to understand and operationalize the IFR language on the medical frailty exclusion, and they were not able to answer questions raised by states at that time.

26. Since publication of the IFR, CMS has asserted that States must attempt to use reliable information, including claims or encounter data, to verify medical frailty, but if that information is not available then states must request documentation. The Oregon Medicaid Program seeks more clarity from CMS about how claims and encounter data alone can be used to reflect an individual's ability to work in light of the IFR's suggestion in the pre-amble that "particular claims or types of claims" will be necessary. The level of encounter data complexity that CMS prescribes that States use will impact the the Oregon Medicaid Program's ability to implement these changes by the January 1, 2027 timeline. Additionally, the requirement to request

documentation in the absence of reliable information is counter to the guidance given as recently as March 27, 2026.

Self-Attestation

27. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 16-17, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

28. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

29. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

30. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

31. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

32. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

33. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase

costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

34. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, the new regulation does not expressly permit this.

Renewal Process

35. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

36. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91

Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act § 1902(xx)(6) [42 U.S.C. § 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "[s]tates must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412 (June 3, 2026).

37. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

38. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

39. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified

in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33,473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

40. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

41. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. For determinations that are supposed to be made regarding the preceding year, the Oregon Medicaid Program may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

The Oregon Medicaid Program's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

42. Following the enactment of H.R. 1, the Oregon Medicaid Program recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, after H.R. 1 was passed in July 2025, the Oregon Medicaid Program began work to prepare to comply with community engagement requirements.

43. Beginning with the passage of H.R. 1 and continuing until the release of the IFR, the Oregon Medicaid Program based its policy and system determination on the statutory language

and the sub-regulatory guidance provided by CMS, as detailed above. Based on this guidance, the Oregon Medicaid Program has already done the following:

- Statutory analysis
- Development and documentation of IT system requirements
- Redesign of existing member notices and creation of new required notices
- Submission and approval of state funds required to support implementation (received approval for significantly less funding than requested from legislature given State budget deficit secondary to H.R. 1)
- Held 152 engagements with community partners, 19 engagements with clinical partners, member advocates, and managed care entities, as well as training sessions for over 1100 application assisters
- Requested new eligibility staff positions from the State legislature based on work models

44. With respect to implementing the medically frail exclusion in particular, the Oregon Medicaid Program has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025, CMS Slide Deck at 11.

45. The Oregon Medicaid Program faces several urgent deadlines with respect to implementing community engagement requirements. The Oregon Medicaid Program must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, the Oregon Medicaid Program must substantially finalize eligibility system requirements by July 10, 2026, in order to enable full system deployment, with time for basic testing. There is

not adequate time for sufficient system testing even if that date is met given the overall implementation timeline. After March 16, 2026, the Oregon Medicaid Program has had limited ability to make further system changes for use by January 1, 2027. This is because the system design was already approved. Implementing the required systems changes to operationalize the policy shifts in the IFR will require Oregon and our contractors to reopen the systems design and make changes, resulting in additional work, reviews, and approvals within an already constrained timeline. Due to the volume and scope changes required by the IFR's policy shifts and the absence of additional time to accommodate these systems changes, Oregon will not be able to conduct an end-to-end review of the design document. This introduces significant project risk, prevents adherence to best Project Management Practices, and requires the Oregon Medicaid Program to accept these risks and move forward with the work without feasible mitigation strategies in order to do everything in the State's ability to come into compliance and prevent federal financial penalties that would be detrimental to Oregon's state budget.

46. Implementing the required systems changes to operationalize the policy shifts in the IFR creates significant development and testing impacts for the Oregon Medicaid Program. Development was already in progress and mostly complete for all the Oregon Medicaid Program's eligibility system updates. These scope changes will require our contractor to make coding changes, perform additional development activities, and retest the updates. System Integration Testing (SIT) was already in progress, and test cases will need to be re-executed after these new development changes are completed. The schedule does not allow for additional testing time, so this adds significant risk to the project and overall quality. Guidance must be provided to the Oregon Medicaid Program by August in order to allow for the very minimum required time to complete design, development, and testing.

47. Implementing the required systems changes to operationalize the policy shifts in the IFR creates significant release impacts for the Oregon Medicaid Program. Due to the compressed timeline, the coding changes can no longer be delivered in a single release. The work must now be split across two releases, one release in September and another in November. This adds a significant layer of complexity and risk to the project. New release planning is required to accommodate the new approach and will require coordination with other teams like MMIS, which will also be impacted by this new release schedule.

48. Combined, these design, development, testing, and release impacts have consequential resource impacts on Oregon as well as overall efforts to implement H.R. 1. The strain on existing resources is significant. As of June 24, 2026, Oregon is continuing to conduct an impact analysis to the other HR1 projects in progress, as Oregon has overlapping resource constraints. State resources have been and may continue to be reassigned from other H.R. 1 projects to focus on the MWR redesign, redevelopment, retesting, and increase the impact on release cycles in September, November and into 2027.

49. Moreover, the Oregon Medicaid Program is required by H.R. 1 to issue notices prior to the implementation of community engagement requirements addressing the changes occasioned by the IFR. For the Oregon Medicaid Program to issue any notice to members, it needs clear guidance on the policy contents of the notice approximately three months in advance of issuing those notices to allow sufficient time for designing, drafting, translating, printing, and mailing. Given CMS has not issued clear guidance about many policies that need to be included in the notice (i.e., "significant impairment" threshold), even receiving this guidance in August will still not leave sufficient time for the Oregon Medicaid Program to complete redesign, translations, printing, and mailings to members.

50. Nevertheless, the Oregon Medicaid Program still lacks clarity on several crucial issues from the IFR. While the IFR says that the Oregon Medicaid Program will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how the Oregon Medicaid Program should determine this. CMS guidance is also required to clarify how States will both not rely on claims alone to verify the new "significant impairment" requirement while also using reliable data, such as claims, to verify medical frailty. While CMS has said more sub-regulatory guidance will be provided, the Oregon Medicaid Program must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only the Oregon Medicaid Program, but also the messages that the Oregon Medicaid Program can provide its members and clinical providers: if the Oregon Medicaid Program does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members and their providers about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources the Oregon Medicaid Program is required to have integrated as of January 1, 2027, and which can be integrated later. The Oregon Medicaid Program requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

51. Of note, the consequences for the Oregon Medicaid Program from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If the Oregon Medicaid Program is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at

the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Oregon and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

52. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. States were incentivized to create streamlined, automated technology systems with the goal of making real-time eligibility determinations for Medicaid applicants whenever possible using available and reliable data sources. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

53. Oregon studies conducted before the IFR was released suggest that (1) at least 20% of the Oregon Medicaid Program's Medicaid expansion population members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires Medicaid expansion population members' eligibility to be reevaluated every six months), and (2) Oregon adult uninsured rates could more than double , increasing from 4.1% to 9% (using 2024 estimates from the Oregon Health Insurance Survey). Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

54. Indeed, the Oregon Medicaid Program expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not

meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. The Oregon Medicaid Program members may think they do not qualify as "medically frail," given the added complexity, and the Oregon Medicaid Program may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people the Oregon Medicaid Program can automatically verify as medically frail, because, under the IFR, the ex parte verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, see 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day, month-to-month, or season/quarters, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold. For example, an individual with rheumatoid arthritis (i.e. a condition that can have seasonal fluctuations) could be up for renewal in March, yet have had a flare up in February preventing them from working and be unable to schedule with a rheumatologist until after their renewal in March. In this scenario, if the individual had already self-attested once in a prior renewal period, the IFR's self-attestation policy would prohibit them from self-attesting at this time and they would be subject to procedural disenrollment despite remaining eligible. For all these reasons, the IFR's additional "significant impairment" requirement creates barriers to members understanding what is needed to keep their Medicaid coverage, barriers to providers in understanding what documentation is needed and sufficient to meet a threshold that is not

statutorily defined or based in extant evidence-based practice literature, and a more labor intensive process for both members and providers to submit complete applications or renewals.

55. Furthermore, the way that the IFR is written is ambiguous to the extent that the "significant impairment" threshold applies to community engagement activities - at this time, it is not known whether it is applicable to an individual's existing and current work, volunteering, schooling, or training activities, versus any future or hypothetical opportunity. For example, someone cannot work as a forestry logger with a fractured leg; however, they could work a remote computer-based position or stationary in-person position. This lack of guidance on the applicability of the "significant impairment" threshold makes it unclear whether the intention is to apply this broadly, which would be entirely subject to the opportunities available to an individual, such as regionality, accessibility, work experience, and more, as well as the individual's ability to access those opportunities, many of which lie outside of an individual's control. Furthermore, this lack of guidance of the applicability of "significant impairment" threshold has already created confusion among members, providers, and advocacy groups of which have contacted the Oregon Health Authority with questions. And most notably, the Oregon Medicaid Program is unable to successfully operationalize and be in compliance with the IFR policies given the lack of sufficient specificity as written.

56. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document “significant impairment” may return to the Oregon Medicaid Program sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of “churn” in Medicaid enrollment both raises costs for the Oregon Medicaid Program and decreases quality of care for members.

57. The Oregon Medicaid Program expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In the Oregon Medicaid Program's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, the Oregon Medicaid Program expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

58. The Oregon Medicaid Program also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in the Oregon Medicaid Program) develop a pulmonary embolism or a stroke. Under the IFR, assuming continuous Medicaid coverage during that period, the member could not self-attest to medical frailty based on the embolic event and thus could lose coverage if they could not obtain documentation for this diagnosis and its impact on their ability to be compliant with the community engagement requirement.

59. The H.R. 1 medical exemptions, and IFR's "significant impairment" and self-attestation limit, combined with H.R. 1's requirement to process as many applications and renewals on an *ex parte* basis as possible, pose additional uncertainty and risk to coding and billing. The Oregon Medicaid Program only receives diagnosis information if and when it is linked to a service utilization. If we have any information at all, it will be inclusive of both diagnosis and service utilization. Best practices for health encounter coding encourage providers to only list health

conditions addressed at the point of care in that unique patient-provider encounter visit. This poses several serious risks:

- Individuals with chronic disabling conditions may not have the associated diagnosis and service utilization in the claims encounter data within the application or renewal lookback period. This would lead to those individuals' applications/renewals not being processed on an *ex parte* basis, which is contrary to H.R. 1 itself. This would put many individuals at risk of procedural disenrollment who are otherwise eligible.
- The medical exemptions in H.R. 1, combined with the IFR's "significant impairment" threshold, put undue burden on providers to change coding practices—for a purpose that is beyond the scope of providers' work—and thereby have wide ranging impacts for the Oregon Medicaid Program, the federal Medicaid system, and health care costs overall. This burden on providers is exacerbated by requiring providers to fill out additional information of an assessment of an individual's ability to work without having a definition or criteria for what meets "significant impairment" threshold.

60. Members who lose their coverage would lose access to treatment for chronic conditions such as diabetes, receive delayed diagnoses for conditions like cancer and face greater risks of death, and be unable to obtain needed prescriptions. Members who lose their coverage would be at risk of incurring a catastrophic financial event and medical debt. Medical events are estimated to be a contributing factor to over half of all personal bankruptcies in the United States, and Medicaid eligibility has been shown to reduce personal bankruptcies and medical debt.

61. The Oregon Medicaid Program is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. § 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, the Oregon Medicaid Program is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

62. The significant risks associated with the design, development, testing, and release changes needed to operationalize the unexpected policy shifts in the IFR mean that members, and anyone interacting with the eligibility system and member portal (e.g., the Oregon Medicaid Program staff, contractors, eligibility assistors) face increased odds of erroneous procedural disenrollment due to technology and systems issues that are the biproduct of the IFR's unexpected shifts in policy. These significant and compounding systems risks may lead to people being unable to finish an application or renewal as there could be system bugs, page timeouts, broken navigation, and/or accessibility features (e.g., screen readers, voice input, etc.) that are incomplete or broken. Eligible individuals may not complete an application and may lose coverage or experience delays in accessing needed medical care. There are risks that uploading documentation can fail or become confusing, given document submission flows are changing quickly to accommodate the IFR's new and yet still undefined documentation requirements. Upload buttons may not work across all web browsers or mobile devices, the system may fail to clearly indicate whether a document successfully uploaded, and there could be inconsistent file-type or size restrictions that limit eligible individual's ability to demonstrate the required proof despite having the required documents.

63. The most significant risk under the circumstances described above is increased system bugs due to insufficient testing secondary to the IFR's further compressed timeline. This is anticipated to lead to incomplete user acceptance testing; uncaught defects in functionality like identify verification, income calculations, eligibility determinations, renewal workflows, or case updates; and higher rates of crashes, frozen pages, or error loops. Members experiencing systems impacts will lead to higher burdens on call centers and caseworkers, resulting in call center volume spikes, eligibility workers manually verifying or re-entering information where automated steps fail, staff spending significant time answering questions, and overall delayed processing times. This results in significantly increased risk of incorrect eligibility determinations and wrongful terminations of coverage, delayed enrollment, and unnecessary appeals or fair hearings. People with limited English proficiency or disability would be disproportionately harmed due to these barriers to access. For example, in 2025, members in the Oregon Medicaid Program had 270 unique written language preferences and 293 unique spoken language preferences.

64. The Oregon Medicaid Program has spent years conducting outreach and building relationships with Oregon Medicaid Program enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Oregon

Burdens on the Oregon Medicaid Program

65. The State of Oregon works on a two-year budget cycle which starts on July 1st of odd years. When large federal policy changes occur after this start date, it is much harder for individual agencies and the state to reallocate resources, as programs are already in stages of implementation. In the case of H.R. 1, the Oregon Medicaid Program instantly started working to

provide estimates of what was needed to implement H.R. 1 provisions. However, revenue constraints already placed on the state made it harder for Oregon to reallocate resources to the level needed for implementation. In addition, the condensed timelines of implementing H.R. 1 required additional strain on current resources and less ability to assess options and leverage cost savings.

66. Because CMS had never before imposed community engagement requirements across eligibility categories, the Oregon Medicaid Program's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. The Oregon Health Authority did receive a budget adjustment of $12.4 million in the Spring of 2026 to be able to implement Medicaid and SNAP requirements of H.R. 1. Of that, $1.7 million was for Information System Infrastructure updates for the state's "ONE" eligibility system and Medicaid Management Information System. With limited resources available, this funding did not include any contingency built in, only allowing for what was originally priced. For any new federal policy changes, the work would need to be scoped for additional costs and resources. Funding would then be requested later in the fall, with legislative approval not planned until Feb or March of 2027, putting the agencies in the position of doing work prior to ensuring funding is available or ensuring cashflow is feasible.

67. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require the Oregon Medicaid Program to rapidly change its operational approach and systems development. In addition to analyzing, developing, and implementing new ways to evaluate medical frailty, the Oregon Medicaid Program may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from

accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, the Oregon Medicaid Program expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, the Oregon Medicaid Program will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

68. The Oregon Medicaid Program also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, the Oregon Medicaid Program expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Oregon

69. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on the Oregon Medicaid Program, but on Oregon more generally. As noted above, the Oregon Medicaid Program members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of the Oregon Medicaid Program 's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in the Medicaid expansion population . Oregon's budget will suffer harm due to loss of federal matching funds when eligible individuals

lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from the Oregon Medicaid Program will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on Oregon Medicaid. Most importantly, the Oregon Medicaid Program expects poorer health outcomes across Oregon, as fewer people will be able to access appropriate care and manage chronic conditions.

70. In addition, the Oregon Medicaid Program expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 29th day of June 2026.

/s/ Vivian Levy
VIVIAN LEVY
Interim Medicaid Director
Medicaid Division, Oregon Health Authority

EXHIBIT 20

DECLARATION OF HOA PHAM

I, Hoa Pham, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Pennsylvania. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Secretary of the Pennsylvania Department of Human Services' ("DHS") Office of Income Maintenance of information and records gathered by DHS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Deputy Secretary for Pennsylvania DHS' Office of Income Maintenance ("OIM"). In this role, I am responsible for administering assistance programs that primarily serve low-income Pennsylvanians such as Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Low Income Home Energy Assistance Program (LIHEAP). That work includes but is not limited to overseeing core eligibility determination policy and operational functions.

3. DHS is the single state agency responsible for administering Medicaid in Pennsylvania, known in Pennsylvania as Medical Assistance. Through its Medicaid program, DHS provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. DHS' Medicaid coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care.

4. DHS seeks to promote whole-person health for all Pennsylvanians served by Medicaid and CHIP by modernizing systems and programs, ensuring access to the highest value healthcare available, and removing barriers to equity and wellness.

5. DHS' Medicaid program insures approximately 2.8 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

6. Pennsylvania DHS administers the Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. DHS receives federal Medicaid and CHIP funding, known as Federal Financial Participation (FFP), which typically covers 56.06% of DHS's expenditures on eligible Medicaid enrollees and 69.24% of expenditures on CHIP enrollees. There are exceptions to these rates for certain specific populations.

Medicaid Expansion in Pennsylvania

7. In 2015, Pennsylvania implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level with a mandatory 5% income disregard primarily through DHS' Medicaid program.

8. Enrollees in Pennsylvania's Medicaid expansion program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Pennsylvania's Medicaid expansion program requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; and (3)

have household income less than or equal to 133% of the Federal Poverty Level with a mandatory 5% income disregard.

9. As of May 2026, approximately 751,092 Pennsylvanians are enrolled in Medicaid through DHS' Medicaid expansion program. There are 2,897,539 Pennsylvanians enrolled in Medicaid, so the expansion program covers roughly 26% of Pennsylvania's total Medicaid enrollment. For the current state fiscal year (2025-26), approximately $8.139 billion or 25.77% of Pennsylvania's federal Medicaid funding comes from the 90% Federal Financial Participation rate for 803,177 Medicaid expansion members (which is the program monthly average).

CMS's Pre-IFR Guidance to Pennsylvania

10. I and my staff at OIM, as well as colleagues across DHS, have been closely following enactment and implementation of H.R. 1, and in particular Section 71119, because it imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA.

11. Before H.R. 1, the Medicaid Act had never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, DHS does not have systems in place to verify work, volunteer, or other community engagement activities for Medicaid.

12. CMS launched a Community Engagement Requirements Workgroup in December 2025. DHS regularly participated in these Workgroup meetings. Between December 2025 and May 2026, CMS consistently described the statutory medical frailty exemption that exists for the community engagement requirements in categorical, diagnosis-based terms that would allow for self-attestation of a qualifying medical condition and did not include an obligation to establish how the condition may impair functioning.

13. DHS sent a memo to CMS on March 11, 2026, outlining its proposed approach to evaluating medical frailty (described more fully below), and then met with CMS on April 16, 2026, to review the March 11 memo. During the April 16, 2026, meeting, DHS repeatedly asked if it could proceed with implementing its proposed approach. CMS did not indicate that DHS would need to revise its approach to include a functional test to assess medical frailty. In fact, CMS asked if it could refer other states to Pennsylvania to learn about DHS's proposed approach.

14. During a May 1, 2026 meeting of the Community Engagement Requirements Workgroup, CMS reinforced that H.R.1 Section 71119 defines individuals meeting medical frailty as individuals meeting one or more categories (e.g., who is blind or disabled; with an SUD; with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition), CMS elaborated that states may need to consider severity of medical condition as a part of evaluation for medical frailty exclusions but notably did not indicate that states must evaluate ability to work or participate in community engagement requirements.

CMS Issues the Interim Final Rule

15. On June 1, 2026, CMS promulgated an Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for DHS to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to Pennsylvania's Medicaid program and Medicaid expansion members once implemented.

16. Most acutely, the IFR's definition of an individual excluded from the community engagement requirements on the basis of medical frailty is dependent upon the condition

significantly impairing the individual's ability to work or otherwise comply with the community engagement requirement (effectively a functionality standard). The IFR's application of a functional test is more restrictive than what is specified in H.R.1, and would require substantially more manual effort from clients and DHS to verify an individual's medical frailty status. DHS has already expended nearly $1 million in manpower hours across clinical experts and data analysts to develop a medical frailty approach that would allow it to rely on existing databases including claims and encounter information. DHS must redeploy subject matter experts to reclassify thousands of medical condition diagnostic codes to account for an evaluation of an individual's functionality. Further, DHS expects that it will be highly unlikely that administrative data alone can be used to successfully verify the IFR's medical frailty status. That means individual Medicaid expansion recipients and their healthcare providers must all complete hours of assessment, documentation and reporting to DHS to verify the IFR's definition of medical frailty status, which DHS must then process.

DHS's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

17. Following the enactment of H.R. 1, DHS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026, notice deadline and January 1, 2027, implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, DHS began to prepare to comply with the new community engagement requirements.

18. Beginning in November 2025 and continuing until the release of the IFR, DHS has based its policy and system determination on the statutory language and the subregulatory

guidance provided by CMS, as detailed above. Based on this guidance, DHS had already done the following at the time the IFR was released:

- Designed and began operationalizing an automated, data-driven medical frailty determination process. This work has involved significant investment across clinical review, policy design, analytics, IT development, claims and encounter data processing, eligibility-system planning, and technical coordination with managed care organizations and Pennsylvania's health information exchange. DHS conservatively estimates this work to date to have cost $1 million.
- Initiated public outreach to keep Pennsylvanians and strategic partners informed about upcoming Medicaid community engagement requirements and drive necessary implementation preparation. Outreach has included extensive stakeholder engagement through mass digital communications; partner meetings; town halls and workgroup activations.
- Retooled DHS' internal technical teams, vendors and their associated contracts to transition its longstanding System Development Lifecycle away from a waterfall-based, 12-18 month project timeline to an agile lifecycle to support iterative development, testing and deployment. DHS formally launched technical system design workgroups in February 2026. As of the IFR's publication, DHS already completed eight separate sprints to address Medicaid member and parallel DHS caseworker portal changes; changes to eligibility determination logic; verification and exemption logic; augment automated *ex parte* renewal processes; update electronic data exchanges; support Marketplace coordination; update internal reporting structures to support performance management and auditing; and update

automated notices and forms to Medicaid members. This technical effort has already cost DHS nearly $6M.

- Drafted notices and forms to Medicaid expansion members outlining community engagement requirements, consequences of noncompliance, and Constitutionally-required appeal rights. These drafts included feedback from over 14 unique stakeholders groups ranging from county partners to community advocates to managed care organizations and healthcare providers across the Commonwealth of Pennsylvania.
- Incorporated feedback from managed care organizations to inform DHS' coordinated strategies related to member education and outreach and automated data exchanges.

19. Despite DHS' significant expenditure of human resources and nearly $6M to date to prepare to implement the community engagement requirement. DHS will need to expend additional resources to accommodate new requirements included in the IFR. DHS has already added 5 additional weeks of discovery and technical development to its project timeline to account for new and pending guidance from CMS (see Sections 16-20 for outline of undue burden created by new IFR guidance). For example, the IFR (Section H(3)(e), *Notifying Individuals about Eligibility Decisions and Changes in Eligibility Requirements*) imposes a novel requirement to provide advanced notice and fair hearing rights consistent with §§ 435.917 through 435.918 and part 431 subpart E for individuals who lose a specified exclusion status. DHS now needs to quickly develop new technical functionality to trigger advanced notification; DHS will now assume ongoing mail production costs for this new notice.

20. DHS faces several urgent deadlines with respect to implementing community engagement requirements. DHS must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, DHS needed to substantially finalize eligibility system requirements by June 12, 2026, and conduct extensive testing to ensure full functionality to meet its originally targeted October 31, 2026, system deployment date. Of note, the IFR will likely require DHS to delay this deployment further. After full system deployment, DHS will have only limited ability to make further system changes for use by January 1, 2027. Moreover, DHS is required by H.R. 1 to begin the outreach process by August 31, 2026, addressing the changes occasioned by the IFR. In order to do that, DHS needs to account for multiple time-sensitive milestones, including finalizing language of required notices, document translation into six languages, configuration of recipient files, mail printing and processing through the U.S. Postal Service. If DHS does not finalize the language of the notices by August 1, 2026, DHS is at risk for issuing untimely notices.

21. Of note, the consequences for DHS from building its systems inconsistent with CMS's incomplete and as-yet unissued guidance are significantly heightened. If DHS is not able to configure its systems quickly enough, or if it configures its systems inconsistent with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it significantly harder for Pennsylvania and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

22. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare.

23. DHS originally projected that the Medicaid eligibility changes necessitated by H.R.1 would result in 310,000 people in Pennsylvania losing their Medicaid eligibility, and with no healthcare coverage, would lead to increased uncompensated care across Pennsylvania's hospital ecosystem.

24. DHS has recent experience enforcing similar work requirements in its SNAP program and has already experienced significant eligibility loss despite internal data indicating that the majority of SNAP recipients are already working. From June 2025 to April 2026, nearly 89,000 Pennsylvanians lost SNAP eligibility, likely as a result of failure to meet administrative work reporting requirements.

25. The IFR imposes an impairment test to qualify for a medical frailty exemption that extends beyond H.R.1, and DHS expects that this more narrow definition and administrative requirement will cause significant member confusion; strain on healthcare providers experiencing an influx in requested appointments to conduct impairment assessments; increase costs; and ultimately result in even more Pennsylvanians losing Medicaid eligibility and increased uncompensated care.

Administrative, Operational, and Financial Burdens on Pennsylvania

Burdens on DHS

26. Because CMS had never before imposed community engagement requirements across eligibility categories, DHS's eligibility system was not built to support community

engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement. DHS has worked quickly to wholesale retool its technical teams to meet CMS' requirements within a significantly compressed timeline. This has included hours of contract renegotiation, retraining technical teams to deliver faster products, carefully stacking technical projects—in some cases, wholly delaying some projects—across DHS' eligibility system to minimize risk and downstream impact to other DHS programs, like SNAP and the nearly 2 million Pennsylvanians it serves, and the other technical systems that rely upon data from DHS' eligibility system such as the Pennsylvania Department of Treasury or the Internal Revenue Service.

27. Retooling DHS' eligibility system, again, to comply with the IFR within a condensed timeframe, seriously jeopardizes DHS' good faith efforts to effectively implement community engagement requirements, as well as DHS' other technical and policy mandates. These mandates include, notably, other technical projects also directed by CMS, such as changing Medicaid eligibility and enrollment system functionality for certain noncitizen groups and augmenting automated *ex parte*.

28. DHS has already expended over $6M in up front technical work, and earmarked $10M in annual verification service transaction costs to meet CMS' "minimum viable product" (MVP) requirements for Community Engagement Requirements.

29. When H.R.1 was enacted into law, DHS projected it would need 500-800 additional casework staff to fulfill the new Medicaid-related administrative requirements. Beyond the MVP, with the IFR requirements and what other requirements may be clarified from additional pending guidance from CMS, DHS expects other technical work and costs associated with enhanced verification services will be needed to effectively implement community engagement requirements

in a way that reduces member abrasion, maximizes efficiencies and aligns with other assistance program requirements like SNAP—as envisioned by HR1.

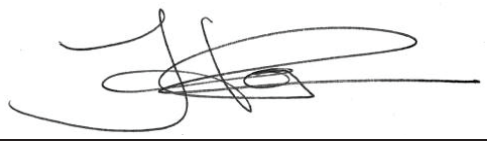
30. Failure to effectively implement clear eligibility processes with community engagement requirements will likely lead to increased strain on DHS' performance tracking and quality assurance functions, financial claims processing and fair hearings and appeals processing.

Burdens on the Commonwealth of Pennsylvania

31. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on DHS, but Pennsylvania's healthcare ecosystem. DHS projects that community engagement requirements, as outlined by the IFR, will lead to Pennsylvanians losing healthcare coverage from Medicaid; will exclude Pennsylvanians from enrolling in healthcare coverage through the Marketplace; and ultimately increase strain on Pennsylvania hospitals, particularly rural and urban hospitals which serve higher proportions of Medicaid patients. Health Management Associates, using publicly available data sources on the uninsured, approximates that in Pennsylvania a 1% increase in uninsured individuals will drive $10.8 million in uncompensated care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.



Hoa Pham

Deputy Secretary
Pennsylvania Department of Human Services
Office of Income Maintenance

EXHIBIT 21

DECLARATION OF KRISTIN PONO SOUSA

I, Kristin Pono Sousa, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Rhode Island. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Director of the Rhode Island Medicaid Program of information and records gathered by the Rhode Island Medicaid Program and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Rhode Island State Medicaid Program and Children's Health Insurance Program (CHIP) (together, the "Rhode Island Medicaid Program").

3. The Rhode Island Executive Office of Health and Human Services ("EOHHS") is the single state agency responsible for administering the Rhode Island Medicaid Program. The Rhode Island Medicaid Program provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. The Rhode Island Medicaid Program's coverage includes medical, dental, mental health and substance use treatment, and long-term services and supports. The Rhode Island Medicaid Program's mission is to improve the overall health of Rhode Island residents by promoting affordable access to medically necessary care.

4. The Rhode Island Medicaid Program insures approximately 285,133 people, providing health coverage to children, families, and older adults, including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. EOHHS administers the Rhode Island Medicaid Program pursuant to federal law and regulations as well as the terms of its federally approved State Plan and its Section 1115 Demonstration Project. The Rhode Island Medicaid Program receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which, for fiscal year 2026, covers an average of 57.5 percent of the Rhode Island Medicaid Program's expenditures on eligible enrollees.

Medicaid Expansion in Rhode Island

6. Effective January 1, 2014, Rhode Island implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 138% of the Federal Poverty Level. Members of the Rhode Island Medicaid Program that are eligible due to this expansion of the Rhode Island Medicaid Program are referred to as "MAGI Expansion" (which stands for "modified adjusted gross income") members.

7. MAGI Expansion members in the Rhode Island Medicaid Program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, MAGI Expansion eligibility requires that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; (3) not be eligible for or enrolled in Medicare; and (4) have household income less than or equal to 138% of the Federal Poverty Level.

8. As of May 2026, approximately 72,144 of members are enrolled in the Rhode Island Medicaid Program based on MAGI Expansion eligibility. For the current state fiscal year 2026, approximately six hundred million dollars, or nearly 25%, of the Rhode Island Medicaid Program's federal Medicaid funding comes from the FFP for MAGI Expansion members.

CMS's Pre-IFR Guidance to Rhode Island

9. I and my staff at the Rhode Island Medicaid Program have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, the Rhode Island Medicaid Program does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Rhode Island relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-

attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed States a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be challenging and costly for the Rhode Island Medicaid Program to design by August 31, 2026, and implement before January 1, 2027. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V), codified at 42 U.S.C.

1396a(xx)(A)(ii)(II)(V). In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has stated that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be difficult for members and challenging to implement.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, may put medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase

costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if

necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6), codified at 42 U.S.C. 1396a(xx)(6). This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. For determinations that are supposed to be made regarding the preceding year, the Rhode Island Medicaid Program may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

The Rhode Island Medicaid Program's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, the Rhode Island Medicaid Program recognized that it would be challenging to complete the necessary system and process changes required by the August 31, 2026 notice deadline and January 1, 2027 implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, the Rhode Island Medicaid Program began work to prepare to comply with community engagement requirements.

41. Beginning in July 2025 and continuing until the release of the IFR, the Rhode Island Medicaid Program based its policy and system determination on the statutory language and the sub regulatory guidance provided by CMS, as detailed above. Based on this guidance, the Rhode Island Medicaid Program has already done the following:

- Sought and received additional state funding for H.R. 1 requirements, including the community engagement requirements. Such funding is earmarked for staff augmentation, new systems and data sources, modifications to existing systems, communications, and other implementation functions.
- Received CMS approval for an Advance Planning Document related to "Work Requirements (formally known as Community Engagement)".
- Analyzed H.R. 1 for applicability to Rhode Island Medicaid members, systems, and operations. Such analysis continues and remains ongoing as more information from CMS is released.
- Engaged vendors to implement new systems or existing system modifications and integrations. This work with vendors remains ongoing.
- Pursued communications support from an external agency to support outreach campaigns to Rhode Island Medicaid members.
- Engaged with community and provider groups to inform change management procedures related to the community engagement requirements.
- Drafted operational procedures for training purposes. Such drafting remains ongoing.
- Conducted bi-weekly Steering Committee meetings to monitor agency progress and compliance. Such meetings are ongoing.

- Provided bi-monthly updates to CMS demonstrating community engagement compliance progress.

42. With respect to implementing the medically frail exclusion in particular, the Rhode Island Medicaid Program has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

43. The Rhode Island Medicaid Program faces several urgent deadlines with respect to implementing community engagement requirements. The Rhode Island Medicaid Program must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, Rhode Island must finalize eligibility system requirements by June 30 2026, in order to enable full system deployment, with appropriate testing, in August and September of 2026. After June 2026, the Rhode Island Medicaid Program will only have limited ability to make further system changes for use by January 1, 2027. Moreover, the Rhode Island Medicaid Program is required by H.R. 1 to issue notices in August 2026 addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, the Rhode Island Medicaid Program needs to send information by July 15, 2026.

44. Nevertheless, the Rhode Island Medicaid Program still lacks clarity on several crucial issues from the IFR. While the IFR says that the Rhode Island Medicaid Program will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how states should determine this. While CMS has said more sub regulatory guidance will be provided, the Rhode Island Medicaid Program must

develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only the Rhode Island Medicaid Program, but also the messages that the Rhode Island Medicaid Program can provide its members: if the Rhode Island Medicaid Program does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources the Rhode Island Medicaid Program is required to be integrated as of January 1, 2027, and which can be integrated later. The Rhode Island Medicaid Program requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

45. Of note, the consequences for the Rhode Island Medicaid Program from building its systems inconsistent with CMS's incomplete and as-yet unissued guidance are significantly heightened. If the Rhode Island Medicaid Program is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Rhode Island and other states to comply.

Impact of Community Engagement Requirements

46. The purpose of Medicaid coverage is to provide low-income individuals comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no cost. However, the community engagement requirements included in H.R. 1 could result in

disenrollment of members, potentially including members who are eligible but cannot verify their eligibility.

47. In the April 2026 Caseload Estimating Conference, Rhode Island estimated that 20,195 Rhode Island Medicaid Program members will be disenrolled at some point due to the community engagement requirements.

48. The Rhode Island Medicaid Program expects the "significant impairment" requirement to require additional member engagement and lower the ex parte renewal numbers resulting in the potential for more members losing coverage than would otherwise have lost coverage under the process of utilizing claims data for determining medically frailty during the renewal process. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. The "significant impairment" requirement will likely decrease the number of people the Rhode Island Medicaid Program can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase potential coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold. Rhode Island Medicaid Program may also see an increase in

member "churn" due to the added requirement to provide additional documentation to maintain coverage.

49. The IFR's limitations on self-attestation may increase member confusion and therefore lead to loss in coverage. The requirement to obtain third party documents creates a procedural hurdle for members that may impact their eligibility.

50. The Rhode Island Medicaid Program is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, the Rhode Island Medicaid Program is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

51. The Rhode Island Medicaid Program is developing a communications and community outreach plan in support of the HR 1 requirements. Incomplete or incorrect information concerning eligibility determination requirements risks increasing member confusion on eligibility requirements and could result in members needing medical care going without Medicaid coverage.

Administrative, Operational, and Financial Burdens on Rhode Island

Burdens on the Rhode Island Medicaid Program

52. Because CMS had never before imposed community engagement requirements across eligibility categories, the Rhode Island Medicaid Program's eligibility system was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community engagement.

53. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require the Rhode Island Medicaid Program to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, the Rhode Island Medicaid Program may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, the Rhode Island Medicaid Program expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, the Rhode Island Medicaid Program will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

54. The Rhode Island Medicaid Program also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, the Rhode Island Medicaid Program expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Rhode Island

55. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on the Rhode Island Medicaid Program, but on Rhode Island

more generally. As noted above, Rhode Island Medicaid Program members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of the Rhode Island Medicaid Program's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are MAGI Expansion enrolled. Rhode Island's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from the Rhode Island Medicaid Program will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on Rhode Island's public health infrastructure. Most importantly, the Rhode Island Medicaid Program expects poorer health outcomes across Rhode Island, as fewer people will be able to access appropriate care and manage chronic conditions.

56. In addition, the Rhode Island Medicaid Program expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from

their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Kristin Pono Sousa

Kristin Pono Sousa
Director, Rhode Island Medicaid Program

EXHIBIT 22

DECLARATION OF MAJORIE STINCHCOMBE

I, Majorie Stinchcombe, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Vermont. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as the Helpline Director at the Office of the Health Care Advocate, of information and records gathered by Vermont Office of the Health Care Advocate and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. I am the Helpline Director at the Vermont Office of the Health Care Advocate. The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters.

3. The Vermont Agency of Human Services, Department of Vermont Health Access administers Vermont Medicaid. Vermont Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Vermont Medicaid's coverage includes medical, dental, mental health and substance use treatment, and long-term services and supports. Vermont Medicaid's mission is to improve Vermonters' health and well-being by providing access to high-quality, cost-effective health care.

4. Vermont Medicaid insures approximately 174,000 people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Vermont administers its Medicaid program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Vermont Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 63% of Vermont Medicaid's expenditures on eligible enrollees.

6. On January 1, 2014, Vermont implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level.

7. As of March 2026, approximately 49,000 (28%) of Vermont Medicaid members are enrolled under Medicaid expansion. For the current state fiscal year 2026, ending on June 30, 2026, approximately $331 million, or 24%, of Vermont Medicaid's federal Medicaid funding comes from the FFP for the Medicaid expansion population.

8. I and my staff at the Office of Health Advocate have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

9. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Vermont Medicaid does not have in place systems by which to verify work, volunteer, or other community engagement activities.

10. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On information and belief, Vermont relied on CMS guidance to

determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

11. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be challenging for Vermont Medicaid to design and implement before January 1, 2027 as required by H.R. 1 § 71119(d), and are expected to cause significant harm to members and Vermont Medicaid once implemented.

12. The IFR added a new "significant impairment" requirement with respect to the medically frail exclusion (42 CFR § 435.554(c)(5)(i)), which does not exist in the text of H.R.1 Section 71119. This requirement was not mentioned in any CMS written or verbal guidance prior to publication of the IFR. The IFR provides very little concrete guidance about how to verify whether an individual meets this new "significant impairment" requirement, and the limited guidance provided is in direct conflict with prior guidance provided by CMS. On information and belief, this change will result in burdens to Vermont Medicaid, members, and providers.

13. Beginning in September 2025 and continuing until the release of the IFR, Vermont Medicaid based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, on information and belief, Vermont Medicaid has already done significant work, including but not limited rulemaking, updating draft notices to members, and projected fiscal and staffing needs to implement HR.1.

14. On information and belief, Vermont Medicaid faces several urgent deadlines with respect to implementing community engagement requirements. Vermont Medicaid must apply

community engagement requirements to applications and renewals as of January 1, 2027. Moreover, Vermont Medicaid is required by H.R. 1 to issue notices by September 1, 2026, addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, Vermont Medicaid needs to send information by mid- to late-August 2026. Vermont Medicaid is also developing an appendix to initial and renewal application forms

15. Vermont Medicaid's eligibility system was not built to support community engagement requirements. On information and belief, Vermont Medicaid has been diligently working toward reconfiguration of its system to incorporate the new eligibility factors necessary to evaluate community engagement. This is a complex change, and its system design was based upon statutory requirements in H.R.1 Section 71119 and the guidance CMS issued prior to June 1, 2026.

16. The "significant impairment" requirement the IFR added to medically frail determinations—plus the uncertainty of how to implement it—will require Vermont Medicaid to rapidly change its operational approach and systems development. Vermont Medicaid will need to analyze, develop and implement new ways to evaluate medical frailty, add more data elements to the enrollment process, and create more complicated code lists, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, Vermont Medicaid expects more calls, more documents to process, and more appeals of adverse actions. Vermont Medicaid will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

17. On information and belief, Vermont Medicaid also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will complicate training staff, assisters, and community organizations on eligibility processes.

18. The new administrative processes required by the IFR and not contemplated in H.R.1 Section 71119 or in previous CMS guidance will not fall just on Vermont Medicaid, but on Vermont more generally.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 29th day of June, 2026.

Marjorie Stinchcombe

Helpline Director, Office of the Health Care Advocate

EXHIBIT 23

DECLARATION OF STEVEN FORD

I, Steven Ford, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Virginia. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by Department of Medical Assistance Services ("DMAS") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Director for the Virginia State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Virginia as Cardinal Care).

3. DMAS is the single state agency responsible for administering Medicaid in Virginia. Virginia Medicaid provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Medicaid coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Medicaid's mission is improving the health and well-being of Virginians through access to high-quality health care coverage.

4. Virginia Medicaid insures approximately 1.8 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Virginia administers Medicaid pursuant to federal and state law and regulations as well as the terms of its federally approved State Plan and approved Waivers. Virginia receives

federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers about 50% of expenditures for most Medicaid members and 90% of expenditures for people with Medicaid expansion coverage.

Medicaid Expansion in Virginia

6. On January 1, 2019, Virginia implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Medicaid expansion program.

7. Enrollees in the Medicaid expansion program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the Medicaid expansion program requires that an individual (1) be an adult 21-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of June 15, 2026, approximately 540,000 individuals (about 30% of total enrollment) are enrolled in Virginia's Medicaid expansion program. For the current state fiscal year 2026, approximately $5.6 billion of Virginia's federal Medicaid funding comes from the FFP for Medicaid expansion program members.

CMS's Pre-IFR Guidance to Virginia

9. I and my staff at DMAS have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "work requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other work requirements to establish Medicaid eligibility. Consequently, Virginia does not have in place systems by which to verify work, volunteer, or other community engagement activities for Medicaid applicants and enrollees.

11. Since November 2025, CMS has been providing guidance on expected work requirements policy. On November 19, 2025, CMS presented a slide deck on work requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing work requirements. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Virginia relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. Virginia likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025

CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with work requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the work requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with work requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

19. In response to this and concerns that CMS would change its policy direction related to work requirements, DMAS sent a letter to CMS on May 28, 2026, conveying DMAS's concerns with limiting the definition of medically frail and the use of self-attestation. This letter is attached as Exhibit A.

CMS Issues the Interim Final Rule

20. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to work requirements. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions will be very challenging and costly for DMAS to implement before January 1, 2027, and are expected to cause significant harm to Medicaid members and health care providers once implemented. These provisions include the following:

Medically Frail Definition

21. With respect to the medically frail exclusion, H.R. 1 excludes individuals from work requirements if they are medically frail, defined as having certain health needs across five categories in the statute. *See* Social Security Act § 1902(xx)(9)(A)(ii)(V) [42 U.S.C. 1396a(xx)(A)(ii)(V)]. The IFR added a new requirement that, in addition to falling into one of these five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the work requirements." 42 CFR § 435.554(c)(5)(i). Thus, per the IFR, having cancer or HIV/AIDS may or may not be enough to be deemed exempt from H.R. 1's work requirements; states will need to determine whether the individual also is impaired in

their ability to work or comply with the work requirements, using a process that remains unclear. 91 Fed. Reg. 33,373 (June 3, 2026).

22. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(V) [42 U.S.C. 1396a(xx)(A)(ii)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026 following the IFR, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with work requirements in order to be considered medically frail. CMS cited no statutory basis for this new, more restrictive requirement.

23. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

24. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* generally rely solely on claims data indicating someone's medical diagnosis or condition, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using

administrative claims data that assign acuity scores to individuals," *id.*, but does not explain how to build these algorithms or how states should connect the acuity of someone's condition to their ability to work.

25. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, as of the date this declaration was executed, this guidance has not yet been provided.

Self-Attestation

26. Self-attestation is a longstanding tool used in Medicaid under federal regulations for individuals to verify certain eligibility criteria. Additionally, H.R. 1 expressly allows individuals to self-attest to their exemption from work requirements in certain circumstances. *See* Section 1902(xx)(3)(A) of the Social Security Act. However, the IFR significantly limits members' ability to self-attest to work requirement eligibility factors after January 1, 2028.

27. Within this framework, the IFR applies different and complex restrictions to medical frailty specifically. Under the IFR, beginning in 2028, individuals who are medically frail may only self-attest to their medically frail status once during a single period of enrollment. 42 C.F.R. § 435.557(f)(ii). Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. Beginning in January 2027, a renewal cycle lasts at most 6 months for individuals with Medicaid expansion coverage—and thus, individuals subject to work requirements—as a result of another provision in H.R. 1 (section 71107 of H.R. 1). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains continuously enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the work requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation of medical frailty. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity. It also increases the risk of confusion on the part of the members and creates unnecessary barriers to coverage.

30. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare and increase costs and complexity to the state in implementing the rule.

Short-term Hardship Exceptions

31. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

32. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

33. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

34. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. Despite this, the IFR specifically requires states to only use data from the 12 preceding months in order to determine whether an individual is medically frail. 42 C.F.R. § 435.557. This means DMAS may not yet have the relevant claims data to identify whether someone qualifies for this exemption from work requirements. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

DMAS's Efforts to Implement the Work Requirements Before and After the IFR Issued

35. Following the enactment of H.R. 1, DMAS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026 deadline in H.R. 1 for notifying Medicaid members about these changes and the January 1, 2027 implementation deadline, given the magnitude of changes needed for the work requirements and the short period of time afforded by H.R. 1

36. Beginning in November 2025 and continuing until the release of the IFR, DMAS based its policy and system determinations on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, in coordination with the Virginia Department of Social Services (which administers Virginia's eligibility system for Medicaid), DMAS has devoted significant time and resources toward the following:

- Establishing core definitions for the activities individuals can show to demonstrate compliance with work requirements, as well as the exemptions individuals may meet to otherwise satisfy these requirements;
- Engaging with a vendor to design and implement necessary changes to Virginia's eligibility system, including the design of a new portal for individuals to upload information related to work requirements;
- Identifying and leveraging new data sources within and outside the state to automatically determine individuals' compliance with, or exemption from, work requirements;
- Evaluating current state processes for verifying eligibility to determine how to consistently and efficiently integrate work requirements in this framework, including how individuals generally verify their eligibility information, when self-attestation is permitted, and how existing state eligibility systems store this information;
- Establishing a data verification hierarchy to determine how the state eligibility system should integrate and coordinate multiple data sources to most effectively and accurately verify eligibility;

- Revising the Medicaid application and renewal form to incorporate work requirements;
- Designing and initiating a public engagement, education, and outreach strategy by drafting member notices and FAQs, coordinating with managed care plans to prepare for member outreach, and engaging with providers, community-based organizations, and other stakeholders;
- Completing contract negotiations across several areas based on information prior to the IFR, including contracts to expand call center capacity, implement a unit to handle data entry and verification processing, and conduct outreach via texting;
- Evaluating internal workforce needs to implement work requirements and requested and received funding from the General Assembly based on our understanding prior to the IFR;
- Executing amendments to existing contracts with the state's managed care plans;
- Designing comprehensive IT-system updates and changes necessary to stand up these requirements; and
- Developing a comprehensive framework for identifying and verifying medical frailty, as described further below.

37. With respect to implementing the medically frail exclusion in particular, DMAS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data"). To this end, to implement an approach for medical

frailty based on H.R. 1's statutory text and CMS guidance, DMAS has engaged in a comprehensive review and validation of thousands of diagnostic and clinical condition codes, procedure codes, and prescription drug codes to establish a clinically-driven and robust framework for verifying this exclusion. DMAS has collaborated with other states to learn from their approaches and validate its findings. In addition, based on CMS guidance, DMAS has designed processes to verify medical frailty for individuals for whom data is unavailable by designing a screening tool for medical frailty that could be incorporated in the Medicaid application and renewal form.

38. DMAS faces several urgent deadlines with respect to implementing work requirements. H.R. 1 requires Virginia to apply work requirements to applications and renewals as of January 1, 2027. To do this, DMAS must substantially finalize eligibility system requirements by mid-July 2026 to enable appropriate testing and full deployment by late fall of 2026. This timing is necessary to launch these major eligibility changes by the statutory deadline of January 1, 2027. As a result, DMAS will be extremely limited in its ability to make any eligibility system changes after July 2026 and still meet the statutory deadline.

39. Moreover, H.R. 1 requires Virginia to issue notices no later than August 31, 2026, which will need to address the changes occasioned by the IFR. To issue those notices in a timely fashion, DMAS intends to finalize the information included in these notices by mid-July 2026 in order to enable appropriate translation and distribution. My current understanding is that the latest date by which DMAS would be able to pull the notice back from the vendor and make any needed changes before mailing the notice to members is August 7, 2026. After that date, DMAS could try to provide updated information on the agency's website and engage in additional messaging campaigns, but the agency would not be able to pull back the notice being mailed to members.

40. Given this landscape, it will be extremely challenging to implement work requirements by January 1, 2027 in light of the complex and significant changes in the IFR.

41. Adding to these challenges, DMAS still lacks clarity on several crucial issues from the IFR. While the IFR says that DMAS will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only limited guidance about how DMAS should determine this. While CMS has said more subregulatory guidance will be provided, DMAS must develop its eligibility systems and processes without knowing what this future guidance is, which could risk further systems changes, delays, and costs if CMS's *future* guidance conflicts with this system development. This lack of clarity also impacts the messages that DMAS can provide its members: if DMAS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, H.R. 1 requires states to use data where possible to verify exemptions, including medical frailty, and the IFR expressly contemplates that states will use data for this purpose. However, the IFR does not clarify how states can effectively use data to make determinations of medical frailty when medical claims data do not generally convey information about individuals' ability to work. DMAS requires clarity on these fundamental issues in order to implement work requirements in a timely fashion and to ensure that its members are prepared for these major changes to Medicaid eligibility.

42. Of note, the consequences for DMAS from building its systems inconsistent with CMS's incomplete and as-yet unissued guidance are significantly heightened. If DMAS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties, which CMS acknowledges in the IFR. 91 Fed. Reg. 33, 377 (June 3, 2026). In other words, at the same

time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on work requirements is making it harder for Virginia and other states to comply.

Human Costs of Work Requirements, Made Worse By the IFR

43. The purpose of the Affordable Care Act (ACA) and the expansion of Medicaid was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare. However, the work requirements included in H.R. 1 are expected to create major barriers to coverage and result in members losing coverage, including members who are eligible but cannot verify their eligibility due to administrative challenges.

44. As noted above, about 540,000 individuals with Medicaid expansion coverage in Virginia will be subject to new work requirements, in addition to new applicants for Medicaid. DMAS studies conducted before the IFR suggest that more than 200,000 individuals—about 37 percent of the Medicaid expansion population in Virginia—could be exempt based on medical frailty, allowing these individuals to maintain continuous coverage and, thus access to needed medical care. DMAS expects CMS's "significant impairment" requirement in the IFR to result in more Medicaid members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. Medicaid members may think they do not qualify as "medically frail," given the added complexity and ambiguity, and DMAS may see an increase in non-responses from members and decreased rates of application.

The "significant impairment" requirement will also likely decrease the number of people DMAS can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. As noted above, CMS has not clarified how states can use medical claims data to make decisions about whether someone can or cannot work or satisfy the work requirements. This will further increase coverage loss because individuals will need to take steps to affirmatively show they are medically frail, either through self-attestation (when allowed) or through documentation, potentially even requiring the involvement of medical providers. These steps create administrative complexities that become barriers to coverage, leading eligible people to lose Medicaid and access to critical health services. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold. Ultimately, the IFR means continued access to Medicaid for roughly 200,000 Virginians with significant health needs is now in question, as many of these individuals will no longer be exempt and many others will now need to navigate additional requirements that could lead them to inadvertently lose the coverage they need.

45. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to Medicaid sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for DMAS and decreases quality of care for members.

46. DMAS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In DMAS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, DMAS expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility.

47. DMAS also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members for whom medical data will not be available—for example, people who develop multiple conditions at different points in time or face challenges accessing medical services. For example, a member could be hospitalized and self-attest to medical frailty on that basis while getting treatment, and then later (while still enrolled in Medicaid) experience a stroke. As noted above, providers have up to 12 months to submit claims for reimbursement. Months-long lags exist between the time services are delivered and related data appears in DMAS databases. Because of this, individuals who are recently diagnosed with new conditions may not have their health needs reflected in data available to the state. In these cases, self-attestation is an important tool for these individuals to verify their medical frailty, particularly for individuals who face challenges accessing medical providers from whom they can obtain other documentation—such as individuals living in rural regions or who are experiencing homelessness. Arbitrarily restricting medically frail individuals to one use of self-attestation during a period of enrollment undercuts this important verification tool, which has long been used by the Medicaid program in other contexts consistent with federal requirements.

48. DMAS is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. See Social Security Act § 1902(xx)(8)(A)

[42 U.S.C. 1396a(xx)(8)] (directing States to begin outreach no later than four or more months before December 31, 2026). At present, DMAS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

49. DMAS has spent years conducting outreach and building relationships with Medicaid enrollees. Confusion and lack of clarity over eligibility determinations risk harming that relationship, lowering institutional trust, and creating more barriers to re-enrollment for eligible individuals.

Administrative, Operational, and Financial Burdens on Virginia

Burdens on DMAS

50. Because CMS had never before imposed work requirements across eligibility categories, Virginia's eligibility system for Medicaid was not built to support work requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate the work requirements. About $141.7 million dollars have been allocated for implementation of the work requirements to date. Additional funding and personnel will be requested and needed due to significant changes in the IFR.

51. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DMAS to fundamentally change its operational approach and systems development—a process that will take substantial time and resources, putting our ability to meet the January 1, 2027 deadline at risk. In addition to requiring changes to our approach to data and systems, the IFR's requirements for medical frailty mean more individuals will need to submit documentation to verify their exemption. This means more resources will be needed to develop this process, establish which

documents are allowable, actually review and verify documentation submitted, and train state workers as well as, potentially, health providers to evaluate whether someone is impaired in complying with the work requirements. As more individuals are denied coverage, DMAS expects more calls, more documents to process, and more appeals of adverse actions, all of which further generate costs and resource demands. These changes to medical frailty in the IFR further require DMAS to revise our education and outreach efforts to members, staff, and other stakeholders about what the requirement means and how it can be met.

52. DMAS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. DMAS expects the IFR's requirements on self-attestation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals, all of which will require additional resources from the state. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Virginia

53. The burdens from work requirements imposed by H.R. 1 and made worse by the IFR fall not just on DMAS, but on Virginia broadly. As noted above, more Medicaid members will lose coverage—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of DMAS's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in Medicaid expansion. As the uninsured rate increases, there will be a greater financial strain on providers—in particular, rural, community, and safety net hospitals as well as

community health centers—that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals disenrolled from Medicaid will likely lose access to primary and preventive care as well as care necessary to treat their statutorily recognized medical conditions—resulting in more individuals seeking high-cost, emergency care and poorer health outcomes. This will undermine public health and increase health care costs across the Commonwealth as fewer people are able to access appropriate care and manage serious health conditions.

54. In addition, DMAS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations on medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to assessing and providing documentation demonstrating whether a member is medically frail and significantly impaired in their ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Steven Ford
Director, Department of Medical Assistance Services

EXHIBIT A

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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DIRECTOR

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May 28,2026

Dear Director Brillman,

First, let me express my thanks to the CMS team for the hard work they have engaged in thus far with us and other states to implement H.R. 1, including Medicaid work and community engagement requirements. As you well know, these are major changes to Medicaid, and we have significantly relied on the guidance you have provided over the past many months to stand up core aspects of our program.

I have become aware that major changes to CMS's prior guidance may be under consideration for the forthcoming final rule. These include, potentially, restricting medical frailty to individuals who cannot work and potentially eliminating the use of self-attestation when data are unavailable. If finalized, these policies would be significant departures from CMS's prior guidance. I am writing to express our strong legal, policy, and operational concerns with these changes, and to encourage CMS to not pursue these policies in its final rule.

First, these policies seem to conflict with H.R. 1's text. The law exempts people who are medically frail, including people who are disabled, have a substance use disorder, disabling mental health condition, or serious or complex condition. The law does not mention capacity to work in this definition. Similarly, with respect to attestation, H.R. 1 explicitly allows states "to not require an individual to verify information resulting in" an exception or specified exclusion. Restricting the use of self-attestation for exemptions would seem to contradict this explicit flexibility.

Second, Virginia is concerned that these policy changes would increase the risk of unintended coverage loss among eligible individuals, particularly people with serious health conditions and disabilities. Virginia has been developing clinically informed, data-driven approaches to medical frailty that rely on diagnosis, procedure, prescription drug, and claims data to identify medically frail individuals in an automated and administratively efficient manner. Tying medical frailty to work capacity could potentially require document-based verification and individualized assessments, creating

substantial new administrative barriers for eligible individuals, including new paperwork requirements, provider certifications, and delays in processing eligibility and exemptions. These burdens are likely to result in eligible individuals losing or failing to maintain coverage despite having significant medical needs or disabilities, undermining the core purpose of the exemption. With respect to eliminating self-attestation, scaling back this flexibility would similarly require significantly increased paperwork and complexity that could drive further coverage loss due to procedural issues.

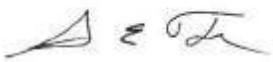
Finally, Virginia is deeply concerned about the operational and implementation impacts of these late-stage policy changes. In reliance on CMS's prior guidance – including written guidance shared in December on states' minimum viable product for 2027 in which CMS explicitly allowed states to accept self-attestation for compliance and exemptions for 2027, regular ongoing conversations with CMS staff, and repeated engagement with your systems teams on updates to Virginia's eligibility systems – Virginia has already spent significant time and resources implementing core aspects of work requirements. We have developed a new work requirement portal; developed a comprehensive, data-driven approach to medical frailty; initiated extensive modifications to the VaCMS and MES systems; begun contract modifications and implementation work for call centers, work support vendors, data exchanges with managed care organizations, and verification sources; and commenced hiring and training activities for new and existing classified staff. Reversing course now to implement fundamentally different verification and exemption processes would require major system redesigns, operational restructuring, additional procurement activity, new staffing models, and significant additional funding and time.

The Commonwealth is concerned these potential changes cannot reasonably be implemented by January 2027 without substantial operational risk, systems errors, implementation delays, or noncompliance with federal requirements. This could mean we will need to pursue a good faith waiver requesting additional time for implementation.

Virginia respectfully urges CMS to reconsider these potential policy changes and maintain the flexibility previously provided to states regarding medical frailty determinations and self-attestation processes.

Again, I appreciate CMS's ongoing engagement and support regarding implementation of Medicaid work and community engagement requirements under H.R. 1. and look forward to our continued partnership.

Sincerely,



Steve Ford
Director

Cc: Deputy Director Costello

EXHIBIT 24

DECLARATION OF JUDY ZERZAN-THUL

I, Judy Zerzan-Thul, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Washington. I am over the age of 18 and have personal knowledge, or knowledge based on review of information and records gathered by the Washington State Health Care Authority and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Chief Medical Officer for the Washington State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Washington as Apple Health).

3. The Health Care Authority is the single state agency responsible for administering Apple Health. Apple Health provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Apple Health's coverage includes medical, dental, mental health and substance use disorder treatment, long-term services and supports, and long-term care. The mission of HCA is "powered by the people we serve, we improve health across Washington by advancing equitable access to quality, whole-person care."

4. Apple Health insures approximately 1.9 million people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Washington administers the Apple Health program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115

Demonstration Project. Apple Health receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 67 percent of Apple Health's expenditures on eligible enrollees.

Medicaid Expansion in Washington

6. On January 1, 2014, Washington implemented Medicaid expansion under the Affordable Care Act (the "ACA"). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 138% of the Federal Poverty Level primarily through Apple Health.

7. Enrollees in Apple Health as part of the ACA expansion population receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for Apple Health under the ACA expansion requires that an individual (1) be an adult 19 to 64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 138% of the Federal Poverty Level.

8. The monthly average caseload of the ACA expansion population is approximately 602,000 in state fiscal year 2026, with approximately $4.7 billion of Washington State Apple Health program's federal Medicaid funding coming from the federal government for these clients.

CMS's Pre-IFR Guidance to Washington

9. I and my staff at the Washington State Health Care Authority have been closely following enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December, 2025, through April, 2026, and switched to a weekly cadence starting in May, 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Washington relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. November 19, 2025, CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov.

19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June, 2026, did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* November 19, 2025, CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon and was subject to change.

CMS Issues the Interim Final Rule

19. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are more restrictive than statutory language. These provisions also will be very challenging and costly for the Health Care Authority to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and Apple Health once implemented. These provisions include the following:

Medically Frail Definition

20. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

21. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in

order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

22. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

23. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use or what would be an acceptable analysis of such data.

24. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

25. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, the IFR significantly limits the occasions when an individual may rely on self-

attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members.

26. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

27. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

28. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

29. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g., Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)).

However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

30. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

31. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

32. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to

which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* November 19, 2025, CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

33. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

34. If a state cannot verify whether a member is still eligible for Medicaid through its own data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot verify compliance with community engagement requirements without the member's input, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This

disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

35. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

36. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

37. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33,473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

38. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely forgoing necessary care in the meantime or further straining our emergency health care system.

Other

39. Several of the timelines set out in the IFR do not take account of the fact that providers have 12 months to submit claims data. For determinations that are supposed to be made regarding the preceding year, the Health Care Authority may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

The Health Care Authority's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

40. Following the enactment of H.R. 1, the Health Care Authority recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026, notice deadline and January 1, 2027, implementation dates, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, the Health Care Authority began work to prepare to comply with community engagement requirements.

41. Beginning in November 2025 and continuing until the release of the IFR, the Health Care Authority based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, the Health Care Authority has already done the following:

- Statutory analysis and policy updates
- Developed system specifications and built system infrastructure including meetings with the CMS data and systems group twice monthly to review the state's minimum viable product check list
- Budget allocation and expenditures on systems, vendors and workforce

- Drafted new member notices and application questions
- Developed a medical code list to define medical frailty
- Initiated public outreach including webinars and publications and have put out the medical code list for public comment

42. With respect to implementing the medically frail exclusion in particular, the Health Care Authority has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." November 19, 2025, CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

43. The Health Care Authority faces several urgent deadlines with respect to implementing community engagement requirements. The Health Care Authority must apply community engagement requirements to applications and renewals as of January 1, 2027, and to do this, the Health Care Authority must substantially finalize eligibility system requirements by September 10, 2026, in order to enable full system deployment, with appropriate testing, in December. After September 10, 2026, the Health Care Authority will only have limited ability to make further system changes for use by January 1, 2027. Moreover, the Health Care Authority is required by H.R. 1 to issue notices no later than the date four months preceding December 31, 2026, addressing the changes occasioned by the IFR. In order to issue those notices in a timely fashion, the Health Care Authority needs to send information by July 30, 2026.

44. Nevertheless, the Health Care Authority still lacks clarity on several crucial issues from the IFR. While the IFR says that the Health Care Authority will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only

the most limited guidance about how the Health Care Authority should determine this. While CMS has said more subregulatory guidance will be provided, the Health Care Authority must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only Apple Health, but also the messages that the Health Care Authority can provide its members: if the Health Care Authority does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement.

45. Of note, the consequences for the Health Care Authority from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If the Health Care Authority is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Washington and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

46. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

47. Washington estimates conducted before the IFR was released suggest that (1) at least thirty-two percent of Apple Health's expansion population members will be disenrolled at some point due to the combination of community engagement requirements and six-month redeterminations (a provision of H.R. 1 that requires Apple Health expansion population members' eligibility to be reevaluated every six months), and (2) Washington uninsured rates will increase. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, these studies likely underestimate the impact to members.

48. Indeed, the Health Care Authority expects the "significant impairment" requirement to result in more members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. Apple Health members may think they do not qualify as "medically frail," given the added complexity, and the Health Care Authority may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of people the Health Care Authority can automatically verify as medically frail, because, under the IFR, the verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which may not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from

day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

49. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to Apple Health sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for the Health Care Authority and decreases quality of care for members.

50. The Health Care Authority also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later (while still enrolled in Apple Health) develop congestive heart failure. Under the IFR, assuming continuous Medicaid coverage during that period, the member could not self-attest to medical frailty based on the congestive heart failure and thus could lose coverage if they could not obtain documentation for this diagnosis.

51. The Health Care Authority is statutorily required to provide notice to members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. § 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, the Health Care Authority is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will

not have the clarity required to communicate to members how they can comply with the new requirements.

52. The Health Care Authority has spent years conducting outreach and building relationships with Apple Health enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, the Health Care Authority expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, the Health Care Authority will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

53. The Health Care Authority also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, the Health Care Authority expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Administrative, Operational, and Financial Burdens on Washington

Burdens on the Health Care Authority

54. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require the Health

Care Authority to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, the Health Care Authority may need to integrate new data sources to evaluate members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data.

Burdens on Washington

55. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on the Health Care Authority, but on Washington more generally. As noted above, Apple Health members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of Apple Health's most medically needy members. The IFR will have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled as part of the expansion population. Washington's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from Apple Health will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will result in increased communicable disease outbreaks and more strain on the Health Care Authority. Most importantly, the Health Care Authority expects poorer health outcomes across Washington, as fewer people will be able to access appropriate care and manage chronic conditions.

56. In addition, the Health Care Authority expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of June 2026.

Judy Zerzan-Thul, MD, MPH
Chief Medical Officer

EXHIBIT 25

DECLARATION OF DEBRA STANDRIDGE

I, Debra Standridge, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Wisconsin. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as the Deputy Secretary of the Wisconsin Department of Health Services (WI DHS) of information and records gathered by WI DHS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the Deputy Secretary of WI DHS. Wisconsin DHS is the single state agency responsible for administering Wisconsin's Medicaid program, and the Division of Medicaid Services within WI DHS is responsible for the administration of the state's Medicaid program and Children's Health Insurance Program (CHIP).

3. Wisconsin DHS operates Wisconsin's Medicaid program and CHIP, which insure approximately 1.25 million people. Wisconsin's Medicaid program and CHIP provide comprehensive health coverage at low or no cost to children and adults of all ages. Our members include some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

4. Wisconsin's full-benefit Medicaid programs include medical, dental, mental health and substance use treatment, and long-term services and supports.

5. BadgerCare Plus is Wisconsin's largest Medicaid program and covers roughly 800,000 members, including children, parents, pregnant people, former foster care youth, and

adults aged 19 to 64 without dependent children. Adults aged 19 to 64 without dependent children are known as our "childless adult" group.

6. Wisconsin administers its Medicaid program pursuant to federal and state law and regulations as well as by the terms of its federally approved State Plan Amendments and other federally approved Waivers and Section 1115 Demonstration Projects. Wisconsin Medicaid receives federal Medicaid and CHIP funding, known as "Federal Financial Participation" (FFP), which covers an average of 60% of expenditures on eligible enrollees.

Wisconsin Medicaid Coverage of Childless Adults

7. In 2013, the Centers for Medicare and Medicaid Services (CMS) approved Wisconsin's section 1115 demonstration, which permits Wisconsin to provide Medicaid coverage under the BadgerCare Plus program to the childless adult group. Wisconsin's section 1115 demonstration extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 100% of the Federal Poverty Level. In 2024, CMS approved a five-year extension of Wisconsin's section 1115 demonstration, effective from January 1, 2025, to December 31, 2029.

8. Childless adults enrolled in BadgerCare Plus receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for BadgerCare Plus for childless adults requires, in part, that an individual (1) be an adult 19-64 years old; (2) be a citizen or qualified immigrant; (3) not be enrolled in Medicare; and (4) have countable income that does not exceed 100% of the Federal Poverty Level.

9. As of May 2026, approximately 193,000 childless adults are enrolled in BadgerCare Plus.

CMS's Pre-IFR Guidance to Wisconsin

10. I and my staff at WI DHS have been closely following enactment and implementation of H.R. 1, including Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

11. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, WI DHS does not have in place operational systems by which to verify work, volunteer, or other community engagement activities for childless adults enrolled in BadgerCare Plus.

12. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026. As of the date of this declaration, this series of workgroup calls is still ongoing.

13. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Wisconsin relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws,

implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

14. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to "use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

15. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

16. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

17. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty"* in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty

at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

18. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

19. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026, call should not be acted upon and was subject to change.

20. In addition, CMS published two informational bulletins, dated November 18, 2025, and December 8, 2025, which define "specified excluded individual[s]" as including those who are medically frail. In defining medical frailty in these information bulletins, CMS does not reference or require a state assessment of an individual's inability to comply with community engagement because of medical frailty.

CMS Issues the Interim Final Rule

21. On June 1, 2026, CMS promulgated the Interim Final Rule ("IFR") relating to the community engagement requirement. The IFR includes several surprising provisions that are vague, differ substantially from CMS's prior guidance, and are more restrictive than statutory language. These provisions also will be very challenging and costly for WI DHS to design by August 31, 2026, and implement before January 1, 2027, and are expected to cause significant harm to members and Wisconsin Medicaid once implemented. These provisions include the following:

Medically Frail Definition

22. With respect to the medically frail exclusion, the IFR added a new requirement that, in addition to falling into one of the five categories enumerated in H.R. 1, a "medically frail" individual must *also* be "an individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirements." 42 CFR § 435.554(c)(5)(i).

23. This "significant impairment" requirement does not exist in the text of H.R. 1 Section 71119. *See* Social Security Act § 1902(xx)(9)(A)(ii)(II)(V) [42 U.S.C. 1396a(xx)(A)(ii)(II)(V)]. In a webinar and slide deck presented to state Medicaid agencies on June 9, 2026, CMS acknowledged that, in addition to the statutory requirement that an individual meet the definition of medically frail supplied by Congress in section 71119, as codified at, 42 U.S.C. § 1396a(xx) (section 1902(xx) of the Social Security Act), the IFR also requires that the individual be significantly impaired in their ability to comply with community engagement requirements in order to be considered medically frail. CMS cited no statutory basis for this second, new requirement.

24. Additionally, the "significant impairment" requirement was not mentioned in any CMS written or verbal guidance before the IFR was published, up to and including the CMS guidance about medical frailty provided to states as recently as May 1, 2026.

25. The IFR provided very little concrete guidance for states about how to verify whether an individual meets this new "significant impairment" requirement. However, the IFR does indicate that, in general, states *cannot* rely solely on diagnosis or condition codes, because doing so "would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373 (June 3, 2026). This is in direct conflict with prior

guidance provided by CMS that states may use claims-based data to verify whether an individual meets the medical frailty exemption in general. Instead, the IFR says that states should verify medical frailty using information from "multiple domains," to determine a member's "condition[s], utilization of services … and their level of impairment." 91 Fed. Reg. 33,406 (June 3, 2026). It also suggests that states could use "algorithms using administrative claims data that assign acuity scores to individuals," *id.*, but does not explain what administrative data a state can use, a state's ability to access potentially relevant data, does not address delay in potential administrative data, or what would be an acceptable analysis of such data.

26. Since the IFR's release, CMS has told states that it is developing significantly more guidance on the medically frail exclusion. However, this guidance has not yet been provided.

Self-Attestation

27. Unlike the guidance provided by CMS through fall 2025 and spring 2026, which indicated that an "auditable self-declaration" could generally be used when reliable data was unavailable, *see supra* ¶¶ 15-16, the IFR significantly limits the occasions when an individual may rely on self-attestation to demonstrate compliance with community engagement. It does so using a complex and limiting framework (that changes again after the first year of implementation) that will be harmful for members and difficult to implement.

28. Thus, the IFR significantly limits members' ability to self-attest to community engagement eligibility factors after January 1, 2028. Of note, several community engagement eligibility factors are ones where documentation is unlikely to be available, such as whether a parent provides "some level of care" to their child (42 CFR § 435.554(a) (definition of "parent")); or the precise number of hours that a family caregiver provides assistance to a child or disabled individual (42 CFR § 435.554(c)(3)(i)(C)).

29. Under Section 1902 of the Social Security Act and 42 CFR § 435.916, state Medicaid agencies are required to periodically (at least annually) conduct a complete redetermination of an individual's Medicaid eligibility, commonly called a "renewal" or "renewal cycle." The Social Security Act does not recognize a "period of enrollment." That concept is introduced for the first time in the IFR and used in a way that hinders states' operational efficiencies, puts medically at-risk members in danger of losing Medicaid coverage, and treats patients differently based on when in this period their medical impairment may arise.

30. A renewal cycle lasts at most 12 months (or when section 71107 of H.R. 1 takes effect, 6 months for certain individuals). In contrast, under the IFR's newly introduced construct, a period of enrollment can last several renewal cycles as long as the individual remains enrolled in Medicaid.

31. Under 42 CFR § 435.916, a renewal of Medicaid eligibility is a *de novo* review of all eligibility factors, except where prohibited to protect member eligibility (e.g. Medicaid agencies cannot require an individual to reverify citizenship under 42 CFR § 435.956(a)(4)(ii)). However, the IFR creates different sets of rules that the state must apply in conducting eligibility determinations related to the community engagement requirements based on whether an individual is within a period of enrollment and whether, during that period, the individual has previously submitted a self-attestation. This distinction on when self-attestation can be used exacerbates the operational complexity the state faces in implementing the requirements with fidelity and increases the risk of confusion on the part of the members.

32. Prior to the IFR and the introduction of the new concept of a "period of enrollment," the use of self-attestation or a failure to verify an eligibility factor in a previous renewal cycle would not adversely impact an individual in their current renewal.

33. Furthermore, there is no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exemption from the community engagement requirements. Therefore, an individual who is prohibited from self-attesting to medical frailty for a second time in the same enrollment period and is subsequently terminated because the individual cannot verify medical frailty, can reapply once fully disenrolled and use self-attestation again at the start of a new period of enrollment. As such, the IFR will likely increase disruptions to an individual's continuity of healthcare, increase costs and complexity to the state in implementing the rule, and, at the same time, fails as a meaningful work incentive or program integrity measure.

Data Feed Integration

34. The IFR places very broad requirements on states to identify reliable data sources for verifying community engagement eligibility factors. The IFR requires Medicaid agencies to use "reliable information available to the State" to verify eligibility, which it defines as "information necessary for determining [community engagement requirements] eligibility to which the agency has access *or should have access*." 42 CFR § 435.557(b) (emphasis added). The IFR thus appears to require states to seek out and, where feasible, incorporate data sources for every factor of community engagement, even though such factors are numerous, have non-centralized data, and often relate to areas that Medicaid agencies have never assessed before, such as school attendance, community volunteer work, and job program enrollment. While CMS has previously indicated there would be a phased approach to adding data sources, *see* 11/19/2025 CMS slide deck pg. 28, the new regulation does not expressly permit this.

Renewal Process

35. The IFR lays out procedures for states to evaluate member compliance with community engagement requirements at renewal. However, these procedures will, in effect, deny members the full window of time they are granted in H.R. 1 to demonstrate they comply with work requirements.

36. If a state cannot verify whether a member is still eligible for Medicaid through its *ex parte* data sources, the state sends the member a pre-populated renewal form to complete. *See* 42 CFR § 435.916(a)(3). According to the IFR, most states begin their renewal process and, if necessary, send this pre-populated form about 60 to 90 days before a member's renewal is due. 91 Fed. Reg. 33,390 (June 3, 2026). According to the IFR, if a state cannot *ex parte* verify compliance with community engagement requirements, the state may either send "a notice of noncompliance" with this renewal form, or as a follow-up after the member returns the renewal form if the state still cannot verify community engagement. 91 Fed. Reg. 33,411–12. The "notice of noncompliance," which is mandated by H.R. 1, provides members with only 30 days to respond, after which the member must be disenrolled if compliance with community engagement still cannot be verified. Social Security Act Section 1902(xx)(6) [42 U.S.C. 1396a(xx)(6)]. This disenrollment must happen no later than the month following the month in which the 30-day period expires. *Id.* The IFR says that this 30-day period cannot be extended and says that "states must complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period. 91 Fed. Reg. 33,412 (June 3, 2026).

37. The effect of this structure is that members will be evaluated for compliance with work requirements before—often *months* before—the time period in which they are entitled to

comply with work requirements is complete. This abbreviated time period will increase the likelihood of coverage loss for otherwise eligible members.

Short-term Hardship Exceptions

38. H.R. 1 allows States to apply exceptions for certain short-term hardship events. These short-term hardship events include receiving inpatient medical services, residing in a county where an emergency or disaster has been declared by the President or where there is high unemployment, or traveling outside one's community for necessary medical services. *See* SSA § 1902(xx)(3)(B).

39. The IFR provides that, the short-term hardship exception requires a new applicant to demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, *immediately preceding the month of application*." 91 Fed. Reg. 33473 (emphasis added). An applicant cannot demonstrate the exception for the same month in which they apply to Medicaid.

40. This requirement ensures that newly eligible individuals experiencing hardship events will have to wait at least until the start of the following month to receive necessary coverage, likely foregoing necessary care in the meantime or further straining our emergency health care system.

Other

41. Several of the timelines set out in the IFR do not take account of the fact that providers have 365 days to submit claims data. For determinations that are supposed to be made regarding the preceding year, WI DHS may not even have the relevant claims data. Once again, this provision will increase the risk of coverage loss for otherwise eligible individuals.

Wisconsin's Efforts to Implement the Community Engagement Requirements Before and After the IFR Issued

42. Following the enactment of H.R. 1, WI DHS recognized that it would be extraordinarily challenging to complete the necessary system and process changes required by the August 31, 2026, notice deadline and January 1, 2027, implementation date, given the magnitude of changes needed for the community engagement requirements and the short period of time afforded by H.R. 1. Therefore, immediately after H.R. 1 was passed in July 2025, WI DHS began work to prepare to comply with community engagement requirements.

43. Beginning July 2025 and continuing until the release of the IFR, WI DHS based its policy and system determination on the statutory language and the subregulatory guidance provided by CMS, as detailed above. Based on this guidance, WI DHS has already done the following:

- Completed detailed statutory analysis;
- Developed detailed systems requirements based on guidance and other information from CMS;
- Hired a dedicated project manager and established a project management structure;
- Assigned state staff and contractors to several related workgroups;
- Secured state funding and vendor resources for automation of new policy;
- Completed requirements and design of systems automation related to the new policy;
- Established a new data exchange to transmit claims information to our eligibility system;
- Completed extensive analysis of diagnosis and procedure codes and claims data to support the new data exchange;

- Drafted member notices, text messages and emails;
- Developed plans for training, call scripts and ongoing technical support for eligibility workers;
- Developed updates to online applications, renewals, and change reports;
- Updated information on our website;
- Communicated new policy requirements to community partners, including training and technical assistance;
- Developed new reports for evaluation and analysis.

44. With respect to implementing the medically frail exclusion in particular, WI DHS has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data, in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 "medical frailty status … available through claims data".

45. Wisconsin DHS faces several urgent deadlines with respect to implementing community engagement requirements. Wisconsin DHS must apply community engagement requirements to impacted BadgerCare Plus applications and renewals as of January 1, 2027, and to do this, WI DHS must substantially finalize eligibility system requirements by the beginning of August 2026, in order to enable full system deployment, with appropriate testing, in October 2026. After October, WI DHS will have limited ability to make further system changes for use by January 1, 2027. Moreover, WI DHS is required by H.R. 1 to issue notices no later than August 31, 2026, addressing the changes to BadgerCare Plus occasioned by the IFR. In order to issue those notices

in a timely fashion, WI DHS needs to identify potentially impacted members and send information in August to allow for mailing in stages given the large number of affected members.

46. Nevertheless, WI DHS still lacks clarity on several crucial issues from the IFR. While the IFR says that states will need to evaluate whether a member's medical condition significantly impairs their ability to work, CMS has provided only the most limited guidance about how states should determine this. While CMS has said more subregulatory guidance will be provided, WI DHS must develop its eligibility systems and processes without knowing what this future guidance is—bearing the risk that the *future* guidance will conflict with its system development. This lack of clarity impacts not only members enrolled in BadgerCare Plus, but also the messages that WI DHS can provide its members: if WI DHS does not understand what it means for a medical condition to "significantly impair" a member's ability to work, it cannot educate its members about how to demonstrate compliance with this requirement. Finally, the IFR does not clarify which data sources WI DHS is required to have integrated as of January 1, 2027, and which can be integrated later. Wisconsin DHS requires clarity on these issues in order to implement community engagement requirements in a timely fashion and to ensure that its members are prepared for this implementation.

47. Of note, the consequences for WI DHS from building its systems inconsistently with CMS's incomplete and as-yet unissued guidance are significantly heightened. If WI DHS is not able to configure its systems quickly enough, or if it configures its systems inconsistently with CMS's eventual guidance, it could face negative audit findings and significant financial penalties under H.R. 1 Section 71106. In other words, at the same time that financial consequences for not complying with guidance are rising, CMS's failure to issue clear and timely guidance on community engagement requirements is making it harder for Wisconsin and other states to comply.

Human Costs of Community Engagement Requirements, Made Worse By the IFR

48. The purpose of the Affordable Care Act (ACA) was to ensure that low-income individuals receive comprehensive healthcare coverage and have access to affordable, integrated, high-quality healthcare at no or low cost. Similarly, the purpose of Wisconsin's 1115 demonstration is, in part, to ensure that low-income childless adults have access to full, comprehensive health care benefits. However, the community engagement requirements included in H.R. 1 are expected to result in large-scale disenrollment of members, including members who are eligible but cannot verify their eligibility.

49. Before the IFR was released, Wisconsin DHS estimated that approximately 33% of childless adults covered by BadgerCare Plus may be disenrolled at some point due to community engagement requirements, likely increasing Wisconsin's uninsured rates. Because the IFR goes beyond H.R. 1, stripping away the protections provided in H.R. 1 to the medically frail and adding new limitations on self-attestation that do not appear in H.R. 1, this estimate likely underestimates the impact to members.

50. Indeed, WI DHS expects the "significant impairment" requirement to result in more BadgerCare Plus members losing coverage than would otherwise have lost coverage under the statutory definition of medically frail. This is either because their condition may not meet the IFR's additional, non-statutory "significant impairment" threshold, or because they cannot obtain the proof required to demonstrate their ability to work is significantly impaired. The "significant impairment" requirement will also likely increase member confusion. BadgerCare Plus members may think they do not qualify as "medically frail," given the added complexity, and WI DHS may see an increase in non-responses from members and decreased rates of application. The "significant impairment" requirement will also likely decrease the number of BadgerCare Plus

members who can automatically verify as medically frail, because, under the IFR, the *ex parte* verification process will generally require not just a diagnosis code, but also other data on utilization of services and level of impairment, *see* 91 Fed. Reg. 33,406 (June 3, 2026), which will not be available for many renewing members. This will further increase coverage loss because individuals will need to provide documentation or additional information to successfully renew. Finally, members with complex medical conditions can see fluctuations in their symptoms from day-to-day or month-to-month, which will make it even more difficult to assess whether their condition meets the "significant impairment" threshold.

51. Members with conditions that meet the statutory categories of medical frailty but who lose coverage due to inability to document "significant impairment" may return to Wisconsin Medicaid sicker and costlier for the loss of health coverage to treat and manage their conditions. This type of "churn" in Medicaid enrollment both raises costs for Wisconsin and decreases quality of care for members.

52. Wisconsin DHS expects the IFR's limitations on self-attestation to increase member confusion and coverage loss as well. In WI DHS's experience, the requirement to obtain third party documents to demonstrate eligibility creates a procedural hurdle that increases termination rates for otherwise eligible members. Thus, as self-attestation tightens, WI DHS expects that more members who are actually eligible will be disenrolled simply because they are unable to demonstrate their eligibility. Further, WI DHS anticipates that potentially eligible individuals may be less likely to enroll in Wisconsin Medicaid because of concern that they will be unable to demonstrate their eligibility.

53. Wisconsin DHS also expects the "once per enrollment period" limitation on medical frailty self-attestations to particularly harm members with multiple medically frail

conditions, especially those who develop one medically frail condition, recover from it, and then develop a second medically frail condition during the same enrollment period. For example, a member could be diagnosed with cancer and self-attest to medical frailty on that basis, and then later while still enrolled in BadgerCare Plus, be diagnosed with COPD. Under the IFR, assuming continuous Medicaid coverage during that period, the member *could not* self-attest to medical frailty based on the new COPD diagnosis and thus would lose coverage if they could not obtain documentation for this diagnosis.

54. Wisconsin DHS is statutorily required to provide notice to BadgerCare Plus members regarding the changes occasioned by the IFR on or before August 31, 2026. 42 U.S.C. 1936a(xx)(8)(A) (directing States to begin outreach no later than four or more months before December 31, 2026). At present, WI DHS is uncertain as to how, for example, a member might establish that they are medically frail. Accordingly, the content of this notice will not have the clarity required to communicate to members how they can comply with the new requirements.

55. Wisconsin DHS has spent years conducting outreach and building relationships with BadgerCare Plus enrollees. Confusion over eligibility determinations risks harming that relationship and lowering institutional trust. Members who do not understand why they were disenrolled or what is required to be eligible may simply forego coverage.

Administrative, Operational, and Financial Burdens on Wisconsin

Burdens on Wisconsin Department of Health Services and BadgerCare Plus

56. Because CMS had never before imposed community engagement requirements across eligibility categories, the eligibility system used for BadgerCare Plus eligibility determinations was not built to support community engagement requirements and is not easily configured to incorporate the numerous eligibility factors necessary to evaluate community

engagement. Wisconsin DHS estimates that systems enhancements will cost $10,000,000. This estimate does not include staff time, costs for any systems rework that may be needed with CMS's change in direction, or costs to incorporate data sources to verify every factor of community engagement.

57. With respect to the medical frailty exclusion, the surprising additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require WI DHS to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways to evaluate medical frailty, WI DHS may need to integrate new data sources to evaluate BadgerCare Plus members' eligibility for the medical frailty exclusion, which will add development costs as well as potential costs from accessing new data. As more individuals are impacted and denied coverage or disenrolled as a result of this requirement, WI DHS expects more calls, more documents to process, and more appeals of adverse actions. And finally, in addition to the costs of operationalizing this new requirement, WI DHS will also incur the cost of educating its members, staff, and other stakeholders about what the requirement means and how it can be met.

58. Wisconsin DHS also expects the new, complex, and variable limitations on self-attestation to increase its operational complexity. These limitations will make it harder to train staff, vendors, assisters, and community organizations on eligibility processes. As with the medical frailty exclusion, WI DHS expects the self-attestation limitation to lead to more calls, more documentation to be scanned and reviewed by staff, and more denials and disenrollments that, themselves, lead to more calls and appeals. In addition, the change in the self-attestation rules from 2027 to 2028 will require additional system development, training, and outreach and education to accommodate the new 2028 rules.

Burdens on Wisconsin

59. The burdens from community engagement requirements imposed by H.R. 1 and made worse by the IFR fall not just on WI DHS and BadgerCare Plus members, but on Wisconsin more generally. As noted above, BadgerCare Plus members will likely face increased denials and disenrollments—and, due to the "significant impairment" requirement for medical frailty, many of those disenrollments could be of some of BadgerCare Plus's most medically needy members. The IFR will likely have a disproportionate impact on members with disabilities and chronic health conditions who are enrolled in BadgerCare Plus. Wisconsin's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Furthermore, individuals that are disenrolled from BadgerCare Plus will likely lose access to primary and preventive care – and care necessary to treat their statutorily recognized medical conditions – resulting in more individuals seeking high-cost, emergency care. In addition, the lack of preventative care will likely result in increased communicable disease outbreaks and more strain on WI DHS. Most importantly, WI DHS expects poorer health outcomes across Wisconsin, as fewer people will be able to access appropriate care and manage chronic conditions.

60. In addition, WI DHS expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on healthcare providers treating impacted members. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and significant

impairment in the ability to work. This will require providers to take time away from their patient care and increase administrative strain on providers, adding to healthcare costs and impacting access to care, potentially increasing provider shortages.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 24th day of June 2026.

s/ Debra Standridge
Debra Standridge
Deputy Secretary of the Wisconsin Department of Health Services

EXHIBIT 26

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Executive Director

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General Counsel
Marc Fleischaker
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November 19, 2025

VIA MAIL AND EMAIL

The Honorable Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Implementation of Medicaid Work Requirements

Dear Secretary Kennedy and Administrator Oz:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We are writing regarding forthcoming guidance and regulations implementing the work requirements provisions of the 2025 Reconciliation Act.[1]

As you know, the 2025 Reconciliation Act requires states to impose work requirements on Medicaid applicants and beneficiaries who fall within the expansion population, effective January 1, 2027.[2] Congress directed the Secretary of Health and Human Services (HHS) to promulgate an interim final rule implementing the work requirements provisions no later than June 1, 2026.[3] In addition, it is our understanding that the Centers for Medicare & Medicaid Services (CMS) is planning to issue further guidance for states prior to promulgating an interim final rule (IFR).[4]

We are submitting comments for your consideration as you develop the guidance and IFR. We ask that the full text of our comments, as well as the full text of each of the studies cited below, be considered part of the formal administrative record on any guidance documents and the IFR.

I. Conditions of Compliance

Under the 2025 Reconciliation Act, an "applicable individual" demonstrates compliance with the work requirements if the individual meets one or more of the seven listed conditions.[5] Through guidance and the IFR, we urge CMS to explain the scope of several of these conditions, as follows.

Work

An individual demonstrates compliance if the "individual works not less than 80 hours."[6] CMS should make clear to states that Congress did not limit "work" to paid work. As a result, "work" includes in-kind and unpaid work. Indeed, that has been the longstanding interpretation of similar language in the statute establishing work requirements for certain SNAP recipients. In the SNAP statute, one of the conditions for compliance with the work requirements is to "work 20 hours or more per week," on average over the month.[7] Regulations implementing the provision define work to include paid work, "in kind" work (meaning work done "in exchange for goods or services"), and unpaid work.[8] That definition makes good sense. For example, it captures unpaid internships, which are common in the non-profit, government, and for-profit sectors, and can lead to full-time paid work.[9] Further, aligning the definition of "work" in SNAP and Medicaid will make implementation of the Medicaid work requirements easier for states (as well as for applicants and beneficiaries).

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[1] An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, 139 Stat. 172 (2025) [hereinafter "2025 Reconciliation Act"].
[2] *Id*. § 71119(a) (codified at 42 U.S.C. § 1396a(xx)). Congress gave states the option to impose the work requirements at an earlier date, "subject to" the provisions of the statute. *Id*. (codified at 42 U.S.C. § 1396a(xx)(1)).
[3] *Id*. § 71119(d).
[4] *See* CMS, *CMCS Informational Bulletin, "Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions* 21 (Nov. 18, 2025) (indicating that additional guidance is forthcoming).
[5] 42 U.S.C. § 1396a(xx)(2).
[6] *Id*. § 1396(xx)(2)(A).
[7] 7 U.S.C. § 2015(o)(2)(A).
[8] 7 C.F.R. § 273.74(a)(2); *see* U.S. Dep't of Agric., Food & Nutrition Serv., *Letter to SNAP Regional Directors, SNAP ABAWD Time Limit Policy and Program Access* 3 (Nov. 19, 2015), https://fns-prod.azureedge.us/sites/default/files/snap/ABAWD-Time-Limit-Policy-and-Program-Access-Memo-Nov2015.pdf.
[9] *See, e.g.*, Jiahong Zhang & Matthew Hora, The Ctr. for College-Workforce Transitions, Wis. Ctr. for Educ. Rsch., Sch. of Educ., Univ. of Wisconsin-Madison, *Data Snapshot #1, Who are the unpaid interns?* (2021), https://ccwt.wisc.edu/wp-content/uploads/2022/04/CCWT_report_data-snapshot-1.pdf.

Community Service

An individual demonstrates compliance if the individual "completes not less than 80 hours of community service."[10] Community service is a distinct form of unpaid work. According to the current Merriam-Webster dictionary, community service is "work that is done without pay to help people in a community."[11] It would include unpaid work with a nonprofit organization or a government agency. In addition, it would include unpaid work that an individual undertakes on their own or with a less formal group. For example, it would include participating in a local effort to clean up a beach, as well as organizing a local support group for people who are dealing with a particular health condition. Further, CMS should make clear to states that community service is not limited to volunteer work; rather, it would include unpaid work that is court-ordered or done to meet an educational requirement.

Education

An individual demonstrates compliance if "the individual is enrolled in an education program at least half-time."[12] Congress did not provide an exclusive definition of the term "education program." Rather, Congress stated that the "term 'educational program' *includes* – (i) an institution of higher education (as defined in section 101 of the Higher Education Act of 1965); and (ii) a program of career and technical education (as defined in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006)."[13]

CMS should define the term "education program" to include all high school programs, as well as GED programs.[14] Individuals who are over 18 (and as a result, subject to work requirements) remain in high school for various reasons, such as starting school late, repeating a grade, or leaving school before graduation to work and then returning later.[15] There is no basis to exclude enrollment in high school or a GED program from the definition

[10] 42 U.S.C. § 1396a(xx)(2)(B).
[11] Merriam-Webster Dictionary, entry for "community service," https://www.merriam-webster.com/ (accessed Oct. 27, 2025).
[12] 42 U.S.C. § 1396a(xx)(2)(D).
[13] *Id*. § 1396a(xx)(9)(B) (emphasis added).
[14] Some specialized high school programs are programs of career and technical education. *See* Carl D. Perkins Career and Technical Education Act of 2006, Pub. L. No. 109-270, § 3(3)(A)-(B), (5), 120 Stat. 683, 685,686.
[15] *See, e.g.*, *Healthy People 2030, High School Graduation*, Off. of Disease Prevention & Health Promotion, HHS, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/high-school-graduation#cit13 (citing research finding that among students who were not reading proficiently in 3rd grade, those who lived in poverty for at least a year between 2nd and 11th grade were less likely than those who did not to finish high school on time or at all); Nat'l Ctr. for Educ. Stats., *The Condition of Education, Ch. 2 Preprimary, Elementary, and Secondary Education, Section: High School Persistence and Completion* (2024), https://nces.ed.gov/programs/coe/pdf/2024/coi_508c.pdf (finding during the 2021-2022 school year, the U.S. average adjusted cohort graduation rate (ACGR) – which measures the percentage of students who graduate within the traditional four years – was 87%, meaning that 13% of students did not graduate within that time).

of an education program. Indeed, having a high school degree (or the equivalent) is correlated with better job prospects and higher earnings.[16]

Further, individuals enroll in a wide range of educational programs that can improve their career and earning prospects, such as professional development, continuing education, certification programs, and English as a second language courses.[17] To the extent that these courses do not fall within the definitions of "an institution of higher education" or "a program of career and technical education," CMS should instruct states to consider them to be an educational program.

As for how to determine the enrollment status of a student, CMS should look to existing SNAP regulations and guidance. While the effect of participation in educational activities is different in Medicaid and SNAP, it nevertheless makes sense for CMS to borrow from SNAP in this context. Aligning the rules for determining enrollment status will be simpler for states, as well as for Medicaid beneficiaries who are familiar with the SNAP rules.[18] In fact, one-third of households enrolled in Medicaid or CHIP participate in SNAP.[19] Thus, CMS should provide guidance to states that an individual is enrolled half-time or full-time if the school designates them as such.[20] And, as in SNAP, that enrollment status begins "on the first day of the school term" and is "deemed to continue through normal periods of class attendance, vacation and recess, unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term (excluding summer school)."[21] For example, this means that a student who is enrolled half-time (or full-time) in

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[16] *See Education Pays, Earnings and Unemployment Rates by Educational Attainment, 2024*, U.S. Bureau of Labor Stats., https://www.bls.gov/emp/chart-unemployment-earnings-education.htm (Aug. 28, 2025); *Healthy People 2030, High School Graduation*, Off. of Disease Prevention & Health Promotion, HHS, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/high-school-graduation#cit13 (noting that not finishing high school is linked to "limited employment prospects, low wages, and poverty").

[17] *See generally* Jill H. Wilson, Metro. Pol'y Program, Brookings, *Investing in English Skills: The Limited English Proficient Workforce in U.S. Metropolitan Areas* (2014), https://www.brookings.edu/wp-content/uploads/2014/09/metro_20140924_investing_in_english_skils_report.pdf (noting that individuals who are proficient in English earn higher wages and finding that "increasing the investment in adult English instruction now would enhance the human capital of immigrants that could lead to more productive work, and benefit their children, sooner").

[18] Ample evidence shows that public benefits recipients are often not aware of or have a hard time understanding complex program rules. *See, e.g.*, HHS, Assistant Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf (documenting low awareness and/or understanding of work requirements, healthy behavior incentives, and "health savings account-like arrangements" in state § 1115 projects). Aligning SNAP and Medicaid work requirements will at least help mitigate this problem.

[19] Jonathan Schwabish, Urban Inst., *About 12 Million Households Receive Both Medicaid and SNAP. The Reconciliation Bill Puts Them At Risk* (2025), https://www.urban.org/urban-wire/about-12-million-households-receive-both-medicaid-and-snap-reconciliation-bill-puts-them.

[20] U.S. Dep't of Agric., Food & Nutrition Serv. (FNS), *Letter to All SNAP State Agencies, SNAP Institutions of Higher Education and Student Eligibility Rules* (Feb. 7, 2023), https://www.fns.usda.gov/snap/ihe-student-eligibility-rules.

[21] 7 C.F.R. § 273.5(c).

a college program maintains that enrollment status during winter break, spring break, and the summer, even if they do not take any classes during those periods. Further, CMS should consider any student with an active Individualized Education Plan to be enrolled in school, even when the student is in between placements, and clarify that any student with an IEP should be deemed in compliance with the work requirements.

Combination of Activities

An individual demonstrates compliance "if the individual engages in any combination of the activities described in subparagraphs (A) through (D), for a total of not less than 80 hours."[22] This means that an individual who engages in any combination of work, community service, work program activities, or educational program activities for 80 hours total has satisfied the work requirements.

To avoid confusion, CMS should explain to states how educational program activities factor into this combination provision. While subparagraph (D) refers to an individual "enrolled in an educational program at least half-time," an individual enrolled in an educational program for less than half-time can use the hours spent in that program to reach the 80-hour threshold. A different interpretation would be nonsensical, as an individual enrolled in an educational program at least half-time would never need to rely on a combination of activities to satisfy the work requirements. Further, there is no reason to distinguish between an individual who is enrolled less than half-time and also working part-time and an individual who is enrolled half-time.

Income

Alternatively, individuals demonstrate compliance if they: (1) have monthly income not less than the applicable federal minimum wage multiplied by 80 hours; or (2) are a seasonal worker and have an average monthly income over the preceding six months not less than the applicable federal minimum wage multiplied by 80 hours.[23] CMS should require states to count *all* gross income – rather than to apply the Modified Adjusted Gross Income (MAGI) standard – to determine compliance under these provisions. This is because MAGI excludes non-taxable income derived from employment (*e.g.*, employee and employer contributions to retirement accounts).[24] Given that the 2025 Reconciliation Act is meant, in part, to incentivize employment, it would not make sense to discount a portion of those wages when determining compliance. For the same reason, the standard 5% disregard to countable income under MAGI[25] should not apply to this determination.

[22] 42 U.S.C. § 1396a(xx)(2)(E).
[23] *Id*. § 1396a(xx)(2)(F) & (G).
[24] *See* 42 C.F.R. § 435.603; Ctr. on Budget & Pol'y Priorities, *Key Facts: Income Definitions for Marketplace and Medicaid Coverage*, (2025), https://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/.
[25] *See* 42 C.F.R. § 435.603(d)(4).

Second, state wage databases, like SWICA and The Work Number, generally do not have the capacity to reflect non-taxable, net income and, instead, show only gross wages.[26] Thus, to determine income eligibility under MAGI, states often have to subtract those deductions manually. Mandating that states also use this manual process to determine whether someone is in compliance under either of these provisions would hinder automated data matching and create unnecessary administrative burden for state agencies.

II. Optional Exceptions for Short-Term Hardship Events

Suggested Definitions for Terms Used to Describe a Hardship Event

Congress directed CMS to specify standards for states to use in establishing their own procedures for evaluating short-term hardship exceptions, if the state elects to offer such exceptions.[27] Individual short-term hardship exceptions are limited to two circumstances.[28] The first offers an exception to those who "receive inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or ***such other services of similar acuity (including outpatient care relating to other services specified in this subclause) as the Secretary determines appropriate***…."[29]

At the outset, CMS should be sure to include other *inpatient* psychiatric settings that are covered under Medicaid but are not specifically listed by the 2025 Reconciliation Act, such as psychiatric residential treatment facilities. Furthermore, in deciding what other services of similar acuity to include, CMS should adhere to the federal government's long-standing position that health care should be provided in the least restrictive, most integrated setting.[30] For example, some services related to inpatient psychiatric care that address or

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[26] *See* 45 C.F.R. § 205.51(c) (listing information SWICA provides); *see also Social Service Verifications*, The Work Number, https://theworknumber.com/solutions/products/social-service-verification (last visited Nov. 17, 2025) (stating The Work Number verification provides "the most recent 12 pay periods of Gross Earnings.").

[27] *See id*. § 1396a(xx)(3)(B)(i).

[28] A third short-term hardship exception exists for individuals living in counties or equivalent units of local governments where there is an emergency or disaster declared or where the unemployment rate is at or above the lesser of 8% or 1.5 the national unemployment rate. *Id*. § 1396a(xx)(3)(B)(ii)(II).

[29] *See id*. § 1396a(xx)(3)(B)(ii)(I).

[30] *Community Living and Olmstead*, HHS, https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html (Sept. 23, 2025); Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *2025 Nat'l Guidelines for a Behavioral Health Coordinated System of Crisis Care* 45 (2025), https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf (listing "least restrictive natural environment" as a SAMHSA System of Care Guiding Principle); *see also* SAMSHA, *Recovery-Oriented, Person Centered Behavioral Treatment* 3 (2024), https://www.govinfo.gov/content/pkg/GOVPUB-HE20_400-PURL-gpo234312/pdf/GOVPUB-HE20_400-PURL-gpo234312.pdf ("Recovery-oriented care promotes individuals to pursue independence and community integration. Institutional and coercive care are to be avoided whenever possible and individuals and families are provided with the services needed to live in home and community-based settings.").

stabilize psychiatric needs but can be provided in less restrictive settings include: partial hospitalization programs;[31] intensive outpatient services;[32] Assertive Community Treatment;[33] mobile crisis response units and crisis stabilization services;[34] psychosocial rehabilitation;[35] and intensive home and community-based services for youth with Serious Emotional Disturbance.[36]

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[31] *See* Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs, 88 Fed. Reg. 81540, 81809 (Nov. 22, 2023) (final rule) (providing background on partial hospitalization program services); *see also* Medicaid and CHIP Payment and Access Comm'n (MACPAC), *Behavioral health services covered under state plan authority* (2021), https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/.

[32] *See* 88 Fed. Reg. at 81811 (describing intensive outpatient services); *see also* MACPAC, *Behavioral health services covered under state plan authority* (Jan. 11, 2021), https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/.

[33] Assertive Community Treatment (ACT) is a team-based, intensive behavioral health intervention for individuals with Serious Mental Illness (SMI) that delivers psychiatric treatment, medication management, rehabilitative supports, crisis intervention, and case management in an environment where an individual is naturally located, rather than in an institutional setting. *See* SAMHSA, *Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT* (2008), https://www.samhsa.gov/resource/ebp/assertive-community-treatment-act-evidence-based-practices-ebp-kit. It is often treated as a bundled service, and some states bill ACT using HCPCS H0040 (per diem) or HCPCS H0039 (15 minutes intervals). *See, e.g.*, *HCPCS Code for Assertive Community Treatment Program, Per Diem*, AAPC, https://www.aapc.com/codes/hcpcs-codes/H0040 (last visited Nov. 17, 2025); *HCPCS Code for Assertive Community Treatment, Face-to-Face, Per 15 Minutes*, AAPC, https://www.aapc.com/codes/hcpcs-codes/H0039 (last visited Nov. 17, 2025); CMS, *Dear State Health Official Letter*, *SHO # 25-004, Best Practices for Implementing the Continuum of Crisis Services under Medicaid and CHIP* (Sept. 5, 2025), https://www.medicaid.gov/federal-policy-guidance/downloads/sho25004.pdf [hereinafter CMS, *SHO #25-004*"].

[34] CMS, *SHO #25-004*.

[35] CMS, *State Operations Manual*, *Appx. F-Community Mental Health Centers (CMHC) Interpretative Guidance* (2024), https://www.cms.gov/files/document/som107apfcmhc.pdf (in discussing community mental health center services intended to provide outpatient treatment to those with acute psychiatric needs, defining intensive outpatient (IOP) services, partial hospitalization services, and psychosocial rehabilitation).

[36] Intensive home- and community-based services for youth with Serious Emotional Disturbance are defined as a coordinated array of behavioral health services designed to prevent institutional or residential placement. Federal guidance identifies the core ICBS bundle as including: (1) Intensive Care Coordination (ICC), often delivered through a wraparound model; (2) Intensive In-Home Behavioral Health Services providing individualized therapy, skills training, and behavioral interventions; and (3) mobile crisis response and stabilization services available 24/7 and delivered by a trained team. *See* CMS & SAMHSA, *Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf; CMS, *SHO #25-004*; CMS, *Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth* (Aug. 18, 2022), https://www.medicaid.gov/sites/default/files/2022-08/bhccib08182022.pdf; MACPAC, *Report to Congress on Medicaid & CHIP, Chapter 3: Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP* (2021), https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf.

Relatedly, CMS should be careful to avoid incentivizing receipt of care in inpatient settings when that same care can be provided more cost-effectively in an outpatient setting.[37] And, in determining the most cost-effective and prudent course of treatment, health care providers should not be asked to consider whether a patient will be subject to work requirements. To address this concern, CMS should consider listing in its guidance those medical services that are often provided in inpatient settings but can be more efficiently provided in a home or community-based setting. For example, CMS should include: home health services (including durable medical equipment, consumable medical supplies, home health aides, and outpatient therapeutic services)[38] and ambulatory surgical centers.[39] Importantly, whether an individual requires acute care at home is not dependent on whether they are homebound.[40]

The second available individual short-term hardship exception applies when an "individual or their dependent must **travel outside of their community** for an **extended period of time** to receive medical services necessary to treat a serious or complex medical condition (as described in § 1396a(xx)(9)(A)(ii)((V)(ee)) that are **not available within their community of residence**."

In determining what constitutes "**travel outside of their community**" and "**not available within their community of residence**," CMS should look to existing federal Medicaid managed care regulations, which require states to develop network adequacy standards that include "the geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by

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[37] Iris Megido et al., *Cost Effectiveness of Home Care Versus Hospital Care: A Retrospective Analysis*, 21 COST EFFECTIVENESS & RES. ALLOCATION 13, 18 (2023), https://resource-allocation.biomedcentral.com/articles/10.1186/s12962-023-00424-0 (finding that hospital services provided at home and in community-based settings "are significantly lower than those of inpatient care"); *see also* Sarah Klein, Commonwealth Fund, "*Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers* (Feb. 4, 2019), https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance; Brad Spellberg et al., *Health Economic Analysis of an All-Virtual, At-Home Acute Care Model*, 8 JAMA NETWORK OPEN e2517114 (2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2835465 (finding that virtual, at-home acute care "achieved significant avoidance of hospital days and associated cost savings, without compromising patient safety").

[38] Home health services would include services the state must cover in accordance with 42 U.S.C. § 1396a(a)(10)(D) and 42 C.F.R.§ 440.70. *See* Off. of the Assistant Sec'y for Plan. & Evaluation, HHS, *Subacute Care: Review of the Literature* (1994), https://aspe.hhs.gov/reports/subacute-care-review-literature-0 (describing discharge to home health services as "subacute care").

[39] Seth A. Strope et al., *Disparities in the Use of Ambulatory Surgical Centers: A Cross Sectional Study*, 9 BMC HEALTH SERVS. RSCH. 121 (2009), https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-9-121 ("Ambulatory surgical centers (ASCs) provide outpatient surgical services more efficiently than hospital outpatient departments, benefiting patients through lower co-payments and other expenses").

[40] Health Care Fin. Admin. (HCFA), *Dear State Medicaid Director Letter, Olmstead Update No. 3* (July 25, 2000), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd072500b.pdf (attachment 3-g, stating use of a "homebound" requirement violates 42 C.F.R. §§ 440.230(c) and 440.240(b)).

Medicaid enrollees."[41] CMS should allow states to adopt their managed care network adequacy standards to establish specific distance and/or travel time standards for deciding when a service is "not available" within a "community of residence." For example, under the network adequacy standards in Arizona, all beneficiaries under age 21 in counties other than Maricopa and Pima must have access to a pediatric cardiologist within 110 minutes or 100 miles from their residence.[42] Thus, if an beneficiary needed to travel more than 110 minutes or 100 miles for their dependent child to see a pediatric cardiologist, they would have traveled outside of their community for services not available within their community of residence.

As CMS has previously acknowledged, states vary widely in provider accessibility across geographic regions, so a certain amount of flexibility is needed to account for these variations.[43] In developing these existing standards, states have already analyzed and factored in these unique provider and enrollee demographics. By allowing states to rely on these existing standards, CMS can capitalize on work that has already been done which, in turn, will reduce state administrative burden in implementing work requirements.

Similarly, in both the Medicaid managed care and fee-for-service contexts, CMS directs states to "determine a geographic distance within which transportation is generally provided" for the prior authorization of non-emergency medical transportation services (NEMT).[44] CMS could allow states to use their existing NEMT standards to also judge whether a service is unavailable in the community.

Finally, all services authorized under 42 C.F.R. § 431.52(b)(3) & (4) (governing Medicaid reimbursement for out-of-state Medicaid services) should qualify as medical services not available in the community of residence.

Thus, CMS should give states the option to use all of the above standards to measure whether care requires travel outside of the community because it is not available within the community.

To establish a measurement for an "extended period of time," CMS should direct states to use the same travel time and distance standards that govern how far an individual within a managed care network must travel before the managed care organization is required to arrange for and cover an alternative out of network provider.[45] Rural residents, in particular,

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[41] 42 C.F.R. § 438.68(c)(1)(vi).
[42] Ariz. Health Care Cost Containment Sys., *AHCCCS Contractor Operations Manual § 436 – Network Standards* 3 (effective Oct. 1, 2025), https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.
[43] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27659 (May 6, 2016) (final rule).
[44] CMS, *Dear State Medicaid Director Letter, SMD #23-006, Assurance of Transportation: A Medicaid Transportation Coverage Guide* (Sept. 28, 2023), www.medicaid.gov/sites/default/files/2023-12/smd23006.pdf.
[45] 42 C.F.R. § 438.68(c)(1)(vi).

already struggle to access health care in their communities and therefore forego critical treatment.[46] As stated above, states have widely disparate demographics as they relate to health care access. If CMS fails to account for these disparities in defining the above terms, then rural residents will be further disincentivized from seeking treatment for serious or complex medical conditions (or transporting their dependents to access the same). This, in turn, will only exacerbate unequal health outcomes between rural and urban populations. The managed care and NEMT standards adopted by states already take these concerns into account. CMS should therefore defer to their conclusions.

Limits on Requesting a Short-Term Hardship Exception

While the 2025 Reconciliation Act provides that, where an individual meets a short-term hardship exception, the state must "deem such individual to have demonstrated community engagement under paragraph (2) *for such month*," the Act does not prescribe a limit or cap on the number of times an individual can request an exception. CMS should make clear to states that, so long as an individual meets the criteria, he or she must remain eligible for the exception. In other words, there is no limit on the duration of a short-term hardship exemption. Any other interpretation would be contrary to statute. Furthermore, given that the exceptions in § 1396a(xx)(3)(B)(ii)(I) & (III) relate to the medical needs of an individual or their dependent, including whether their condition is "serious and complex" – considerations that also factor into whether an individual is a "specified excluded individual" (i.e., "medically frail") – CMS should direct states to assess whether the individual continues to be an "applicable individual" when they qualify for more than one month of a short-term hardship exception. As discussed in the Compliance & Ex Parte Verifications

[46] *See* Macarena C. Garcia et al., *Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States*, 66 MMWR SURVEILLANCE SUMMARIES 1 (2017), https://www.cdc.gov/mmwr/volumes/66/ss/ss6602a1.htm (finding that during 1999–2014, annual age-adjusted death rates for the five leading causes of death were higher in rural areas than in urban areas, and the proportion of potentially excess deaths among persons under age 80 was higher in rural areas compared with urban areas); GAO, GAO 21-93, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services* (2020), https://www.gao.gov/products/gao-21-93 (documenting the effect of rural hospital closures on access to care); John Pender, U.S. Dep't of Agric., Econ. Rsch. Serv., *Charts of Note, Availability of healthcare providers in rural areas lags that of urban areas* (2023), https://www.ers.usda.gov/data-products/charts-of-note/chart-detail?chartId=106208; Thomas A. Arcury et al., *The Effect of Geography and Spatial Behavior on Health Care Utilization Among the Residents of a Rural Region*, 20 HEALTH SERVS. RSCH. 135 (2005), https://pmc.ncbi.nlm.nih.gov/articles/PMC1361130/; Leighton Chan et al., *Geographic Access to Health Care for Rural Medicare Beneficiaries*, 22 J. RURAL HEALTH 140 (2006), https://pubmed.ncbi.nlm.nih.gov/16606425/ (finding that rural patients needed to travel two to three times farther to see medical and surgical specialists than those living in urban areas, and increasing rurality was related to decreased specialist visits and increased reliance on generalists); Daniel Thomas et al., *Rural Mental Health Workforce Needs Assessment – A National Survey*, 12 RURAL & REMOTE HEALTH 2176 (2012), https://pubmed.ncbi.nlm.nih.gov/23088609/ (reporting that many rural people are not receiving care because of excessive travel distances and wait times); Tracy Onega et al., *Geographic Access to Cancer Care in the U.S.*, 112 CANCER 909 (2008), https://pubmed.ncbi.nlm.nih.gov/18189295/ (finding that increased travel time to healthcare services has been associated with greater risk of presenting with advanced cancer, decreased utilization of breast-conserving therapy, and lower enrollment in clinical trials).

section below, states are also required under statute to screen individuals for exclusions, including whether they have a serious and complex medical condition before requiring them to engage in work. This would also align with similar SNAP guidance that requires the state agency, upon learning that more than one exception applies, to apply the exception of the longest duration.[47] It would also reduce administrative burden on states and beneficiaries.

Notice & Process Available for a Short-Term Hardship Exception

In accordance with SNAP regulations, state agencies are required to inform applicants and beneficiaries about the availability of good cause exceptions to SNAP's ABAWD work requirements.[48] Similarly, here, if the state elects an optional short-term hardship under § 1396a(xx)(3)(B)(ii)(I) or (III), CMS should require states to inform applicants and beneficiaries about these options and how to apply.[49] Notably, the 2025 Reconciliation Act requires that states include this information in notices of non-compliance.[50] And unlike in SNAP – where the good cause exception is open-ended[51] – the circumstances under which an individual can meet a short-term hardship event here are limited, making it possible to list all available exceptions in all written communications between the applicant or beneficiary and the state Medicaid agency, including descriptions of the states' Medicaid program, notices, (including notices of denial, non-compliance, or termination, and requests for information), and applications.

Further, CMS should inform states that the process for requesting a hardship exception under § 1396a(xx)(3)(B)(ii)(I) & (III) should align with existing Medicaid regulations that require states to accept applicant information through internet, telephone, mail, in-person delivery, and other commonly available electronic means.[52] And, importantly, states must

[47] 7 C.F.R. 273.24(k); FNS, *Letter to Supplemental Nutrition Assistance Program All Regions*, *Supplemental Nutrition Assistance Program (SNAP) – Question and Answer #1 for the Program Purpose and Work Requirement Provisions of the Fiscal Responsibility Act of 2023 Final Rule* (Dec. 20, 2024), https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-FRA-Final-Rule-Question-and-Answer-1.pdf [hereinafter "*FNS, Question and Answer #1*"].

[48] 7 C.F.R. § 273.7(c)(1)(iii) ("consolidated written notice must include…an explanation of the process for requesting good cause (including examples of good cause circumstances and contact information to initiate a good cause request)"); *see also* FNS, *Supplemental Nutrition Assistance Program (SNAP) Able-Bodied Adults Without Dependents (ABAWD) Policy Guide* 23 (2023), https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-ABAWD-Policy-Guide-September-2023.pdf.

[49] *See* 42 C.F.R. § 435.905(a) (requiring states to inform all applicants, as well as other individuals upon request, of the eligibility requirements, available Medicaid services, and the rights and responsibilities of applicants and beneficiaries).

[50] *See* 42 U.S.C. § 1396a(xx)(6)(B)(i) (describing the information to be included in the notice of noncompliance, including how to make a "satisfactory showing" that an individual "should be deemed to have demonstrated community engagement under paragraph (3)" (which includes the short-term hardship events)).

[51] *See* 7 C.F.R. § 273.7(i)((2) (defining good cause to include any circumstances beyond the individual's control).

[52] 42 C.F.R. § 435.907(a).

conduct an *ex parte* review using reliable information available to states (including claims or encounter data) before it asks for verification directly from the individual.[53]

III. Specified Excluded Individuals

Medically Frail or Otherwise Has Special Medical Needs

Congress excluded from the work requirements an individual "who is medically frail or otherwise has special medical needs."[54] While Congress authorized the Secretary to define the term, it required the definition to include an individual: who is blind or disabled (as defined in section 1614); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or with a serious or complex medical condition.[55]

Before addressing the meaning of several of these categories, we want to raise an overarching concern that CMS should consider in issuing guidance and an IFR. We have already seen draft state work requirements policies that require an individual who falls within one or more of the five listed categories to show that they are also unable to work. CMS should make clear to states that the plain language of the statute prohibits such policies for each of the categories other than "an individual who is . . . disabled (as defined in section 1614)."[56] If Congress had intended for the exclusion to only apply to individuals who cannot work, it would have said so explicitly.[57]

Significantly, the history of the phrase "medically frail or otherwise has special medical needs" reveals that it is unrelated to ability to work. In 2006, when Congress amended the Medicaid Act to give states the flexibility to require beneficiaries to enroll in Alternative Benefit Plans, it exempted from mandatory enrollment any individual "who is medically frail or otherwise an individual with special medical needs."[58] Under the implementing regulation, CMS allows states to define the phrase, but their definition must include at least six listed categories of individuals.[59] In creating the six categories, CMS wanted to ensure that individuals with significant health care needs maintain adequate health coverage.[60] In

[53] 42 U.S.C. § 1396a(xx)(5).
[54] *Id*. § 1396a(xx)(9)(A)(ii)(V).
[55] *Id*.
[56] *Id*. § 1396a(xx)(9)(A)(ii)(V)(aa); *see id*. § 1382c(a)(3) (generally defining disabled as "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months").
[57] *See, e.g.*, 7 U.S.C. § 2015(o)(B)(3) (exempting from the SNAP work requirements an "individual who is medically certified as physically or mentally unfit for employment").
[58] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044, 120 Stat. 4, 90 (codified at 42 U.S.C. § 1396u-7(a)(2)(B)(vi)).
[59] 42 C.F.R. § 440.315(f).
[60] *See, e.g.*, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 42160, 42231 (July 15, 2013) ("To ensure appropriate service protection for individuals with disabilities and special medical needs, we have included a

the 2025 Reconciliation Act, Congress adopted each of the categories in the regulation, dropping only the category that is limited to children under age 19 (who, of course, are not subject to work requirements).[61] In borrowing from this existing language, Congress expressed its intent to exclude from the work requirements applicants and beneficiaries who have a particular need for comprehensive health care coverage. Thus, CMS should inform states that the statute explicitly prohibits them from grafting "inability to work" onto the medically frail categories listed in the 2025 Reconciliation Act (with the exception of an individual who is "disabled (as defined in section 1614) because that definition explicitly incorporates whether an individual can participate in "substantial gainful activity").[62]

In addition, CMS should explain the scope of several of the "medically frail or otherwise has special medical needs" categories as follows:

*Individual with a Substance Use Disorder: S*ubstance use disorders are chronic, relapsing medical conditions that are treatable and manageable, but not curable in the traditional sense.[63] Given that, CMS should define an individual "with a substance use disorder" to include an individual who is in recovery. This aligns with the clinical understanding of the term. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) – the authoritative guide for diagnosing mental health conditions in the U.S. – indicates that an individual continues to have a SUD if their condition is in remission. A SUD is in remission if the individual previously met the diagnostic criteria for the condition, but has not met any of the criteria (other than craving or a strong desire to use the substance) for at least three months.[64] Relatedly, it indicates that an individual who is receiving maintenance therapy for opioid use disorder (OUD) or tobacco use disorder continues to have a SUD.[65]

Individuals with a SUD in remission face serious harm if their Medicaid coverage is terminated. Research shows that continuing care is beneficial for many individuals in recovery.[66] For example, individuals taking methadone to treat OUD need to remain on the

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basic definition of medically frail that we anticipate will ensure that vulnerable individuals with special medical needs are not mandatorily enrolled in an ABP that may not provide appropriate medical treatment for their individual medical condition. Section 440.315(f) provides states with a minimum standard for defining medically frail populations."); *id*. at 42233 (regarding individuals with a substance use disorder).

[61] *Compare* 42 C.F.R. § 440.315(f) *with* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V) (omitting individuals described in 42 C.F.R. § 438.50(d)(3)).

[62] *See* 42 U.S.C. § 1382c(a)(3)(A). Notably, under § 1382c(a)(2), individuals who are blind under this provision do not have to show that they cannot participate in substantial gainful activity.

[63] Nat'l Inst. on Drug Abuse, Nat'l Inst. of Health, *Drugs, Brains, and Behavior: The Science of Addiction, Treatment & Recovery* (2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery; *Treatment of Substance Use Disorders*, CDC, https://www.cdc.gov/overdose-prevention/treatment/ (April 25, 2024).

[64] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 547, 553-54, 575-76, 587-88, 601-02, 608-10, 620-21, 632-34, 645-46, 652-53 (5th ed., text rev.) (2022) [hereinafter "DSM-V-TR"] (distinguishing between early remission (3 months to 12 months) and sustained remission (12 months or longer) for SUDs).

[65] *Id*. at 608-10, 645-46.

[66] *See, e.g.*, James R. McKay, *Impact of Continuing Care on Recovery from Substance Use Disorder* 41 ALCOHOL RSCH. 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7813220/pdf/arcr-

medication for at least 12 months; some individuals need to remain on the medication long-term.[67] Medicaid coverage makes it possible for individuals to access these ongoing services.[68] Losing coverage, and as a result access to SUD treatment services, could result in dire health consequences.[69]

Individual with a Disabling Mental Disorder: Under the DSM-V-TR, a mental disorder is "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects" a problem in mental functioning and "is usually associated with significant distress or disability in social, occupational, or other important activities."[70] Many mental disorders are chronic and/or episodic conditions that are treatable, but not curable.[71] Thus, CMS should provide guidance to states that an individual "with a disabling mental disorder" includes an individual who is receiving successful

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40-1-1.pdf ("Regardless of the intervention selected for use, it is clear that the status of most patients with SUD will change and evolve over time, and interventions need to include provisions to assess patients on a regular basis and to change or adapt treatment when warranted.").

[67] *Methadone*, SAMHSA, https://www.samhsa.gov/substance-use/treatment/options/methadone (March 29, 2024); *see also Buprenorphine*, SAMHSA, https://www.samhsa.gov/substance-use/treatment/options/buprenorphine (March 28, 2024) (noting that treatment with buprenorphine can be indefinite).

[68] *See* Madeline Guth et al., KFF, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* 9 (2020), https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf (collecting research showing that Medicaid expansion is associated with increased access to SUD treatment, including medications to treat OUD); Madeline Guth & Meghana Ammula, KFF, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021*, at 8 (2021) https://files.kff.org/attachment/Report-Building-on-the-Evidence-Base-Studies-on-the-Effects-of-Medicaid-Expansion.pdf; *see also* Mark Olfson et al., *Healthcare Coverage and Service Access for Low-Income Adults with Substance Use Disorders*, 137 J. SUBSTANCE ABUSE TREATMENT 108710 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9086121/ (finding that among low-income adults with an SUD, those with no insurance coverage had lower likelihood of receiving SUD treatment, compared to those with discontinuous or continuous coverage); Joanne Constantin et al., *Medicaid Unwinding and changes in Buprenorphine Dispensing*, 8 JAMA NETWORK OPEN e258469 (2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833436 (finding that Medicaid unwinding was associated with disruptions in buprenorphine use).

[69] *See, e.g.*, Thomas Santo, Jr. et al., *Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People with Opioid Dependence*, 78 JAMA PSYCHIATRY 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8173472/#H1-4-YOI210027 (finding opioid agonist treatment is associated with a 50% lower risk of all-cause mortality).

[70] DSM-V-TR at 14.

[71] *See, e.g.*, *Bipolar Disorder*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/diagnosis-treatment/drc-20355961 (Aug. 14, 2024) (noting bipolar disorder is a lifelong condition); *Schizophrenia*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443 (Oct. 16, 2024) (noting people with schizophrenia need lifelong treatment); *Depression*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007 (noting depression can require lifelong treatment; most people have multiple episodes); *Personality Disorders*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/personality-disorders/diagnosis-treatment/drc-20354468 (July 14, 2023) (noting treatment can last for months or years); Sukhmanjeet Kaur Mann et al., *Posttraumatic Stress Disorder*, STATPEARLS (2023), https://www.ncbi.nlm.nih.gov/books/NBK559129/ ("Chronic PTSD is common, with estimates that one-third of patients still have symptoms 1 year after diagnosis, and another third of patients still have symptoms 10 years after diagnosis.").

treatment for a mental disorder that can be disabling, and as a result, is not experiencing any impairment in their social, work, or family activities.[72]

Like people whose SUD is in remission, individuals receiving treatment for a disabling mental disorder face serious harm if their Medicaid coverage is terminated. Continuing treatment is critical for this population, and Medicaid coverage enables individuals to access that care.[73] Losing access to ongoing care will exacerbate their conditions and lead to higher utilization of more costly, intensive psychiatric services.[74]

Individual with a Serious or Complex Medical Condition: CMS should not permit states to establish an exclusive list of serious or complex medical conditions. Indeed, CMS has previously noted that it would not be possible to create such a list.[75] Instead, CMS should require states to: 1) create a non-exclusive list of serious or complex conditions, allowing for easy identification of applicants and beneficiaries who are medically frail and have a diagnosis; and 2) provide notice to individuals that the list is not exhaustive and other conditions can qualify as serious or complex.[76]

Further, many serious or complex medical conditions are chronic conditions that can be managed with treatment, but cannot be cured.[77] Here too, CMS should provide guidance to

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[72] "Disabling" cannot have the same definition as "disabled (as defined in section 1614)." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa). Otherwise, the "disabling mental disorder" category would be entirely duplicative of the "disabled (as defined in section 1614)" category.

[73] *See, e.g.*, Madeline Guth et al., KFF, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* 9 (2020), https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf (collecting research showing that Medicaid expansion is associated with increased access to behavioral health care); Xu Ji et al., *Effect of Medicaid Disenrollment on Health Care Utilization Among Adults with Mental Health Disorders*, 57 MED. CARE 574 (2019), https://pubmed.ncbi.nlm.nih.gov/31295187/.

[74] *See*, *e.g*, Xu Ji et al., *Discontinuity of Medicaid Coverage: Impact on Cost an Utilization among Adult Medicaid Beneficiaries with Major Depression*, 55 MED. CARE 735 (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC6684341/ (finding that among adults with depression, those whose coverage was disrupted had higher use of ED and inpatient services, suggesting that maintenance of continuous coverage helps prevent acute episodes); Bentson H. McFarland & Jon C. Collins, *Medicaid Cutbacks and State Psychiatric Hospitalization of Patients with Schizophrenia*, 62 PSYCHIATRIC SERVS. 871 (2011), https://pubmed.ncbi.nlm.nih.gov/21807824/ (finding a "strong connection between Medicaid termination and increased state psychiatric hospitalization"); Jeffrey S. Harman et al., *Association Between Interruptions in Medicaid Coverage and Use of Inpatient Psychiatric Services*, 54 PSYCHIATRIC SERVS. 999 (2003), https://pubmed.ncbi.nlm.nih.gov/12851437/ (finding interruptions in Medicaid coverage are associated with increased psychiatric hospitalization among individuals with schizophrenia).

[75] Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 42160, 42233 (July 15, 2013) (noting that that "illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions" but creating an exhaustive list of conditions would not be possible).

[76] *See* 42 U.S.C. § 1396a(xx)(6)(B), (8)(A).

[77] *See, e.g.*, *Lupus*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/lupus/symptoms-causes/syc-20365789 (Oct. 21, 2022) (noting that most people with lupus have episodic "flares" and while the condition is treatable, there is no cure); *Multiple Sclerosis*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/symptoms-causes/syc-20350269

states that an individual "with a serious or complex condition" includes an individual who: 1) has an episodic condition that is in a period of remission; and/or 2) is receiving ongoing treatment for the condition, which is mitigating its negative effects on their health and/or functioning. This is good policy for many reasons. Again, the health of individuals with serious or complex medical conditions will suffer dramatically if they lose Medicaid coverage.[78] CMS should not incentivize individuals to forego treatment and have their condition deteriorate so that they can continue to qualify for Medicaid.

Parents and Other Caregivers

In addition, Congress excluded from the work requirements an individual "who is the parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the RAISE Family Caregivers Act) of a dependent child 13 years of age and under or a disabled individual."[79] CMS should make clear to states that for purposes of this provision, "disabled individual" includes an individual who is "medically frail or otherwise has special medical needs." That would align with CMS's previous position that "all people with disabilities" fall within the medically frail definition."[80] What is more, aligning the groups of specified excluded individuals in this way would make sense from a policy perspective. If CMS were to adopt a more stringent definition of "disabled individual," there could be situations in which the person being cared for is exempt from work requirements as medically frail, but their family caregiver is not.

(Nov. 1, 2024) (noting that people with multiple sclerosis have period "attacks" with periods of remission in between, and while there is no cure, treatment can help manage the condition).

[78] Abundant research demonstrates that gaps in Medicaid coverage lead to negative health outcomes, including premature mortality. *See, e.g.*, Sarah Miller et al., Nat'l Bureau of Econ. Rsch., *Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*, *Working Paper 26081* (2019), https://www.nber.org/system/files/working_papers/w26081/w26081.pdf; Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. HEALTH ECON. 392 (2017), https://dash.harvard.edu/server/api/core/bitstreams/7312037d-ed01-6bd4-e053-0100007fdf3b/content; Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 N. ENG. J. MED. 586 (2017), http://www.nejm.org/doi/full/10.1056/NEJMsb1706645; Benjamin D. Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012), https://www.nejm.org/doi/full/10.1056/nejmsa1202099; Allyson G. Hall et al., *Lapses in Medicaid Coverage: Impact on Cost and Utilization among Individuals with Diabetes Enrolled in Medicaid*, 48 MED. CARE 1219 (2008), https://pubmed.ncbi.nlm.nih.gov/19300311/; Andrew Bindman et al., *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 ANNALS INTERNAL MED. 854 (2008), https://pubmed.ncbi.nlm.nih.gov/19075204/; Leighton Ku and Erika Steinmetz, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid,* Ass'n for Cmty. Affiliated Plans (2013), http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf.

[79] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(III).

[80] Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 4594, 4631 (Jan. 22, 2013) (proposed rule).

IV. Compliance & *Ex Parte* Verifications

The 2025 Reconciliation Act requires that states conduct compliance checks to determine whether an applicable individual has met the work requirements during the period between their most recent eligibility (re)determination and their next regularly scheduled redetermination.[81] However, states "may elect to not require an individual to verify information" for exceptions and exclusions.[82]

Because applicable individuals are those eligible for Medicaid coverage under § 1396a(10)(A)(i)(VIII) (or a waiver that provides coverage that is equivalent to minimum essential coverage), this period is generally every six months (beginning January 1, 2027).[83] However, states may elect to conduct more frequent compliance verifications.[84] Congress has directed CMS to adopt procedures for verification of compliance (as well as exceptions and exclusions, where the state so chooses[85]) but also explicitly requires that those verifications be conducted *ex parte*.[86] That is, the Act requires states to check compliance (and exceptions and exclusions) using information already possessed by the state before it is allowed to request it directly from individuals.

In the guidance or IFR, CMS should list the minimum set of databases that states are required to use in undertaking this mandatory *ex parte* review process. The 2025 Reconciliation Act delineates three areas where the state must utilize an *ex parte* review process: (1) to determine actual compliance with the work requirements; (2) where the state elects to require verification, to determine whether the individual should be deemed compliant because they meet a specific exception (including but not limited to short-term hardship exceptions); and (3) to determine whether an individual is a "specified excluded individual." Manatt Health has published a chart that contains an extensive list of databases that CMS should direct states to engage with when conducting *ex parte* reviews.[87]

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[81] 42 U.S.C. § 1396a(xx)(4).
[82] *Id*. § 1396a(xx)(3)(A).
[83] *See id*. § 1396a(e)(14)(L) (6-month redeterminations are required for individuals enrolled in the Medicaid expansion under the state plan or under a waiver that covers the entire expansion population).
[84] *See id*. § 1396a(xx)(4).
[85] "Exclusions" or, more specifically, those who are "specified excluded individuals" are defined at 42 U.S.C. § 1396a(xx)(9)(A)(ii). Again, Congress does not require states to undertake any verification process for determining whether an individual meets the exceptions under in § 1396a(xx)(3)(A).
[86] *See id*. § 1396a(xx)(5). This directive aligns with current regulations requiring states to determine or renew eligibility based on information possessed by the agency without requiring additional information for the applicant or enrollee unless that information is found not to be reasonably compatible or cannot be obtained electronically. *See* 42 C.F.R. § 435.952(b), (c).
[87] Kinda Serafi et al., State Health & Value Strategies, *Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions* (2025), https://shvs.org/wp-content/uploads/2025/09/Coverage-and-Access_Work-Requirements-Compliance-and-Exeptions-Verification_09.12.2025_Rev.pdf; *see also* Manatt Health & State Health & Value Strategies, *Strategic Verification Hierarchy for Medicaid Work Reporting Requirements* (2025), https://shvs.org/wp-content/uploads/2025/10/Work-Requirements-Verification-Hierarchy_10.06.2025.pdf.

Furthermore, existing regulations require states to attempt to verify financial eligibility for Medicaid by reviewing SNAP eligibility and enrollment data.[88] Forthcoming CMS guidance, including the IFR, should build on this and require states to access SNAP data to verify compliance (*e.g.*, use SNAP verified income to establish that an "individual has a monthly income that is no less than the applicable minimum wage…multiplied by 80 hours").

While *ex parte* verifications will be a critical component in the implementation of the requirements,[89] it is important to note that such verifications are imperfect. Certain systems states rely on to verify applicant and enrollee data have limited utility and can be unreliable.[90] For example, wage data systems – which are costly to the state – often do not capture seasonal, intermittent, or gig work and, when employment information can be captured, it is often out of date.[91] Additionally, state databases will be unable, in certain instances, to capture all possible exemptions. For example, states will likely be unable to capture those who are caring for a dependent with a disability, those enrolled half-time in an educational program, or those who are engaging in unpaid work or community service.[92] And, of course, states may have failed to successfully implement *ex parte* verifications in full as we saw during the unwinding of the public health emergency.[93]

Given the concerns discussed above, CMS should require states to use the least burdensome verification method available, self-attestation. Notably, self-attestation has been found to be a highly reliable form of verification.[94] Further, it is less burdensome for

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[88] *See* 42 C.F.R. § 435.948(a)(2).
[89] *See generally* Pamela Herd et al., *Interventions to Automate Medicaid Renewals Reduce Procedural Denials and Increase Coverage*, 44 HEALTH AFFS. 1336 (2025), https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00316?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed [hereinafter "Herd et al., *Interventions to Automate Medicaid Renewals*"].
[90] Adrianna McIntyre et al., *New Medicaid Enrollment Barriers and Lessons from Unwinding*, 6 JAMA Health F. e254849 (2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2838677 [hereinafter "McIntyre et al., *New Medicaid Enrollment Barriers*"].
[91] *Id.*; *see also* U.S. Gov't Accountability Off. (GAO), *GAO-17-111*, *Supplemental Nutrition Assistance Program: More Information on Promising Practices Could Enhance States' Use of Data Matching for Eligibility* 19 (2016), https://www.gao.gov/products/gao-17-111; GAO, *GAO-21-183*, *Federal Low-Income Programs, Use of Data to Verify Eligibility Varies Among Selected Programs and Opportunities Exist to Promote Additional Use* 37 (2021), https://www.gao.gov/products/gao-21-183.
[92] McIntyre et al., *New Medicaid Enrollment Barriers*.
[93] Herd et al., *Interventions to Automate Medicaid Renewals* at 1342 ("In the case under study, it was not enough to require states to automate renewal processes for beneficiaries.… [S]tates needed both the capacity and the policy and technical expertise to effectively implement automation and ensure that those eligible for critical benefits such as Medicaid can actually access them.").
[94] *See* MaryBeth Musumeci et al., KFF, *Medicaid Public Health Emergency Unwinding Policies Affecting Seniors & People with Disabilities: Findings from a 50-State Survey* (2022), https://www.kff.org/report-section/medicaid-public-health-emergency-unwinding-policies-affecting-seniors-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/ (noting that when New Jersey compared self-attestation with actual electronic asset verification in a representative sample of applicants from 2015-2016, it found a 0% error rate).

the state[95] and the best method for ensuring that eligible individuals do not lose health coverage due to administrative barriers.[96] Ample research demonstrates that additional administrative barriers deter and reduce coverage.[97] For example, when states implemented work requirements through section 1115 projects, many individuals who were required to submit evidence from a provider to verify the existence of a disability-related exemption struggled to find a willing provider or one who could timely sign off.[98] Given that Medicaid beneficiaries are limited to the smaller pool of providers that accept Medicaid and – if subject to managed care models – are also limited to in-network providers, then finding a willing provider becomes even more difficult.[99] And, of course, applicants who are

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[95] MACPAC, Public Meeting Transcript 88-90 (Sept. 18-19, 2025), https://www.macpac.gov/wp-content/uploads/2025/09/09-18-25-and-09-19-25-MACPAC-Public-Transcript.pdf (former CMS official testifying that self-attestation is less expensive and easier to implement from a systems perspective).

[96] *See, e.g.*, Herd et al., *Interventions to Automate Medicaid Renewals* at 1340 ("People frequently lose coverage because they did not receive the renewal form, were confused about how to complete it, or *struggled to find the information and documentation they needed to complete it*.") (emphasis added).

[97] *See, e.g.*, Jennifer Wagner & Judy Solomon, *States' Complex Medicaid Waivers will Create Costly Bureaucracy and Harm Eligible Beneficiaries* 3-4 (2018), https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible; KFF, *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (2018), https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/ (explaining that adding enrollment barriers leads to significant declines in enrollment, while streamlining enrollment and renewal processes contributes to an increase in enrollment and retention); Ashley M. Fox et al., *Administrative Easing: Rule Reduction and Medicaid Enrollment*, 80 PUB. ADMIN. REV. 104 (2020), https://onlinelibrary.wiley.com/doi/epdf/10.1111/puar.13131; Michael Perry et al., KFF, *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* (2000), https://www.kff.org/wp-content/uploads/2013/01/medicaid-and-children-overcoming-barriers-to-enrollmentreport.pdf; Leighton Ku et al., Ass'n for Cmty. Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care* 12-16 (2009), http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf.

[98] Ian Hill et al., Urban Inst., *New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results* 24 (2020), https://www.urban.org/sites/default/files/publication/101608/new_hampshires_experience_with_medicaid_work_requirements_2.pdf [hereinafter, "Ian Hill et al., *New Hampshire's Experience with Medicaid Work Requirements*"].

[99] Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 1 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6452575/; MACPAC, *Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services* (2025), https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf ("In general, physicians are less likely to serve patients covered by Medicaid than those with Medicare or private insurance. In a MACPAC analysis of the 2017 National Electronic Health Records Survey (NEHRS), fewer physicians reported accepting new Medicaid patients (74 percent) compared to those accepting new Medicare patients (88 percent) or new privately insured patients (96 percent)."); Off. of Inspector Gen., HHS, *Rep. No. OEI-02-22-00050, A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.

uninsured often have no access to a provider at all, making it impossible for them to have a provider certify their condition.[100]

Furthermore, acceptance of self-attestation as the standard form of verification would align with existing Medicaid and SNAP regulations. Medicaid regulations give states the option to accept self-attestation for the vast majority of information necessary to prove eligibility.[101] Self-attestation can be accomplished by the individual or, to ensure that the application and redetermination processes are accessible, by an adult in the household, family member, or authorized representative.[102] And, even where states require something other than self-attestation, they:

> must establish an exception [to the required verification process] to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster.[103]

Finally, where the state turns up information during an *ex parte* review or verification period that would otherwise lead to a denial or termination of Medicaid eligibility, individuals must have the opportunity to rebut such information before eligibility is denied or terminated.[104] There is simply no reason that these requirements should not apply equally to verification of compliance with work requirements.

Similarly, under SNAP regulations governing work requirement compliance, states are required to affirmatively screen individuals for potential exceptions from those requirements and act promptly where one is discovered.[105] States are also not required to verify ABAWD exceptions, unless questionable.[106] And, like in Medicaid, where an individual is asked to provide verification to address questionable information supplied in a SNAP application or recertification, the state agency must provide assistance.[107]

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[100] Jane M. Zhu et al., *Medicaid Managed Care Organizations' Experiences with Network Adequacy*, 3 HEALTH AFFS. SCHOLAR 1, 6 (2025) https://doi.org/10.1093/haschl/qxaf049.
[101] *See* 42 C.F.R. § 435.945(a); *see also id*. § 435.956(e) (requiring states to accept self-attestation for pregnancy unless not reasonably compatible with other information already in the state's possession).
[102] *Id*. § 435.945(a).
[103] *Id*. § 435.952(c)(3).
[104] *Id*. § 435.952(d).
[105] FNS, *Question and Answer #1*; *see also* 7 C.F.R. §§ 273.7(b)(3) (work screening), 273.24(k) (ABAWD screening); FNS, *Supplemental Nutrition Assistance Program (SNAP) Provisions of the One Big Beautiful Bill Act of 2025 – ABAWD Exceptions – Implementation Memorandum* (Oct. 3, 2025), https://www.fns.usda.gov/snap/obbb-ABAWD-exemptions-implementation-memo (directing state agencies to "immediately screen for and apply" the new exceptions) [hereinafter, "FNS, ABAWD Exceptions – Implementation Memorandum"].
[106] FNS, *Question and Answer #1*; *see also* 7 C.F.R. § 273.24(l).
[107] FNS, *Question and Answer #1*.

V. Procedures & Notices in the Case of Noncompliance

Under the 2025 Reconciliation Act, Congress directs CMS to adopt standards to guide the procedures states will use in the case of noncompliance.[108] This includes the: (1) timeframe for and content of notice of noncompliance; (2) time period an individual is given to make a "satisfactory showing" of compliance or an exemption; and (3) other important procedural protections, including continuation of benefits through this process, *ex parte* review of other possible eligibility categories prior to termination, and the opportunity for a fair hearing to challenge the state's decision. These processes should align with existing CMS regulations regarding Medicaid eligibility denials and terminations.

Process to Make a "Satisfactory Showing"

CMS should explain to states that to make a "satisfactory showing," an individual need only provide the information that the state would need to make an initial determination of compliance, exception, or exclusion. In other words, a satisfactory showing is not a more demanding standard than the verification requirement under § 1396a(xx)(4).

Where an individual is instructed to show compliance, CMS should require that states accept proof of compliance (or an exception or exclusion) through multiple modalities, including through the internet, telephone, mail, in-person, or other commonly available means. The process for providing proof of compliance should also include the ability for an individual to provide the information via "someone acting responsibly" on their behalf. This would align with existing Medicaid regulations.[109] It would also account for the reality that a significant percentage of adults in the U.S. are not digitally literate and will find it difficult to navigate web-based eligibility systems.[110] And, as stated above, the state agency should be required to assist individuals with obtaining whatever verification is required to prove eligibility.[111]

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[108] 42 U.S.C. § 1396a(xx)(6)(A),

[109] 42 C.F.R. § 435.907(a) (listing the modalities in which the state agency must accept "any documentation required to establish eligibility").

[110] John B. Horrigan, Pew Rsch. Ctr., *Digital Readiness Gaps* (2016) https://www.pewresearch.org/internet/2016/09/20/digital-readiness-gaps/ (Digital literacy is the ability to find, evaluate, and communicate information using typing or digital media platforms. As many as 52% of U.S. adults are relatively unprepared to use digital tools, due to limited digital skills and/or mistrust of online information. Women, minorities, and those with less education and lower incomes are more likely to be among this group.); Emily A. Vogels, *Digital divide persists even as americans with lower incomes make gains in tech adoption*, Pew Rsch. Ctr. (June 22, 2021), https://www.pewresearch.org/short-reads/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/ (finding that 24% of adults with household income below $30,000 do not own a smartphone, 43% do not have broadband service at home, 41% do not own a laptop or desktop, and 59% do not own a tablet); Anuj Gangopadhyaya & Michael Karpman, *The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data*, HEALTH SERVS. RSCH. e14624 (2025), https://pubmed.ncbi.nlm.nih.gov/40205643/ (finding that coverage losses associated with Arkansas's prior work requirements "were concentrated among adults without internet access").

[111] 42 C.F.R. § 435.908(a).

Where an individual makes a satisfactory showing, CMS should require states to issue a notice of approval/compliance that provides such feedback. For those who successfully show compliance at this particular stage, a notice of approval will reinforce their understanding of how to navigate the process and what is required. It is also in line with existing Medicaid and SNAP regulations.[112]

CMS should include in the guidance that states have the opportunity to align their existing Medicaid and SNAP verification processes with the 2025 Reconciliation Act's procedures in cases of non-compliance. To do so, CMS should clarify that, after conducting an *ex parte* review to determine compliance with – or an exception or exclusion from – work requirements, that states have the option to send a request for information or other written communication describing what specific information is needed.

Further, the statute does not require states to move directly from the *ex parte* review process described at § 1396a(xx)(5) to issuing notices of non-compliance so long as the state does both. This flexibility will allow states to overlay these new work requirements with existing eligibility processes which, in turn, will mitigate administrative and financial burden on the states.

For those who make a "satisfactory showing" that they are not an "applicable individual" as described in § 1396a(xx)(9)(A), CMS should direct states to remove the individual from further compliance assessments until the state receives notification that the individual no longer meets an exclusion. This can mitigate the risk of churn because it would eliminate unnecessary paperwork and verification demands on the household.[113]

Content of Notices of Noncompliance

Under § 1396a(xx)(6)(B), states are directed to include specific information in notices of non-compliance, including "how such individual may make a satisfactory showing that such requirement does not apply to…[them]…on the basis that…[they]…do[] not meet the definition of applicable individual under paragraph (9)(A)." An "applicable individual" is only an individual who is enrolled (or seeking enrollment) in Medicaid pursuant to § 1396a(a)(10)(A)(i)(VIII) (or, enrolled under a waiver that provides coverage that is equivalent to minimum essential coverage). Accordingly, states should be directed to include a statement in the notice of non-compliance that individuals have the choice of category under 42 C.F.R. § 435.404 and, if they believe they are eligible under one of the

[112] *See id*. §§ 435.916(b)(1)(i), (ii), 435.917(a) (governing Medicaid approvals); 7 C.F.R. § 273.10(g)(1)(i)(A) (governing approvals in SNAP).
[113] *See* Gregory Mills et al., Urban Inst., *Understanding the Rates, Causes, and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP) – Final Report* 74-77 (2014), https://www.urban.org/sites/default/files/publication/33566/413257-Understanding-the-Rates-Causes-and-Costs-of-Churning-in-the-Supplemental-Nutrition-Assistance-Program-SNAP-.PDF (concluding that "[a]ctions to reduce the burden to clients of establishing their eligibility in order to remain on the program" could lead to a reduction in churn).

other available Medicaid categories, then they should notify the agency of that choice (and CMS and/or states should develop a process for accepting that request).

In addition, the title "Notice of Noncompliance" for a document that is not meant to convey ineligibility but instead is meant to instruct individuals about the steps needed to establish or continue eligibility, is likely to lead to confusion among applicants and beneficiaries or worse, lead them to incorrectly believe the state has already reached an adverse eligibility decision and abandon the process.[114] For that reason, states should be given the flexibility to change the title of such notice so long as they include the information required by the statute and CMS. Again, this can mitigate administrative burden on states by allowing them to align current eligibility processes with the new work requirements.

Finally, the notice should contain a clear explanation of the time period in which someone was required to be in actual compliance with the work requirements.[115] The failure to include this information could result in confusion and erroneous denials or terminations and could violate due process.[116] As HHS has acknowledged, awareness and understanding of prior Medicaid work requirements was low.[117] To avoid erroneous denials and terminations

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[114] Civilla, *Human-Centered Work Requirements in Medicaid Report* 6 (2025), https://civilla.org/assets/files/Civilla-Human-Centered-Work-Requirements-Medicaid-Report.pdf (based on past research and experience redesigning benefits access in Michigan, creating a detailed list of notice content in the implementation of the 2025 Reconciliation Act).

[115] *See* 42 U.S.C. § 1396a(xx)(1).

[116] In New Hampshire's implementation of work requirements, the State's notice giving individuals one month to cure a non-compliance issue caused confusion among beneficiaries "because it was unclear whether beneficiaries only needed to make up the shortfall from the previous month, or whether they were required to work a full 100 hours *plus* the hours needed to meet the prior month's shortfall." Ian Hill et al., *New Hampshire's Experience with Medicaid Work Requirements* at 19.

[117] *See, e.g.*, Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Hum. Servs. 5-6 (March 17, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf; HHS, Assistant Sec'y for Plan. & Evaluation, Off. of Health Pol'y, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf (linking low awareness of work requirements and coverage loss); *see also* L.A. Smith et al., *Knowledge of welfare reform program provisions among families of children with chronic conditions*, 92 AM. J. PUB. HEALTH 228, 228-230 (2002), https://pmc.ncbi.nlm.nih.gov/articles/PMC1447047/; Jessica Greene*, Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFS. BLOG (Sept. 5, 2018), https://www.healthaffairs.org/content/forefront/medicaid-recipients-early-experience-arkansas-medicaid-work-requirement (In-depth interviews with 18 adult Medicaid enrollees in Arkansas in September 2018 revealed "a profound lack of awareness" about the work requirements, with two-thirds of the enrollees having not heard of them); Benjamin D. Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 NEJM 1073, 1080 (2019), https://www.nejm.org/doi/full/10.1056/NEJMsr1901772; Benjamin D. Sommers et al., *Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFS. 1522 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/ (finding that as of late 2019, nearly 35% of Arkansans ages 30-49 with Medicaid or Marketplace coverage in the prior year had heard nothing at all about the work requirements policy, and only 5.7% correctly answered that the requirements were not in effect).

due to these complex requirements, CMS should take all necessary steps to ensure states issue clear and accessible written notice.

Termination of Denials Due to Non-Compliance

The Constitution requires notices of an adverse action regarding Medicaid eligibility determinations to be sent prior to termination and to be reasonably calculated to apprise an individual of the intended action.[118] The notice must also include a statement of the specific facts on which the agency relied to determine that an individual failed to comply with the work requirements.[119] When requested in a timely manner, state agencies must continue benefits pending an appeal.[120] CMS should ensure guidance reinforces these critical procedural protections.

Finally, CMS should direct states to update their administrative hearing guidance to hearing officers instructing them to screen for exemptions regardless of whether the individual has raised the argument. This aligns with SNAP regulations requiring states to affirmatively screen for exemptions from work requirements at all stages of the process.[121] It also helps to address the concern that many public benefits recipients have trouble understanding and navigating complex eligibility criteria.[122]

VI. Conclusion

We appreciate your consideration of our comments. If you have questions about these comments, please contact us.

Sincerely,

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[118] *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950).
[119] Due process requires a notice "detailing the reasons for a proposed termination" and including "the legal and factual bases" for the decision. *Goldberg*, 397 U.S. at 267-68. *See also, e.g., Hamby v. Neel*, 368 F.3d 549 (6th Cir. 2004); *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986); *Turner v. Walsh*, 574 F.2d 456 (8th Cir. 1978); *Vargas v. Trainor*, 508 F.2d 485 (7th Cir. 1974); *Baker v. Alaska DHHS*, 191 P.3d 1005 (Alaska 2008).
[120] 42 C.F.R. § 431.231(c) ("The agency must reinstate and continue services until a decision is rendered after a hearing if…[t]he beneficiary requests a hearing within 10 days from the date that the individual receives the notice of action.").
[121] FNS, *Question and Answer #1*; *see also* 7 C.F.R. §§ 273.7(b)(3) (work screening), 273.24(k) (ABAWD screening); *see also* FNS, ABAWD Exceptions – Implementation Memorandum.
[122] *See* note 116, *supra*.

EXHIBIT 27

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMCS Informational Bulletin

DATE: December 8, 2025

FROM: Dan Brillman
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Director, Center for Medicaid and CHIP Services

SUBJECT: **Section 71119 of the "Working Families Tax Cut" Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals**

I. Introduction

On July 4, 2025, President Trump signed Public Law No. 119-21, which the Centers for Medicare & Medicaid Services (CMS) refers to as the "Working Families Tax Cut" (WFTC) legislation, into law. The WFTC legislation included changes to the Medicaid program to be implemented in the coming years, including the introduction of community engagement requirements for certain adults enrolled in Medicaid. Community engagement has potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency.

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III. Overview

The purpose of this Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) is to provide an overview of the Medicaid-related "community engagement" requirement mandated by section 71119 of subchapter D of chapter 1 of subtitle B of title VII of the WFTC legislation ("section 71119"). Implementation of community engagement requirements will necessitate system, policy, and operational changes to state programs in the coming years. CMS is committed to supporting states in this effort and anticipates that ongoing partnership and engagement with states and other stakeholders will inform areas of need for additional guidance, including rulemaking by June 2026. However, we recognize that planning must begin now, as states enter budget and legislative sessions and begin procurement of new systems and services to support implementation of the Medicaid provisions in the WFTC legislation. It is important to note that community engagement is not new to the Medicaid program. Multiple states submitted new section 1115 demonstration requests, prior to the passage of the WFTC legislation, to implement a community engagement program.

Section 71119 ("Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals") amended section 1902 of the Social Security Act (the Act) to add subsection (xx). Section 1902(xx) of the Act requires that "applicable individuals" demonstrate, as a condition of their Medicaid eligibility, "community engagement" (generally, that they work, are enrolled in an educational program, complete community service, participate in a work program, or any combination thereof) for a minimum period of time preceding their application and during their enrollment. "Applicable individuals" are, generally, those eligible to enroll or who are enrolled under the state plan in the adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act ("adult group") or those who generally fit the description of a person eligible under section 1902(a)(10)(A)(i)(VIII) but who are eligible under or enrolled in a section 1115 demonstration that provides minimum essential coverage (MEC) to such a population (rather than under the state plan). Section 1902(xx) of the Act excepts discrete populations from these requirements and excludes members of certain populations from the definition of an "applicable individual."

Section 1902(xx) of the Act applies in any state and the District of Columbia that elects to provide coverage to the adult group under the state plan or to certain individuals through certain section 1115 demonstrations as described further in the next section of this CIB. The community engagement provision is not applicable to the U.S. territories, regardless of whether they elect to cover the adult group. The requirement under section 1902(xx) of the Act to condition Medicaid eligibility on demonstrating community engagement begins January 1, 2027, unless a state opts to implement it sooner through a section 1115 demonstration or the state plan. Before effectuating the community engagement requirement, states must engage in outreach to applicable individuals to inform them of the requirement, and this notice must include an explanation of the exceptions and how an "applicable individual" is defined. The provisions of section 1902(xx) of the Act cannot be waived under section 1115 demonstration authority. Section 71119 of the WFTC legislation requires the Department of Health and Human Services (HHS) to issue grants to states to support implementation of section 1902(xx) of the Act and other WFTC legislation provisions relating to eligibility determinations and redeterminations, and it requires the Secretary of HHS to promulgate an interim final rule to implement section 71119 not later than June 1, 2026.

IV. Applicable Individuals (section 1902(xx)(9)(A)(i)) of the Act)

The Medicaid applicants and beneficiaries who must demonstrate community engagement as a condition of their Medicaid eligibility are those who reside in one of the 50 states or the District of Columbia[1] and who meet the definition of an "applicable individual." An "applicable

[1] Section 1902(xx)(9)(C) of the Act defines "State" for purposes of 1902(xx) to mean one of the 50 states or the District of Columbia. This means that section 1902(xx) of the Act does not apply to the U.S. territories of the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, or the Virgin Islands.

individual" is someone in one of two groups, subject to certain exclusions discussed further below. The first group is individuals who are eligible for or enrolled under the state plan in the adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act. The second group is individuals who are otherwise eligible to enroll or are enrolled "under a waiver of [the] plan" (which would generally be, in this case, a section 1115 demonstration) that provides coverage that meets MEC[2] requirements, and who are: at least 19 and under 65 years of age, not pregnant, not entitled to or enrolled for benefits under Medicare Part A or Part B, and not otherwise eligible to enroll under the state Medicaid plan.

This means that the community engagement requirements in section 1902(xx) do not apply in states that: a) have not adopted the adult group under the state plan; and b) do not have a section 1115 demonstration that offers MEC to individuals who are at least 19 and under 65 years of age, not pregnant, not entitled to or enrolled in Medicare Part A or B, and not otherwise eligible under the state's Medicaid state plan. For example, the community engagement requirements would not apply to an individual in a state that has not implemented the adult group under the state plan and in which the only section 1115 demonstration-based coverage available to a non-pregnant adult who is at least 19 and under 65 years of age who does not have Medicare is through a limited-benefit family planning demonstration (as family planning-only services are not MEC). In some states that have not adopted the adult group under the state plan, community engagement requirements would apply to certain individuals in a section 1115 demonstration. For example, in a state that provides MEC under a section 1115 demonstration to non-pregnant individuals who are at least 19 and under 65 years of age, not entitled to or enrolled in Medicare, and not otherwise eligible to enroll under the state plan, such individuals would need to meet the new requirements, unless an exclusion or exception applies, in order to be eligible for the coverage provided under the demonstration. CMS continues to evaluate which existing state section 1115 demonstration populations meet the definition of an "applicable individual."

V. Community Engagement (section 1902(xx)(2) of the Act)

To meet community engagement requirements in a given month, applicable individuals must do one or more of the following:

(A) Work at least 80 hours.
(B) Complete at least 80 hours of community service.
(C) Participate in a work program (in accordance with the meaning given such term in section 6(o)(1) of the Food and Nutrition Act of 2008) for at least 80 hours.

[2] MEC is defined in section 1902(xx)(9)(A)(i)(II)(aa) of the Act as follows: "as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and as determined in accordance with standards prescribed by the Secretary in regulations."

(D) Be enrolled in an educational program, including an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) and a program of career and technical education (as defined in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006), at least half-time.
(E) Engage in any combination of the activities described in (A) through (D) for a total of at least 80 hours.
(F) Have a monthly income that is not less than the applicable federal minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours; e.g., currently, $7.25 x 80 = $580 per month.[3]
(G) Have had an average monthly income over the preceding 6 months that is not less than the applicable federal minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938 multiplied by 80 hours, and is a seasonal worker, as described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986.

Exclusions from and Exceptions to Community Engagement Requirements

Exclusions (section 1902(xx)(9)(A)(ii) of the Act)

Individuals meeting the definition of a "specified excluded individual" (meaning that they are excluded from the "applicable individual" definition) for part or all of a relevant month are not subject to demonstrating community engagement for that month. The following persons are "specified excluded individuals":

1. An individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the former foster care children eligibility group);

2. An American Indian or Alaska Native who: (A) is an Indian or an Urban Indian (as defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act), (B) is a California Indian (as described in section 809(a) of such Act), or (C) has otherwise been determined eligible as an Indian for the Indian Health Service under HHS regulations;

3. A parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the RAISE Family Caregivers Act, P.L. 115-119)[4] of a dependent child who is 13 years of age and under or of a disabled individual;

4. A veteran with a disability rated as total under 38 U.S.C. § 1155;

5. An individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a

[3] 29 U.S.C. § 206(a)(1)(C).
[4] See https://www.congress.gov/115/statute/STATUTE-132/STATUTE-132-Pg23.pdf.

physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition;

6. An individual who is compliant with any requirements applied by the individual's state Temporary Assistance for Needy Families (TANF) program under section 407 of the Act (relating to "Mandatory Work Requirements"), or who is a member of a household that receives Supplemental Nutrition Assistance Program (SNAP) benefits under the Food and Nutrition Act of 2008 and is not exempt from a work requirement under such Act;[5]
7. A participant in a drug addiction or alcoholic treatment and rehabilitation program (as defined in section 3(h) of the Food and Nutrition Act of 2008);
8. An inmate of a public institution; or
9. A woman who is pregnant or entitled to postpartum medical assistance under section 1902(e)(5) or (16) of the Act.

Exceptions (section 1902(xx)(3) of the Act)

Applicable individuals are excepted from demonstrating community engagement for a month if, for part or all of that month, they are: under the age of 19; entitled to, or enrolled for, benefits under Medicare Part A, or enrolled for benefits under Medicare Part B; or described in a mandatory categorically needy eligibility group in any of subclauses (I) through (VII) of section 1902(a)(10)(A)(i) of the Act.[6] An additional exception applies to an individual who was an inmate of a public institution at any point during the three-month period ending on the first day of a month in which the individual is otherwise subject to the community engagement requirement.

States also have the option, under procedures established by the State (in accordance with standards specified by the Secretary), to provide an exception for "short-term hardship events" for applicable individuals. A state that elects this option must deem an applicable individual as demonstrating community engagement for a month if, for part or all of the month, the individual:

1. receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to the above-listed services) as the Secretary determines appropriate, and the individual requests such an exception;

[5] Further clarification on the scope of the affected individuals is forthcoming.

[6] Sections 1902(a)(10)(A)(i)(I)-(VII) of the Act generally describes the mandatory categorically needy eligibility groups other than the adult group or former foster care children eligibility group.

2. resides in a county or equivalent unit of local government in which: a) an emergency or disaster has been declared by the President pursuant to the National Emergencies Act or Robert T. Stafford Disaster Relief and Emergency Assistance Act; or b) subject to a request from the state to the Secretary, has an unemployment rate that is at or above the lesser of eight percent or 1.5 times the national unemployment rate; or
3. must travel, or their dependent must travel, outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition that are not available in their community of residence, and the individual requests such an exception.

VI. Demonstrating and Verifying Community Engagement

Demonstrating Community Engagement at Application (section 1902(xx)(1)(A) of the Act)

States must require applicable individuals who have filed an application for Medicaid to meet community engagement requirements detailed in section 1902(xx)(2) of the Act for at least one month immediately preceding the month during which the individual applies. States may elect to require that applicable individuals demonstrate community engagement for up to three consecutive months immediately preceding the month of application.

As an illustrative example, a state must require applicable individuals applying for coverage in January 2027 to demonstrate community engagement in December 2026. If a state elects to require that an applicant demonstrate community engagement for two consecutive months prior to the month of application, an applicable individual applying for coverage in January 2027 in that state would need to demonstrate community engagement in November and December 2026. Should a state elect to require applicants to demonstrate community engagement for three months prior to the month of application, an applicable individual applying for coverage in January 2027 in that state would be required to demonstrate community engagement in October, November, and December 2026.

Demonstrating Community Engagement at Renewal (section 1902(xx)(1)(B) and (4) of the Act)

States must require Medicaid beneficiaries who are subject to community engagement to demonstrate compliance for one or more months in between renewals, as part of the state's routine renewal process. Such Medicaid beneficiaries must demonstrate community engagement for one or more months (as specified by the state), whether or not consecutive. CMS interprets this to mean that a beneficiary is considered to have successfully met the requirements if during any part of the eligibility period the beneficiary demonstrated community engagement for the number of months the state specified. Under CMS's interpretation, the state may not dictate the specific months during which an applicable individual must demonstrate community engagement. If the state requires applicable individuals to demonstrate community engagement

for more than one month between renewals, it must permit, but may not require, them to demonstrate community engagement in consecutive months.

Note that, as required by Section 71107 of the WFTC legislation,[7] states will be required to conduct renewals of eligibility once every 6 months, instead of once every 12 months, for a population[8] that significantly overlaps with the population subject to the new community engagement requirements, beginning with renewals initiated on or after January 1, 2027. As such, individuals subject to both of these provisions will be required to demonstrate community engagement at least every 6 months at each subsequent renewal.

In addition to verifying compliance with community engagement at renewal, states may elect to verify compliance with community engagement more frequently between determinations or redeterminations of eligibility for beneficiaries.[9]

Using Reliable Information (section 1902(xx)(5) of the Act)

States must establish processes and first attempt to use reliable information available to the state, including from the individual case record or information obtained through reliable data sources, to establish whether an individual met the community engagement requirement or was not required to do so. Reliable information could come from, for example and without limitation: payroll data, Medicaid provider payments, or encounter data, and data sources about higher education enrollment, job training participation, or community service. The state may not request additional information or documentation unless it is unable to establish that the individual met community engagement requirements (or was not required to do so) using reliable information available to it.

This requirement for a state to use reliable information available to it for these purposes prior to requiring additional information (where possible) applies both at application and at renewal. Similarly, states electing to verify compliance with community engagement requirements more frequently than the renewal schedule are also required to use information available to the state prior to requesting additional information. CMS expects to provide additional guidance on section 1902(xx)(5) of the Act, including guidance on the use of reliable data sources, and instructions on documenting such policies and procedures.

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[7] In accordance with Section 71107(b) of the WFTC legislation, CMS will issue guidance to support states with implementing the requirement to conduct renewals once every 6 months for certain individuals.

[8] Those subject to renewals once every 6 months include almost all individuals enrolled under the state plan in the Medicaid adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act and almost all individuals described in 1902(a)(10)(A)(i)(VIII) who are enrolled in coverage "under a waiver" of the state plan that provides coverage equivalent to MEC to all individuals described at section 1902(a)(10)(A)(i)(VIII) of the Act. Additional details will be provided in the forthcoming guidance referenced in footnote 7.

[9] See section 1902(xx)(4) of the Act.

VII. Procedures in the Case of Non-Compliance (section 1902(xx)(6) of the Act)

If a state cannot establish that someone met the community engagement requirements or was not required to do so, it must provide notice of noncompliance and allow the applicant or beneficiary 30 calendar days from the date such notice is received to demonstrate compliance or show that the requirement does not apply to them. This notice must include information on how to demonstrate compliance or show that the requirement does not apply, and how to reapply for medical assistance if the individual's application is denied or if the beneficiary is disenrolled. A state must continue to provide an enrolled beneficiary with medical assistance during the 30-day period. If no satisfactory showing of compliance with or inapplicability of the requirement is made, the state must determine whether the individual has any other basis for eligibility for Medicaid or another insurance affordability program. The state must then provide written notice and fair hearing rights in accordance with 42 C.F.R. part 431 subpart E (including advance notice in the case of an eligibility termination or other adverse action) and, if there is no other basis for Medicaid eligibility, deny the application or terminate eligibility by the end of the month following the 30-day period.

How Non-Compliance Affects Certain FMAP Increases and Premium Tax Credit Eligibility (section 1902(xx)(7) of the Act)

Certain FMAP Increases (section 1902(xx)(7)(A) of the Act)

Section 1902(xx)(7)(A) of the Act directs that a state shall not be treated as not providing medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII), or as not expending amounts for all such individuals under the Medicaid state plan or waiver of the plan, solely because it has determined that such an individual is ineligible for Medicaid due to a failure to demonstrate community engagement.

Premium Tax Credit Eligibility (section 1902(xx)(7)(B) of the Act)

An individual who is eligible for Medicaid coverage that provides MEC is generally not eligible for advance payments of the premium tax credit (APTC) and premium tax credits (PTC) used to pay for coverage on a Health Insurance Exchange. Under section 1902(xx)(7)(B) of the Act, an individual is deemed to be eligible for MEC if the individual would have been eligible for Medicaid but for their failure to meet community engagement requirements. As such, an applicable individual who does not demonstrate community engagement and would otherwise be eligible for Medicaid is precluded from eligibility for APTC and PTC.

VIII. Outreach to Applicable Individuals (section 1902(xx)(8) of the Act)

Prior to initial implementation of these community engagement requirements in a state, and periodically thereafter, states are required to notify beneficiaries who are applicable individuals of the requirement to demonstrate community engagement. This outreach notice must include

information on how to comply with the community engagement requirements, including an explanation of the definition of an "applicable individual" and the exceptions; the consequences of non-compliance; and how to report a change in status that could result in the individual qualifying as a specified excluded individual, meeting an exception, or being subject to the community engagement requirement after an exclusion or exception ends.

States must provide this outreach notice to the beneficiary by mail (or in an electronic format, if elected by the individual), and one or more additional formats. Additional formats may include telephone, text message, an internet website, other commonly available electronic means, and other formats the Secretary determines appropriate.

States must notify applicable individuals before implementing community engagement requirements on a timeframe that is based on the state's implementation date (i.e., either January 1, 2027, or an earlier date selected by the state) and the number of consecutive months a state requires applicable individuals to demonstrate community engagement at application. The set number of months prior to initial implementation that outreach is required in a particular state is determined by adding three months to the number of months a state requires an applicable individual to demonstrate community engagement at application. As such, states requiring an applicable individual to demonstrate one, two, or three months of community engagement at application would be required to begin outreach no later than September, August, or July 2026, respectively, for implementation on January 1, 2027. For a visual representation of these outreach timelines, reference the Appendix.

IX. Managed Care Plan Role (WFTC legislation Section 71119(c))

States are prohibited from using Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or other contractors with direct or indirect financial relationships to MCOs, PIHPs, or PAHPs to determine beneficiary compliance with community engagement requirements. There is no other prohibition in the statute on states choosing to delegate some support activities to managed care plans to support states' successful implementation of community engagement requirements. CMS expects to issue further guidance on the potential role that managed care plans can appropriately play in activities that are not related to determining beneficiary compliance.

X. Timeline for Implementation, and Temporary Exemption for Good Faith Effort (Section 1902(xx)(1) and (11) of the Act)

Section 1902(xx)(1) of the Act requires that states implement the new community engagement requirements beginning January 1, 2027, although states may elect an earlier implementation date via a section 1115 demonstration or through a state plan amendment. States interested in an earlier implementation should contact CMS for more details.

The Secretary of Health and Human Services has the authority to provide states with a temporary good-faith-effort exemption to delay implementation of community engagement requirements. To receive a temporary exemption, a state must submit a request to the Secretary, and the Secretary needs to determine that, based on the request, the state is demonstrating a good-faith effort to comply with the statutory requirements. In considering whether a state is demonstrating a good-faith effort, the Secretary will consider actions taken by the state toward compliance, any significant barriers or challenges to meeting the requirements that the state has faced or continues to face, the state's detailed plan and timeline for achieving full compliance, and any other criteria the Secretary determines appropriate. Good-faith-effort exemptions, if granted by the Secretary, must expire no later than December 31, 2028, consistent with section 1902(xx)(11)(C)(i) of the Act. The Secretary may terminate any granted exemptions early if a state fails to comply with quarterly reporting requirements or ceases making good-faith compliance efforts. Good-faith-effort exemptions will be considered on a case-by-case basis and will be approved only for states that make the required showing; in general, CMS anticipates that approvals will be limited to states that are making meaningful efforts towards implementation and experience severe and/or unexpected issues that hinder their progress.

XI. Financial Resources for States

Government Efficiency Grants to States (WFTC legislation Section 71119(e))

Federal funding totaling $200 million for fiscal year 2026 is available for the 50 states and the District of Columbia to establish systems necessary to carry out section 71119 of the WFTC legislation and other sections of WFTC legislation, title VII, subtitle B, chapter 1 related to conducting eligibility determinations or redeterminations. CMS will award states funding through two mechanisms: 1) $100 million distributed equally among all 50 states and the District of Columbia, and 2) $100 million distributed to the 50 states and the District of Columbia based on their share of individuals subject to community engagement relative to the total number of such individuals across all 50 states and the District of Columbia, as of March 31, 2025.

Medicaid Information Technology (IT) System Costs

These new requirements should function seamlessly with new and existing system functionality. It is important for states to ensure the vendors supporting their community engagement implementation clearly understand their role and expectations. Without proper alignment between policy design and technological capabilities, states may create administrative burdens that undermine program effectiveness and cost-efficiency. When establishing state-specific policies related to community engagement, states should consult with their system implementation teams to ensure policies can be operationalized in their systems.

CMS recognizes the program changes will require information technology (IT) system work to fulfill policy implementation. Certain state Medicaid agency IT system costs necessary to

support the community engagement requirements may be eligible for enhanced federal financial participation (FFP). Approval of enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for 90/10 enhanced match for the design, development, and installation of their Medicaid Enterprise Systems (MES) initiatives contributing to the economic and efficient operation of the program. States may also submit an APD to request 75/25 enhanced match for ongoing operations of CMS- approved systems.

States should refer to 45 C.F.R. Part 95 Subpart F – *Automatic Data Processing Equipment and Services-Conditions for FFP* for the specifics related to APD submission.

States should refer to 42 C.F.R. Part 433 Subpart C – *Mechanized Claims Processing and Information Retrieval Systems* for the specifics related to systems approval and claiming enhanced FFP.

XII. Closing

CMS recognizes implementing Section 71119 of the WFTC legislation is a significant undertaking for states that will require policy, operational, and system changes. CMS is currently developing the required interim final rulemaking along with additional guidance on the new requirements. CMS is available to answer questions and provide technical assistance to states; requests can be directed to MedicaidWorks@cms.hhs.gov.

Appendix: State Options for Initial Community Engagement Beneficiary Outreach and Compliance Review Periods at Application

Based on the statutory implementation date of January 1, 2027, the following graphic depicts state options for timelines accounting for the required three months of initial outreach to existing beneficiaries and the state's "review period" – how many months an applicable individual must demonstrate community engagement to qualify for Medicaid at application (one to three months, at state option).

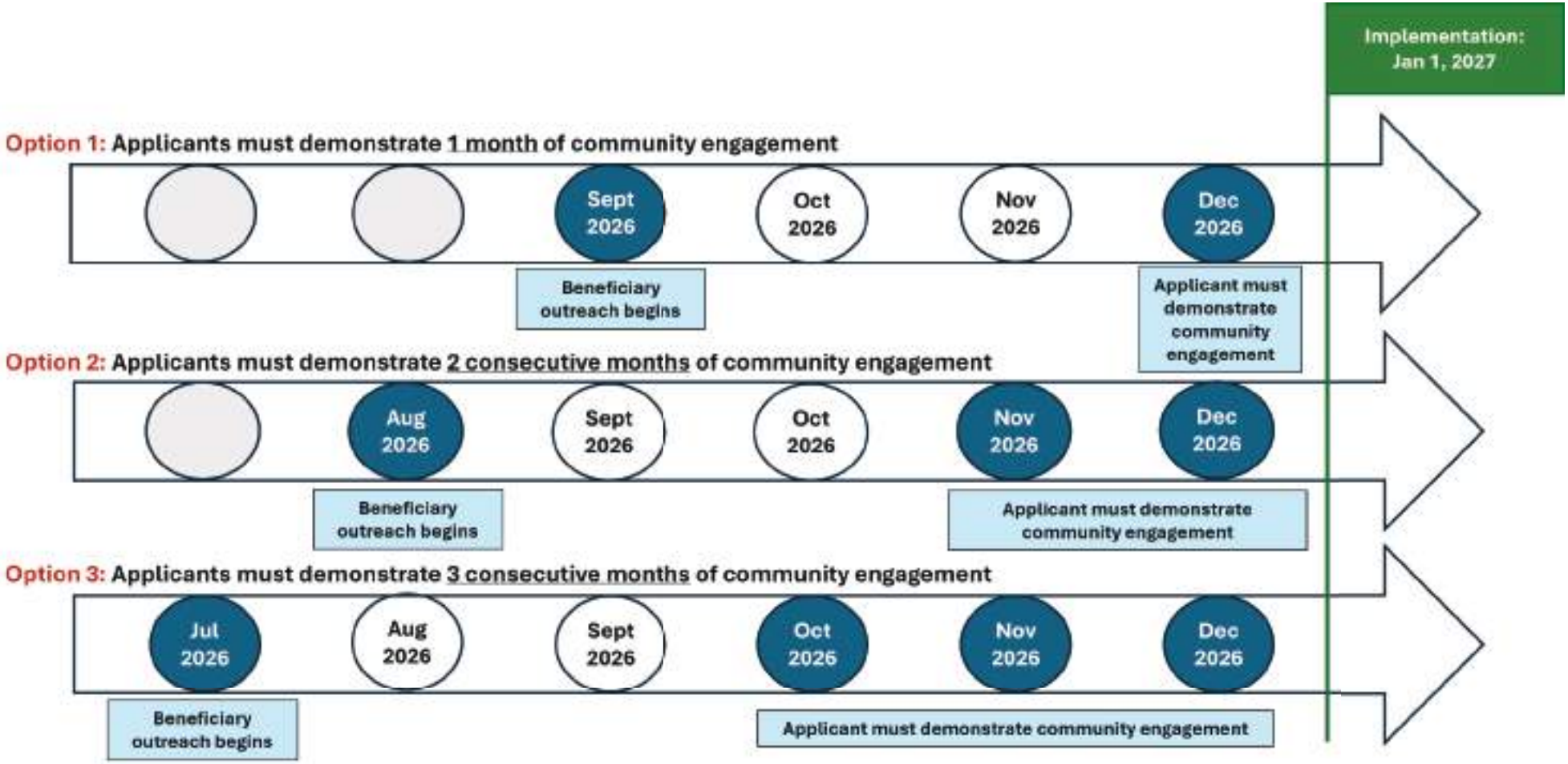

EXHIBIT 28

Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018

Lucy Chen, BS, BA, and Benjamin D. Sommers, MD, PhD

Objectives. To identify risk factors for Medicaid disenrollment after the implementation of Arkansas's work requirements.

Methods. Using a 2018 telephone survey of 1208 low-income adults aged 30 to 49 years in Arkansas (expansion state with work requirements implemented in June 2018), Kentucky (expansion state with proposed work requirements blocked by courts), Louisiana (expansion state without work requirements), and Texas (nonexpansion state), we assessed Medicaid disenrollment rates among the age group targeted by Arkansas's policy.

Results. The Medicaid disenrollment rate was highest in Texas (12.8%), followed by Arkansas (10.5%), Kentucky (5.8%), and Louisiana (2.8%). Over half of those who disenrolled in Texas and Arkansas became uninsured, compared with less than a quarter in Kentucky and Louisiana. In multivariate models, Arkansas had significantly higher disenrollment compared with the 3 comparison states; men and non-Hispanic Whites experienced higher disenrollment than women and racial minorities. In Arkansas, having a chronic condition was associated with higher disenrollment.

Conclusions. As states debate work requirements and Medicaid reforms, our findings provide insights for policymakers about which populations may be most vulnerable to losing Medicaid coverage. (*Am J Public Health.* 2020;110:1208–1210. doi:10.2105/AJPH.2020.305697)

Medicaid churn (i.e., disruptions in coverage) is common, and low-income nonelderly adults who disenroll from Medicaid often become uninsured and experience reduced access to care.[1] Prior work has shown that Medicaid expansion is associated with reduced churning.[2–5] Better understanding the characteristics of those who disenroll is especially relevant now that 20 states have proposed work requirements, which may exacerbate disenrollment. In Arkansas, the first state that implemented work requirements, over 18 000 individuals lost coverage before a federal judge halted the program, and recent research found that the work requirement was associated with an increased uninsured rate.[6] Starting in June 2018, Arkansans were disenrolled if they did not meet monthly online reporting requirements for 3 months, demonstrating at least 80 hours per month of work or another qualifying community engagement activity (e.g., job training or community service) or an exemption (e.g., disability or pregnancy).

As policymakers consider alternative approaches in Medicaid, it is important to understand risk factors for disenrollment. Although some individuals disenroll after losing eligibility, prior literature shows that increased administrative burdens also lead to higher churn among those still eligible.[7] Demographic and health characteristics may be risk factors, as individuals in rural areas may have fewer job opportunities or those with less education may face challenges reporting.[8] The potential impact of these policies on racial disparities is also an important public health issue. We examined Medicaid disenrollment rates in Arkansas and 3 comparison states after implementation of work requirements and assessed risk factors for disenrollment.

METHODS

We conducted a random digit-dialing telephone survey among US citizens aged 30 to 49 years in Arkansas (n = 610), Kentucky (n = 212), Louisiana (n = 144), and Texas (n = 242) with self-reported family income below 138% of the Department of Health and Human Services' federal poverty level. We focused on this age group because Arkansas implemented work requirements for those aged 30 to 49 years, and we oversampled for Arkansas because it was the only state with work requirements in effect at the time of the survey.

In Kentucky, work requirements were approved in early 2018 but were blocked in June 2018, before our survey was conducted, and were never implemented. Louisiana is an expansion state without work requirements. As a nonexpansion state, Texas is another useful comparator, because in some states, expansion with work requirements has been proposed as a compromise between traditional expansion and nonexpansion.

Conducted in late 2018 on landlines and cellphones in English and Spanish, the survey had a response rate of 14%, similar to those of other widely cited telephone surveys.[9] We weighted survey estimates to account for potential nonresponse bias, and prior survey

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TABLE 1—Characteristics of Low-Income Adults Aged 30 to 49 Years Who Were Ever on Medicaid in the Past Year: 4 US States, November–December 2018

	Arkansas (n = 408), %	Kentucky (n = 149), %	Louisiana (n = 91), %	Texas (n = 118), %
Disenrolled from Medicaid in the past year	10.5	5.8	2.8	12.8
Currently on Medicaid	89.5	94.2	97.2	87.2
Female	63.5	65.2	71.4	68.5
Race/ethnicity				
Hispanic	3.4	1.2	4.8	43.7
Non-Hispanic White	62.7	87.1	37.2	24.5
Non-Hispanic Black	28.4	8.8	54.9	29.6
Other non-Hispanic[a]	5.6	2.9	3.2	2.2
< high school diploma	16.7	16.0	35.6	29.0
Income < 50% FPL	38.8	27.6	41.2	29.9
Rural	48.5	56.2	29.5	15.1
Any chronic health condition[b]	80.0	83.6	77.1	74.3
Fair or poor health status	49.6	43.7	51.1	50.0

Note. FPL = federal poverty level (per Department of Health and Human Services). Respondents who did not report current Medicaid coverage were asked if they had disenrolled from Medicaid in the past 12 months. Using a χ^2 test comparing respondents in Arkansas with those in the 3 control states, we found that disenrollment rates did not significantly differ ($P = .22$).

Source. Authors' analysis of data from a November–December 2018 telephone survey of 766 US citizens aged 30 to 49 years with self-reported family incomes less than 138% of the FPL who reported that they were ever on Medicaid in the previous year (either currently on Medicaid or disenrolled from Medicaid in the past 12 months).

[a]"Other non-Hispanic" included Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or self-reported other race not previously listed.

[b]Chronic health conditions included hypertension, coronary artery disease, asthma, chronic obstructive pulmonary disease, diabetes, depression, anxiety, cancer, or substance use disorder.

waves have been validated against federal government survey data.[10]

Outcomes

Our primary outcomes were Medicaid coverage and uninsured rates at the time of the survey, and the share who reported losing Medicaid in the previous 12 months. We then calculated state-specific disenrollment rates by dividing the share that lost Medicaid by the share that had ever been on Medicaid in the past year.

Statistical Analysis

Multivariate linear regression models identified predictors of disenrollment among those who had been on Medicaid (n = 766). We included state, race/ethnicity, gender, income, education, urban versus rural residence, presence of at least 1 of 9 common chronic conditions (hypertension, coronary artery disease, asthma, chronic obstructive pulmonary disease, diabetes, depression, anxiety, substance use disorder, and cancer), and self-reported fair or poor health. We estimated robust standard errors.

RESULTS

In our sample of 1208 low-income citizens aged 30 to 49 years, current Medicaid coverage was reported by 59.6% of Arkansans, 63.4% of Kentuckians, 63.4% of Louisianans, and 43.7% of Texans. By state, 7.0% of Arkansans, 3.9% of Kentuckians, 1.8% of Louisianans, and 6.4% of Texans reported dropping out of Medicaid in the past 12 months. For overall uninsurance rates, 14.6% of Arkansans, 6.9% of Kentuckians, 9.7% of Louisianans, and 29.3% of Texans reported being uninsured.

The Medicaid disenrollment rate was highest in Texas (12.8%), followed by Arkansas (10.5%), Kentucky (5.8%), and Louisiana (2.8%; Table 1). Over half of those who disenrolled in Texas and Arkansas reported being uninsured at the time of the survey, compared with 20.4% in Kentucky. In Louisiana, there was a single disenrolled individual, who obtained other coverage.

In the multivariate model, living in Arkansas was associated with a significantly higher disenrollment rate, compared with living in Kentucky, Louisiana, or Texas ($P < .05$; Table A, available as a supplement to the online version of this article at http://www.ajph.org). In all 4 states, men (compared with women) and non-Hispanic Whites (compared with non-Hispanic Blacks) were more likely to disenroll. In Arkansas, those with any chronic condition were more likely to disenroll (compared with those with none). Results were similar when we used multivariate logistic regression (Table B, available as a supplement to the online version of this article at http://www.ajph.org).

DISCUSSION

Our results suggest that state policies may play an important role in shaping Medicaid

disenrollment rates. The disenrollment rate was significantly higher in Arkansas, after adjustment for covariates, than in the control states. This is consistent with other published evidence that many in Arkansas lost coverage in association with the new work requirements.[6,11,12] We found higher disenrollment rates among non-Hispanic Whites and men. These findings are similar to Medicaid disenrollment patterns before enactment of the Affordable Care Act,[8] and suggest that these groups may be less attached to the health care system or public insurance. Qualitative research may help further unpack these differences in churning rates in Arkansas.

Those with any chronic condition were also more likely to disenroll in Arkansas, raising concerns about potential adverse health impacts. Although our sample sizes for the 3 control states were small and not powered to detect differences between them, the pattern of disenrollment rates was suggestive. The highest rate was in Texas, a nonexpansion state, consistent with studies showing that expansion itself reduces churn.[2–5] The lowest rate was in Louisiana, which expanded Medicaid and had no work requirement waiver.

Limitations

Our questions about disenrollment applied to a small sample of respondents. We also only asked individuals whether they disenrolled from Medicaid; because Arkansas expanded through use of the private option (i.e., using Medicaid funds for subsidized Marketplace coverage), we may not have fully captured those who lost Marketplace coverage, which could underestimate the disenrollment rate. We were unable to evaluate how much churn was directly due to work requirements, since prior work showed that many beneficiaries were unaware of the policy, suggesting likely confusion about any coverage losses.[6] Finally, our survey relied on self-reported data, which is not as accurate as enrollment data for studying churn. However, we were able to identify uninsured individuals.

Implications and Conclusions

Access to care is an important public health challenge, and improving Medicaid retention is a key strategy to increase access. Our study found that Medicaid work requirements in Arkansas—which substantially increased the administrative burden of remaining enrolled—were associated with worsened Medicaid retention, compared with states without work requirements. Of note, those with chronic conditions were more likely to lose Medicaid in Arkansas, which may raise concerns about the distributional impacts and health effects of work requirements. As Medicaid reforms such as work requirements continue to be considered, it is important to understand how they may affect enrollment. AJPH

CONTRIBUTORS

L. Chen and B. D. Sommers conceptualized and designed the study and gave final approval of the version to be published. L. Chen analyzed the data and drafted the initial manuscript. B. D. Sommers reviewed the results, significantly contributed to the manuscript, and critically edited it for important intellectual content.

ACKNOWLEDGMENTS

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Note. The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the funders.

CONFLICTS OF INTEREST

The authors declare that they have no financial conflicts of interest.

HUMAN PARTICIPANT PROTECTION

This study was deemed exempt by the institutional review board of the Harvard T. H. Chan School of Public Health.

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EXHIBIT 29

Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements

December 17, 2025
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Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements

LINCOLN, NE – Governor Jim Pillen was joined by Dr. Mehmet Oz, administrator of the Centers for Medicare & Medicaid Services, and Nebraska Department of Health and Human Services (DHHS) CEO Steve Corsi in announcing that Nebraska is the first state in the nation to pursue work requirements for Medicaid expansion members. At the news conference today, Gov. Pillen signed a letter to CMS, detailing Nebraska's intent to implement requirements by May 1, 2026.

The new work requirements are the result of HR1, the One Big Beautiful Bill. Among its key provisions is a requirement that able-bodied adults in the Medicaid expansion population engage in work or other qualifying activities as a condition of receiving Medicaid benefits.

Governor Pillen praised the Trump administration for passage of the OBBB and emphasized that the policy will promote long-term independence and stronger community ties.

"These requirements will help Nebraskans achieve greater self-sufficiency through employment and other meaningful activities," said Governor Pillen. "Working not only provides purpose but helps people become active, productive members of their communities. Nebraska will be ready to move forward with these requirements prior to the federally mandated start of Jan. 1, 2027."

Under the new rules, able-bodied adults ages 19–64 in the Medicaid expansion population will be required to participate in work, approved work programs, community service, or educational activities for at least 80 hours per month, unless they qualify for an exemption.

*"*Across the nation, our goal is to support people engaged in meaningful work, involved in their communities, and connected to the support that sets them up for long-term success," said CMS Administrator Dr. Mehmet Oz. "Nebraska is leading the way as the first state to launch its community engagement requirements, and we congratulate Governor Pillen and his team for

their commitment to helping more Nebraskans move toward greater independence and opportunity. CMS will be working together with Nebraska and its 50 counterparts to ensure every program is implemented smoothly, responsibly, and in compliance with federal law."

This reform will deliver meaningful benefits to Nebraskans. Work requirements are associated with higher and more stable incomes, greater success in securing better-paying employment, and access to benefits that extend beyond what government assistance alone can provide.

Most importantly, children in working households benefit from more stable routines, improved educational outcomes, and stronger examples of workforce participation. Higher employment rates are also linked to lower crime rates, increased civic engagement, and a stronger economy.

DHHS CEO Steve Corsi said not only will these changes help more Nebraskans move toward economic stability, it will also help Nebraska's businesses and economy.

"Employment provides financial stability, fosters personal growth, and will help Nebraska's small businesses in need of workers," said Corsi. "These new requirements move Nebraska forward by encouraging greater economic and social participation."

Current Nebraska Medicaid members will be assessed for the new requirements during their regularly scheduled renewal after the implementation date. Individuals applying for Medicaid on or after May 1, 2026**,** will need to provide verification of their community engagement activities or qualifying exemption.

Of particular note:

- The rule changes apply to able-bodied adults ages 19-64 in the Medicaid expansion population.
- Medicaid expansion includes individuals 19-64 with low incomes who receive health coverage through Nebraska Medicaid.
- Eligibility is based on income up to 138 percent of the federal poverty level (in 2025 for a single person was $21,610, or for a family of four was $44,380).
- Work requirement activities are requirements that Medicaid expansion members and applicants must meet in order to receive coverage through Nebraska Medicaid.
- Qualifying work requirement activities include employment, attendance at school, participation in an apprenticeship, participation in an approved work program, or volunteering.

Nebraska Medicaid will use available data to verify compliance during application and renewal. If verification cannot be completed, members will be responsible for submitting documentation. Individuals found non-compliant will receive notice and have 30 days to meet the requirement or claim an exemption before denial or disenrollment.

Exemptions:

Certain individuals are excluded from this requirement, including:

- People who are disabled

- People who are currently in foster care
- People through age 25 who aged out of foster care
- Members of recognized Native American tribes
- Pregnant women
- Parents or guardians of children up to age 13
- Caregiver of an individual with disabilities
- Disabled veterans (with a ‘total’ disability status)
- People who are medically frail
- People compliant with work requirements under the SNAP or TANF programs
- People receiving treatment for a substance use disorder
- People who are incarcerated or have been within the last 90 days
- People who qualify for Medicare Part A or Part B

Individuals seeking assistance with employment opportunities may use the Nebraska Department of Labor’s **NEworks** job service at neworks.nebraska.gov (https://neworks.nebraska.gov/vosnet/default.aspx) or download the NEworks mobile app from the App Store or Google Play.

DHHS will send a notice by mail, email, or text to beneficiaries who must participate in community engagement (or have an exemption). More information regarding the requirement can be found at dhhs.ne.gov/workrequirements (https://dhhs.ne.gov/Pages/WorkRequirements.aspx).

EXHIBIT 30

SICKLE CELL DISEASE PARTNERSHIP

Via Electronic Submission

October 22, 2025

The Honorable Mehmet Oz, M.D.
Administrator of the Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: Medicaid Community Engagement Requirements for Americans with Sickle Cell Disease

Dear Administrator Oz,

The Sickle Cell Disease Partnership[i] (Partnership) is a public policy and advocacy collaboration of patient advocates, health care providers, biopharmaceutical manufacturers, and other health care stakeholders committed to advancing policies that will improve the lives of those living with Sickle Cell Disease (SCD). In 2022, the Partnership was founded under the leadership of Brett Giroir, M.D., who served as HHS Assistant Secretary for Health in the first Trump Administration. The goal of the Partnership is to advance actionable federal health care policies that improve the lives of individuals living with SCD, informed through the Trump Administration-funded National Academies blueprint[ii] for SCD.

The American Society of Pediatric Hematology/Oncology[iii] (ASPHO) joins the Partnership on this letter. Founded in 1981, ASPHO is the professional membership organization for over 2,000 physicians and other health care professionals dedicated to promoting the optimal care of children, adolescents, and young adults with blood disorders and cancer by advancing research, education, treatment, and professional practice. ASPHO sponsors educational and professional development programs and co-sponsors the *Pediatric Blood & Cancer* journal. ASPHO works in partnership with appropriate organizations to advance its health policy and advocacy priorities related to childhood cancer and blood disorders to ensure individuals of all backgrounds receive necessary care.

The Partnership and ASPHO are grateful to see the Trump Administration's continued support of Americans with SCD, including through continuing the Centers for Medicare and Medicaid Services (CMS) Innovation Center's Cell and Gene Therapy Access Model, an innovative payment model for SCD gene therapies. In addition, the Partnership and ASPHO were appreciative to see you and Health and Human Services (HHS) Secretary Kennedy both verbally affirm their support for Americans with SCD during their confirmation hearings. Your commitment to helping Americans impacted by SCD is appreciated.

As your agency works to promulgate regulations implementing the Medicaid community engagement requirements of OBBBA, P.L. 119-21, the Partnership and ASPHO are writing to convey our perspective about how the Administration can best help to protect Americans with SCD and to request a meeting with you to further discuss. Based on our careful review of data and discussions across multiple stakeholders, the Partnership and ASPHO request that in its forthcoming guidance, CMS categorically exclude Americans with SCD from Medicaid community engagement requirements, or otherwise issue practical guidance for states to ensure exceptions for Americans with SCD. The severity of the disease, the importance of continuous coverage to access care, sudden pain crises and complications, and the

disruptions these Americans face to consistently work create legitimate barriers to meeting the requirements for community engagement. The reasoning for such an exclusion is delineated in the following sections below, and the Partnership and ASPHO would like to further discuss with you in a meeting.

The Severity of SCD and the Importance of Medicaid Coverage

SCD is a chronic, debilitating disease that is also the most common inherited blood disorder in the United States.[iv] Although it is a rare disease, SCD affects more than 100,000 Americans – about half of whom are enrolled in Medicaid. Americans living with SCD face severe health complications, including recurring and life-altering pain crises, repeat infection, acute chest syndrome, lung problems, severe and chronic pain, leg ulcers, organ damage, and stroke. Due to inadequacies in comprehensive care management, only about 1 in 4 patients with SCD receive a standard of care described in guidelines,[v] resulting in Americans with SCD needing to visit the emergency department far more often than the average population.[vi] These and other factors increase the cost of care for Americans with SCD and on the system overall. As a result of systemic inadequacies and the severity of the disease, Americans with SCD have an estimated life expectancy that is over two decades shorter than the average life expectancy in the nation.

The importance of continuous Medicaid coverage for SCD cannot be overstated. Approximately 52,524 Medicaid enrollees had SCD in 2021,[vii] representing about half of all Americans with SCD. Further, about half of Americans with SCD have severe forms of the disease, requiring more frequent medical care.[viii] When coverage is inconsistent, Americans with SCD face barriers to accessing the medical care they need, leading to heightened health care costs and higher emergency room utilization. For example, without continuous coverage, SCD patients become reliant on emergency services, contributing to $2.4 billion in avoidable annual ED costs according to government data.[ix]

The Partnership and ASPHO are concerned that community engagement requirements may increase churn in Medicaid enrollment for Americans with SCD, meaning enrollees with SCD would cycle on and off of coverage, often due to stringent reporting requirements rather than not meeting the community engagement requirements themselves. In SCD, the disease trajectory makes it difficult to consistently adhere to community engagement requirements, creating more opportunities for coverage loss compared to a healthy individual without the disease.

How SCD Hampers an Individual's Ability to Work

SCD interrupts work primarily through unpredictable, recurrent vaso-occlusive (VOC) pain crises, which occur when sickled cells traveling through small blood vessels get stuck and block blood flow throughout the body.[x] VOC pain crises can occur suddenly and severely, causing pain in the hands, feet, chest, and back, in addition to ongoing chronic pain throughout one's lifetime.[xi] VOC can lead to emergency room or extended inpatient care, which accumulates into repeated absences, reduced on-the-job productivity, and, over time, decreased labor force participation. Lost wages begin in early adulthood and intensify with crisis frequency.

While the specific frequency of VOC pain crises can vary, up to 67 percent of Americans with SCD experience at least three VOC pain crises per year.[xii] The typical hospital admission length for severe pain crises is five days,[xiii] with an average of 1-3 admissions per year.[xiv] One survey found that 17.5 percent of adults with SCD had missed more than ten days of work in the previous year due to SCD complications.[xv] In another survey, adults with at least four VOC pain crises per year missed an estimated 35 percent of scheduled work hours per week.[xvi] Furthermore, employment status declines as disease severity increases:

each additional annual hospitalization raises the odds of being unemployed by 33 percent.[xvii] Ultimately, modeled lifetime earnings are $695,000 lower than for peers of similar demographics without SCD.[xviii]

Given the severity and recurring nature of VOC pain crises – and despite wanting to contribute to the workforce – fewer than one-third of adults with SCD maintain steady work.[xix] Therefore, community engagement requirements tying coverage to work-hour or volunteer or education thresholds for Americans with SCD risks butting up against with the realities clinical needs of Americans SCD. Irrespective of the intent behind community engagement requirements, if CMS guidance does not specifically exempt Americans with SCD, through the varied process of states' implementation, the Partnership is concerned that administrative processes and practical implications from this policy could inadvertently disrupt access to coverage – which would delay access to care and increase crisis frequency, which would increase emergency room and inpatient visits, causing personal and program costs to climb.

Regulatory Request

With these challenges in mind, the Partnership and ASPHO urge CMS to leverage its regulatory authority in implementing the community engagement requirements of OBBBA P.L. 119-21 to exempt Americans with SCD from such requirements. Section 71119 of the Act provides that states must require certain Medicaid enrollees to complete 80 hours per month of qualifying activities (i.e., work, community service, work program, half-time education, or income equivalent) to maintain eligibility. However, the statute also provides for mandatory exceptions from community engagement requirements, to be further defined by the HHS Secretary via regulation, and the statute allows CMS to grant state flexibility in implementation of the requirements. As such, the Partnership and ASPHO urge CMS to take the following actions when it implements OBBBA, listed in order of priority to protect Medicaid enrollees who have SCD:

1. **Exclude Americans with SCD from community engagement requirements under the authority provided to the Secretary to define "medically frail," "special medical needs," "physical [] disability," and/or "complex medical condition."** (Pub. L. 119-21, Sec. 71119(a); (xx)(9)(A)(ii)(V)). Given repeat pain crises, hospitalizations, severe health complications, and the above-delineated impact on activities of daily living, these terms plainly encompass Americans with SCD. Without an exclusion specific to people with SCD, patients will face disruptions in coverage – worsening health outcomes and increasing health care costs. CMS has previously defined "complex medical condition" to include SCD in its letter to State Medicaid Directors regarding the implementation of Section 1945A of the Social Security Act, enacted as part of the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), which authorizes states to cover an optional health home state plan benefit for Medicaid-eligible children with medically complex conditions.[xx]

   Additionally, without an exclusion, the state administrative burden significantly increases in the case of SCD due to frequent good-cause requests, appeals, and verifications through hospitals and enrollees. More broadly, if the Secretary articulates specific conditions, such as SCD, that HHS considers to meet the mandatory exception requirements because they fall under these terms, HHS would reduce the administrative burden for states by simplifying the exceptions process.

   Finally, HHS should emphasize that states should not verify compliance with community engagement requirements for Americans with SCD more than once during the standard determination/redetermination process. (See below, Section 2c, for additional information).

2. **If CMS decides not to name SCD as a condition meeting a mandatory exclusion in full, the Partnership urges CMS to include practical implementation guidance for states that makes clear the following:**

    a. **Specifics on how to deem an individual to have met a specified exclusion.** (Pub. L. 119-21, Sec. 71119(a); (xx)(9)(A)(ii)(V)).
    To ensure Americans with SCD are properly excluded from community engagement requirements when provided for by law, HHS should equip states with the disease criteria and clinical markers that they should use to help determine whether an individual with SCD meets a specified exclusion, including for medical frailty, special medical needs, physical disability, or a serious or complex medical condition. These criteria should reflect the episodic and unpredictable nature of SCD, which can often interfere with the ability to maintain consistent work or community engagement.

    b. **SCD emergency room visits, hospitalizations, pain crises, and transfusions qualify as either "inpatient hospital services" or "other services of similar acuity" under the state-optional hardship exception rules.** (Pub. L. 119-21, Sec. 71119(a); (xx)(3)(B)(ii)(I)).
    The state-optional hardship rules allow a state to except certain Medicaid enrollees from community engagement requirements for the month in which the enrollee experiences a qualifying short-term hardship event. HHS should make it clear that states can automatically except an individual with SCD under the state-optional hardship rules given a documented emergency room visit, hospitalization, transfusion, or other complication due to SCD during a particular month.

    c. **When making ex parte verifications, states should use all information available to it to determine whether an individual with SCD is excluded from community engagement requirements or meets the requirements for a state-optional hardship rule.** (Pub. L. 119-21, Sec. 71119(a); (xx)(5)).
    In making ex parte verifications for the purpose of verifying whether an individual has met the requirements for an exclusion or a state-optional hardship rule, states must follow standards established by HHS and use reliable information available to the state in making such a determination. HHS should emphasize that states should not verify compliance with community engagement requirements for Americans with SCD more than once during the standard determination/redetermination process. HHS should also advise states to work closely with providers to determine applicable diagnosis codes which may exclude an individual from community engagement for a period of time – allowing the state to better determine when an individual meets an exception based on health care services provided without burdening that individual with administrative paperwork to maintain continuity in coverage.

We look forward to collaborating with CMS to ensure Americans with SCD have continuity in care under Medicaid and that they receive the flexibilities permitted by law when subject to community engagement requirements. Please use Liz Hassett (Elizabeth.Hassett@LeavittPartners.com) as a point of contact for the Partnership, and Sally Weir (sweir@aspho.org) as a point of contact for ASPHO.

Respectfully,

The Sickle Cell Disease Partnership
The American Society of Pediatric Hematology/Oncology

[i] https://www.sicklecellpartnership.org/
[ii] https://www.nationalacademies.org/our-work/addressing-sickle-cell-disease-a-strategic-plan-and-blueprint-for-action
[iii] https://aspho.org/
[iv] https://www.hematology.org/education/patients/anemia/sickle-cell-disease
[v] https://minorityhealth.hhs.gov/news/coming-together-confront-sickle-cell-disease
[vi] https://www.jscimedcentral.com/public/assets/articles/hematology-3-1037.pdf
[vii] https://www.norc.org/research/library/spotlight-new-analysis-of-sickle-cell-disease-prevalence-among-medicaid-enrollees.html
[viii] https://pmc.ncbi.nlm.nih.gov/articles/PMC9898623/
[ix] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Opioid-Prescription-in-Medicare-Beneficiaries-Report.pdf
[x] https://www.cdc.gov/sickle-cell/complications/pain.html
[xi] *Id.*
[xii] https://pmc.ncbi.nlm.nih.gov/articles/PMC8561926/
[xiii] https://hcup-us.ahrq.gov/reports/statbriefs/sb251-Sickle-Cell-Disease-Stays-2016.jsp
[xiv] https://pmc.ncbi.nlm.nih.gov/articles/PMC7153675/
[xv] https://pmc.ncbi.nlm.nih.gov/articles/PMC10909714/
[xvi] https://pmc.ncbi.nlm.nih.gov/articles/PMC7253500/
[xvii] https://ashpublications.org/blood/article/132/Supplement 1/4930/262374/Association-between-Employment-Status-and
[xviii] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755485
[xix] https://pmc.ncbi.nlm.nih.gov/articles/PMC9458333/
[xx] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf

EXHIBIT 31

Kearns, Katherine (AGO)

From: Klunder, Nita (AGO)
Sent: Monday, July 20, 2026 1:25 PM
To: OIRA_submission@omb.eop.gov; dominic_mancini@omb.eop.gov
Subject: RE: RIN-00938-AV98 - request for original submission

All,

Forgive the serial emails, I think I have corrected all typos in the recipient email addresses. Please see below.

Nita

From: Klunder, Nita (AGO)
Sent: Thursday, July 16, 2026 4:53 PM
To: 'OIRA_sumission@omb.eop.gov' <OIRA_sumission@omb.eop.gov>
Cc: 'Dominic_J._Mancini@omb.eop.gov' <Dominic_J._Mancini@omb.eop.gov>
Subject: RIN-00938-AV98 - request for original submission

Hi there,

Pursuant to Executive Order 12866 Sections 6(a)(3)(B), (C), and (E) I'm requesting the original version first submitted to OIRA of RIN-00938-AV98, Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social Security Act. I would also like a redline between that version and the final version with notation of any changes that were made at the request of OIRA.

Thanks very much, and please let me know if you need anything additional from me prior to fulfilling this request.

Nita

EXHIBIT 32

DECLARATION OF HANNAH KATCH

I, Hannah Katch, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the District of Columbia. I am over the age of 18 and have personal knowledge of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. I was previously a senior advisor in the Office of the Administrator at the Centers for Medicare & Medicaid Services (CMS) and worked closely with experts at the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE).

3. I am familiar with Drs. Benjamin Sommers, Ari Ne'eman, and Adrianna McIntyre. I have worked with Dr. Sommers in various capacities since 2020 and was familiar with his research for years prior to our working relationship.

4. On April 9, 2026, Drs. Sommers, Ne'eman, and McIntyre provided me with some research they had prepared relating to the new Medicaid work requirement. Among other findings, the research applied a claims-based frailty framework to evaluate approaches for using Medicaid data to automatically exclude individuals from work requirements when their diagnoses met the statutory definition of "medically frail." Their research found that a 24-month lookback period would automatically exclude 34.5% of Medicaid expansion enrollees subject to work requirements (7,260,275 people), compared with 26.9% (5,660,065) under a 1-year lookback — meaning shortening the lookback from two years to one could strip automatic exclusions from roughly 1.6 million medically frail enrollees. Their findings showed that excluded enrollees were substantially sicker than non-excluded enrollees, with markedly higher hospital, emergency department, HCBS, and nursing home use and a one-year mortality rate more than four times higher (0.9% vs. 0.2%,

p<0.001). These results indicate that a 1-year claims lookback period for medical frailty meaningfully narrows the excluded population relative to 2-years, and the excluded group's utilization and mortality profile confirms the framework captures genuinely high-need individuals.

5. I understand Drs. Sommers and Ne'eman shared this information with CMS on or about April 2 and in follow up communication on or about May 21, 2026.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 20 day of July 2026.

/s/ Hannah Katch

Hannah Katch
Founder and Principal, Katch Strategies, LLC

EXHIBIT 33

DECLARATION OF PATRICIA DENNIS

I, Patricia Dennis, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Arizona. I am over the age of 18 and have personal knowledge in my capacity as Assistant Director of the Arizona Health Care Cost Containment System (AHCCCS) Division of Member and Provider Services and serving as the agency's Executive Sponsor of H.R. 1, as well as knowledge based on review of information and records gathered by AHCCCS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, AHCCCS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that AHCCCS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

4. As to the Medically Frail exclusion, AHCCCS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May

2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

5. Based on this understanding, between the fall of 2025 and June of 2026, AHCCCS designed a system based on claims data and diagnosis codes to determine whether individuals were medically frail as defined in H.R. 1. While programming and testing remained to be done on that system, AHCCCS was planning to go live with that system by the statutory implementation deadline. This build-out was costly, time consuming, and demanded extensive dedication of resources. Specifically, the build-out involved approximately 2,200 work hours in the following areas as described below:

Work Activity	**Estimated Hours**
Original 5,000+ ICD-10 workbook development	600
Clinical review and reduction to ~1,000 codes	450
CMS category mapping and validation	200
Medically frail matrix development	150
Claims and encounter analysis	250
MMIS/API/technical design sessions	240
CDPS+RX evaluation and policy analysis	120
Stakeholder review, focus groups, and research	140
Formal meetings	38
Estimated Total	**2,188 Hours**

6. On June 1, 2026, CMS published an Interim Final Rule with Comment Period (IFR) implementing the community engagement (work requirement) provisions of P.L. 119-21 (H.R. 1),

Section 71119. AHCCCS was surprised to learn that CMS had unexpectedly imposed further restrictive criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language to the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for many months ahead of June 1, 2026, but also requires significant changes to our system design, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

7. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirement due to medical frailty. First, AHCCCS must determine if an individual falls within one of the five excluded categories established by Congress. And second, pursuant to the additional IFR provisions, AHCCCS must now determine if that person's ability to comply with the Work Requirement is significantly impaired.

8. Although the IFR's most restrictive verification requirements do not take effect until January 1, 2028, the required re-engineering of AHCCCS's verification workflows cannot be deferred to the 2027 planning cycle. Planning, procurement, system design, development and testing for the 2028 overhaul is proceeding, and must proceed, concurrently with the January 2027 implementation build, creating substantial resource conflicts across IT, contracting, operations, and staffing.

9. Accordingly, AHCCCS has had to redesign the agency's planned system changes in order to determine whether an individual meets the five congressionally established categories of medically frail exclusions specified by H.R. 1. Additionally, AHCCCS is further compelled to determine whether the individual's ability to participate in community engagement is significantly

impaired. The resulting redesign requires a significant unplanned investment and utilization of resources, including considerable costs and dedication of staffing.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It means using data available to AHCCCS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, AHCCCS first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If AHCCCS can verify a member's eligibility using available data, then AHCCCS will find the member eligible without requiring input from the member. Only if AHCCCS cannot verify eligibility using available data does AHCCCS send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on both members and AHCCCS and reduces the probability that individuals are unnecessarily disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that members who are eligible remain enrolled, reducing unnecessary eligibility processes and operations associated with the reapplication and determination process.

12. *Ex parte* verification also reduces administrative burdens and costs on AHCCCS by allowing AHCCCS to process renewals without performing the operations and associated costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work

requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). AHCCCS also understood, based on the plain language of H.R. 1, and confirmed by multiple communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were intended to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, AHCCCS would begin by *ex parte* consulting data available to AHCCCS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form requesting additional information with which AHCCCS can determine whether the individual meets the criteria for medical frailty. The precise information AHCCCS must collect – and thus the particular wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR are operative.

15. Since the IFR was published, however, AHCCCS is confronted with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period AHCCCS can use when relying on Claims and Encounter data. However, the IFR does not similarly limit the time period for the other six categories of data upon which AHCCCS can rely when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories which do not specify a designated, limited timeframe, more people would qualify

for *ex parte* determinations and not be denied Medicaid simply because of administrative burdens. Moreover, the eligibility determination process would be substantially streamlined resulting in reduced outlay and demand of resources.

17. If AHCCCS cannot rely on *ex parte* verification to determine medical frailty, or if AHCCCS is only permitted to use a limited algorithmic approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid, with likely considerable increased costs to AHCCCS resulting from appeals of denials and resources associated with the reapplication and the eligibility determination process.

18. Beginning on January 1, 2028, AHCCCS members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by AHCCCS will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, adversely affecting their health status and monumentally increasing uncompensated care for providers in a state that already experiences significant health care workforce challenges.

19. To quantify the potential impact of this added requirement, Arizona estimates that more than 429,000 adult expansion members, including an estimated 250,000 "applicable individuals" will be subject to the new community engagement requirements under H.R. 1. Of the 250,000 "applicable individuals," approximately 29% of members (about 72,000 members) are estimated to already lack sufficient claims history for the preceding 12 months required under the

IFR for ex parte medical frailty determinations and will have to obtain provider documentation to establish eligibility for an exemption.

20. It is estimated that more than 70% of "applicable individuals" have substantial claims histories to support determinations of medical frailty under H.R. 1, but the IFR now makes those histories insufficient due to the new dual requirement: both the existence of a medical condition and the resulting functional impairment that limits compliance with community engagement requirements.

21. Arizona's claims data suggest approximately 34 percent of "applicable individuals" had 25 or more claims in the past 12 months and 10 percent had more than 100 claims. Thus, nearly half of "applicable individuals" have moderate to high healthcare utilization and are therefore more likely to have significant chronic conditions, functional limitations, or complex care needs. These individuals would likely have been among the populations AHCCCS would have categorized as medically frail without additional documentation absent the IFR.

22. This group of "applicable individuals" with moderate to high healthcare utilization who would have had substantial claims histories to support determinations of medical frailty if not for the IFR's requirements will be most susceptible to losing coverage due to the IFR. In addition to the anticipated deterioration of this population's health status and conditions, their ensuing loss of coverage will exacerbate the impact of Arizona's health care workforce shortage and the growing costs of uncompensated care.

23. Arizona's hospital uncompensated care costs are already increasing year over year. Most recently, Arizona's total Hospital Uncompensated Care has increased from $539.5 million in 2023 to $638.5 million in 2024, an increase of approximately 18 percent. This figure is only expected to rise with the anticipated coverage losses in this population.

24. The members losing coverage and forgoing preventive care would also further strain Arizona's non-hospital healthcare workforce. Currently, Arizona meets approximately 40 percent of its mental health care workforce needs and ranks forty-seventh among states in behavioral health workforce availability. Approximately 96.5 percent of Arizona psychiatrists practice in urban areas, in a state where roughly 90 percent of the population is urban. Greenlee and La Paz counties are maternal care deserts, and Cochise, Gila, Graham, and Santa Cruz counties have limited access to maternal care. There are no practicing obstetrician-gynecologists in Arizona's isolated small rural towns. Arizona carries Health Professional Shortage Area designations for primary care, mental health, and dental care across counties and tribal areas throughout the state.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

/s/ *Patricia Dennis*
(original signature on file with AZ AGO)
Patricia Dennis
Assistant Director of the Division of Member and Provider Services
AHCCCS

EXHIBIT 34

DECLARATION OF YINGJIA HUANG

I, Yingjia Huang, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of California. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Director of Health Care Benefits and Eligibility of information and records gathered by California Department of Health Care Services (DHCS) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DHCS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that DHCS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-

year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, DHCS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between fall of 2025 and June of 2026, DHCS was building a framework based on claims data, diagnosis codes, procedure codes, pharmacy, and healthcare utilization codes to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that framework and testing the data generation, DHCS was planning to go live with automating the medically frail data feed into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) by the statutory implementation deadline. This build out was costly and time consuming given the complexity of ingesting a completely new framework of "medical frailty" into a Medicaid eligibility determination.

7. On June 1, 2026, DHCS was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system, challenging our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the interim final rule ("IFR") appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DHCS must determine if an individual falls within one of the five excluded categories established by Congress. And second, DHCS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, DHCS has had to come up with a new verification framework in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to the Medicaid agency to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, county eligibility workers first attempt to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If the eligibility worker can verify a member's eligibility using available data, then the member is found eligible without requiring input from the member. Only if eligibility cannot be verified using available data is the member sent a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and DHCS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on DHCS by allowing DHCS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DHCS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DHCS would begin by *ex parte* consulting data available to DHCS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DHCS can determine whether the individual meets the criteria for medical frailty. The precise information DHCS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, DHCS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period DHCS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DHCS can rely upon when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If DHCS cannot rely on *ex parte* verification to determine medical frailty, or if DHCS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. As stated above, renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, California Medi-Cal members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DHCS will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026, and January 1, 2027, which DHCS has to create a new system for eligibility compliant with the IFR, we will be unable to do the usual systems testing we would do before going live by January 1, 2027, creating significant risks of inconsistent and inaccurate Medicaid eligibility determinations.

20. If the Court were to vacate the Challenged Provisions, DHCS would need up to six months to update systems as of January 1, 2027.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 30th day of August 2026.

/s/ Yingjia Huang

Deputy Director, Health Care Benefits and Eligibility

EXHIBIT 35

DECLARATION OF ADELA FLORES-BRENNAN

I, Adela Flores-Brennan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Colorado. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by the Department of Health Care Policy and Financing ("HCPF") and HCPF staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.
2. Since the passage of H.R. 1, HCPF has worked to be ready to implement H.R. 1's community engagement requirements on January 1, 2027.
3. The community engagement requirements apply to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that HCPF will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the community engagement requirements.
4. Based on the community engagement requirements as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour per month community engagement requirements. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion

for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, HCPF understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals who fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).
6. Based on this understanding, between fall of 2025 and June of 2026, HCPF was developing policy and processes, and systems coding based on claims data and diagnosis codes to determine whether individuals were medically frail as defined in H.R. 1. While additional refinement and operational details remained to be finalized, HCPF was planning to go live with that system by the statutory implementation deadline. This build out was costly and time consuming as the teams required weekly or biweekly planning meetings, spoke with a number of stakeholders, built and rebuilt many data models, data transfer, and matching processes.
7. On June 1, 2026, HCPF was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant limitations be integrated to our use of data and ability to determine medical frailty on an ex-parte basis, required last-minute reworking of our application, and completely changes how HCPF considers operationalizing the medical frailty definition.
8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the community engagement requirements as medically frail. First, HCPF must

determine if an individual falls within one of the five excluded categories established by Congress. And second, HCPF must determine if that person's ability to comply with the community engagement requirements is significantly impaired.

9. Accordingly, HCPF has had to rework our process to rely on self-attestation in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has caused additional unplanned costs and resource burdens as HCPF made changes to the application and delayed decisions on how to use diagnosis and claims data.

DISABILITY VS MEDICAL FRAILTY

10. The June 1, 2026 IFR does not establish a clear operational boundary between a medically frail condition and a disability for purposes of the Medicaid community engagement exemption. Instead, the rule creates substantial conceptual and functional overlap between the two categories while leaving states responsible for making many of the distinctions needed for implementation.
11. A central source of ambiguity is that disability itself is incorporated into the IFR's medical frailty framework. Under 42 C.F.R. § 435.554(c)(5), medical frailty encompasses several categories, including a disabling mental disorder and a physical, intellectual, or developmental disability that significantly impairs an individual's ability to perform one or more Activities of Daily Living (ADLs). The IFR separately addresses individuals who are blind or disabled using the Social Security Act § 1614 standard. As a result, disability can operate both as a distinct eligibility category as well as a characteristic supporting a determination of medical frailty.
12. The distinction becomes less clear because the IFR asks states to not only consider the presence of a particular diagnosis or condition, but also the extent to which the condition impairs an individual's ability to engage in community engagement activities (including but not limited to

work). In order to be deemed medically frail, an individual's condition must significantly impair his or her ability to meet the community engagement requirement. For a physical, intellectual, or developmental disability within the medical-frailty provision, CMS states that the disability must significantly impair at least one ADL and the individual's ability to comply with the community engagement requirement. The IFR does not establish an exhaustive list of diagnoses that automatically constitute a serious or complex medical condition. CMS considered conditions such as HIV/AIDS, end-stage renal disease, cancer, and sickle cell disease but declined to categorically designate them as serious or complex because severity and individual circumstances may differ. This reinforces that medical frailty is intended to depend substantially on the severity and functional effect of a condition, rather than simply the presence of a particular diagnosis.

13. This creates a practical overlap. An individual may have a recognized disability but not satisfy the IFR's medical-frailty standard if the disability does not cause the specified level of functional impairment. Conversely, an individual may have a serious or complex medical condition that significantly limits the ability to comply with community engagement requirements without necessarily meeting a traditional disability determination. Thus, the distinction is not simply disability versus medical condition. It depends on which federal definition applies, the severity of the condition, its effect on ADLs where applicable, and its effect on the individual's ability to satisfy community engagement requirements. CMS provides examples of potentially qualifying disabilities and conditions but expressly states that these examples are not exhaustive and leaves states considerable responsibility for establishing criteria and verification processes. The IFR provides a framework for identifying medically frail individuals but does not provide a clear distinction between medical frailty and disability. The categories overlap and are not mutually

exclusive classifications. For state implementation, this creates uncertainty about how to consistently classify individuals whose conditions could reasonably fall within either category, what evidence is sufficient to distinguish one pathway from another, and how to translate CMS's functional standards into objective and administratively workable eligibility rules.

EX PARTE VERIFICATION PROCESS

14. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to HCPF to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, HCPF first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If HCPF can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if HCPF cannot verify eligibility using available data does HCPF send the member a renewal form for the member to complete.
15. *Ex parte* verification reduces the burden on members and HCPF and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.
16. *Ex parte* verification also reduces administrative burdens and costs on HCPF by allowing HCPF to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.
17. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] …

the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). HCPF also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis where possible.

18. In practice, to verify medical frailty for the community engagement requirements, HCPF would begin *ex parte* by consulting data available to HCPF to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which HCPF can determine whether the individual meets the criteria for medical frailty. The precise information HCPF will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

19. Since the IFR was published, however, HCPF is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty. Because of these restrictions in the definition of medical frailty, HCPF cannot use an *ex parte* process for the launch of community engagement requirements in January 2027. At this time, HCPF's ability to utilize data to facilitate an *ex parte* determination and the timing for implementation of the same is unknown.

20. Additionally, the IFR limits the time period HCPF can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which HCPF can rely upon when determining compliance with or exclusion from the community engagement

requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

21. If HCPF cannot rely on *ex parte* verification to determine medical frailty, or if HCPF is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

22. If HCPF cannot rely on *ex parte* verification to determine medical frailty, then a great deal more work will fall to county eligibility workers and outside vendors. HCPF had not previously accounted for these costs because we anticipated based on the text of the statute that we would be able to automate a great majority of our medical frailty determinations. As it stands now, HCPF has released a Request for Information that is the first step in procuring a vendor to help support the research and review needed to verify medical frailty for Health First Colorado members. This cost was not anticipated and is not yet known.

23. As I noted in my previous declaration in support of the Motion for Preliminary Injunction, in Colorado, an estimated 378,000 adults per year in the Health First Colorado expansion population will be subject to H.R. 1's community engagement and six-month redetermination requirements (a provision of H.R. 1 that requires Medicaid expansion adults' eligibility to be reevaluated every six months). Of those 378,000 individuals, approximately 155,000 will be required to demonstrate community engagement or qualify for an exclusion or exception. The IFR analysis indicates the number of people impacted may be as low as 150, 000 and as high as 200,00.

24. These numbers were developed prior to the issuance of the IFR. Because the IFR goes beyond H.R. 1 in stripping away the protections provided to the medically frail and adding new limitations on self-attestation that do not appear in statute, these numbers likely underestimate the impact to members.

25. Beginning on January 1, 2027, Colorado Medicaid members who would be determined eligible but for the Challenged Provisions will face confusion due to our inability to unequivocally communicate about medical frailty. While HCPF will utilize self-attestation in 2027, we will need to be able to verify what is attested in the very near future. As of right now, HCPF does not have the necessary clarity to conduct those verifications or to support members with the information and resources they will need to be able to navigate an as-yet undetermined process. The turmoil and uncertainty introduced by the IFR increases the risk that individuals will lose coverage due to administrative barriers.

26. Colorado's budget will suffer harm due to loss of federal matching funds when eligible individuals lose Medicaid coverage and because additional dollars now need to be allocated to operationalizing a highly manual process. HCPF will incur as yet unknown additional costs to support a manual verification process both in the county eligibility sites and through procurement of a vendor who can help process manual verifications consistent with the new two-part test. Health First Colorado also anticipates that more people will move into disability categories of coverage, which are higher cost and draw a significantly lower federal match of 50% Colorado's current 90% expansion population match under the Affordable Care Act.

27. As the uninsured rate increases, there will be a greater financial strain on providers – in particular rural, community, and safety net hospitals as well as community health centers – that will be called upon to provide even greater levels of uncompensated care. Additionally, they will likely be called

upon to provide documentation that supports a medical frailty determination, which is uncompensated work.

28. Furthermore, individuals who are disenrolled from Health First Colorado will likely lose access to primary and preventive care – and care necessary to treat their medical conditions – resulting in more individuals seeking high-cost, emergency care. This lack of preventative care will result in increased communicable disease outbreaks and more strain on Health First Colorado. Most importantly, Health First Colorado expects poorer health outcomes across Colorado, as fewer people will be able to access appropriate, timely care and manage chronic conditions.

29. Finally, Health First Colorado expects that the new medical frailty requirements—both the "significant impairment" requirement and the limitations of medical frailty self-attestation—will place a significant administrative strain on treating healthcare providers. In order to support members seeking medical frailty exemptions, providers may need to devote time to providing documentation to demonstrate that a member is medically frail and experiencing significant impairment in their ability to work. This will require providers to take time away from their patient care and will increase administrative strain, adding to healthcare costs and impacting access to care. Providers are already sharing their concerns about additional paperwork, the lack of medical training for the specific purpose of opining on ability to work, and the malpractice insurance implications.

STATE EFFORTS GOING FORWARD

30. Given the limited time between June 1, 2026 and January 1, 2027 for which HCPF has to create a new system for eligibility compliant with the IFR, we will be unable to implement an *ex parte*

verification process for January 2027. This means that anyone seeking an exemption based on medical frailty will be required to fill out a form that indicates which category of medically frail they fall into. Further, it is likely given the two-part test and the restrictions on the use of data apparent in the IFR that a large number of medically frail individuals will need a manual verification process. Operationalizing a manual process for medical frailty determinations was not something that HCPF anticipated or budgeted for at this scale.

31. If the Court were to vacate the Challenged Provisions, HCPF would need a minimum of six months to identify a suitable data set, program IT systems, test IT systems, communicate to members, retrain eligibility workers and implement.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 19th day of August 2026.

Adela Flores-Brennan
Medicaid Director

EXHIBIT 36

DECLARATION OF PETER HADLER

I, Peter Hadler, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the State of Connecticut. I am over the age of 18. I am employed by the State of Connecticut as the Deputy Commissioner of the Department of Social Services ("DSS"). I have personal knowledge, or knowledge based on my review of information and records gathered by the Connecticut Department of Social Services and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DSS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special medical needs including, but not limited to, serious or complex medical conditions, or physical, mental, intellectual, or developmental impairments that significantly impair daily living activities. Practically speaking, this means that DSS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exclusion or prove

compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medical Frailty exclusion, DSS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that medically frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between July of 2025 and June of 2026, DSS was working towards building a system based largely on claims data to determine whether individuals were medically frail as defined in H.R. 1. While additional development and testing remained to be done on that system, DSS was planning to go live with that system by the statutory implementation deadline. DSS spent hundreds – perhaps thousands – of personnel hours in defining, analyzing, comparing, and assessing the applicability of claims-based methodologies that covered over 10,000 different medical codes in various permutations, as well as how potential technological interfaces might be built to link those codes to Medicaid enrollees across multiple computer systems with maximum levels of automation. This build out effort has been costly and time consuming.

7. On June 1, 2026, DSS was surprised to learn that CMS had issued an Interim Final Rule that added criteria to the statutory definition of medical frailty in H.R. 1. In particular, CMS had imposed new criteria on the medical frailty definition that not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires

significant changes to our system design approach, jeopardizing our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DSS must determine if an individual falls within one of the five excluded categories established by Congress. And second, DSS must now also determine if that person's ability to comply with the Work Requirement is significantly impaired by their medical frailty.

9. Accordingly, DSS has had to now modify its anticipated system plans in order to determine whether someone meets the five statutorily established categories of medical frailty exclusions *and* meets the new regulatory category of being "significantly impaired" by their medical frailty. This has been a significant additional unplanned cost and use of staff time because a relatively straightforward (though technologically challenging) assessment of medical frailty leveraging existing data sources has now been converted into a multistep process that requires accessing more or different data and which will certainly require more complex system design work, if it is possible to design and build at all.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DSS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DSS first attempts to use available data (such as data regarding income and identity) to determine whether the member remains eligible. If DSS can verify a member's

eligibility using available data, then they find the member eligible without requiring input from the member. Only if DSS cannot verify eligibility using available data does DSS request additional information from the member as part of the renewal process.

11. *Ex parte* verification substantially reduces the burden on members and DSS as the program administrator, ensures that eligible members remain enrolled, and ensures that fewer people are disenrolled due to administrative hurdles.

12. *Ex parte* verification also significantly reduces administrative burdens and costs on DSS by allowing the agency to process renewals without any manual efforts. Every renewal that cannot be completed through *ex parte* verification processes costs the agency in time and materials.

13. Through H.R. 1, Congress reinforced its longstanding preference for using *ex parte* verification in Medicaid eligibility to the verification of work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DSS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DSS would begin by *ex parte* consulting data available to the agency to determine if the individual qualifies as medically frail. If an individual cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), DSS will request additional information from the individual to determine whether the individual meets the criteria for medical frailty. The precise information DSS will need to collect – and thus the wording and structure of verification forms –

will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, DSS is dealing with a new high level of uncertainty around the use of *ex parte* verifications to validate medical frailty because in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty. Prior to the IFR, DSS fully expected that use of diagnosis and condition codes would be the foundational approach to a successful *ex parte* eligibility determination.

16. If DSS cannot rely on *ex parte* verification to determine medical frailty, or if DSS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of medically frail members, then the additional criteria imposed by the IFR will lead to more eligible members losing Medicaid. As is well known from research literature and personal knowledge and experience, many Medicaid members, especially those who are among the most vulnerable members, do not respond to renewal notices. Correspondingly, a decreased ability to perform *ex parte* verifications will necessarily result in fewer people having access to Medicaid.

17. Consistent with the IFR, when verifying an exclusion from the Work Requirement, some portion of Connecticut's process will use a system that reviews claims that have been adjudicated in the preceding 12 months and encounter data for the preceding 12 months. These systems can be relatively easily modified to include claims that go back 2 to 5 years. The burden of adding months, or even years, of claims and encounter data to a system that already has this capability is minimal. In contrast, the lookback limitations contemplated by the IFR will necessarily limit our ability to make *ex parte* determinations regarding medical frailty, and result

in a time consuming and costly process of additional member interaction to seek documentation to establish medical frailty.

18. In the event that DSS is unable to use the *ex parte* process to determine medical frailty due to the new restrictions in the IFR, DSS estimates that between 59,000 and 131,000 medically frail members comprising between 19% and 41% of all Connecticut Medicaid low-income adult enrollees, would be newly at risk of being disenrolled.

19. Beginning in January, 2027, medically frail HUSKY Health members who would be determined eligible but for the challenged provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that administrative systems cannot be developed timely, *ex parte* eligibility processes will be undermined, and Connecticut residents will lose access to affordable health care coverage. In turn, those low income and medically frail individuals formerly covered by Medicaid will forgo preventive care and enter the health system only if they are acutely ill, and they will not have the means to pay for their emergency services. As previously indicated, this will correspondingly lead to negative health outcomes including premature deaths, increased uncompensated care which will strain the state's healthcare capacity, increased personal medical bankruptcy, and financial pressures on the Medicaid program due to the loss of federal funding to support the healthcare costs of these low-income residents. In addition, DSS' fair hearings unit will likely experience significantly increased demands as a result of members who claim to have wrongfully lost coverage.

STATE EFFORTS GOING FORWARD

20. Given the limited time between June 1, 2026, and January 1, 2027, which DSS has to create a new system for eligibility compliant with the IFR, we will be unable to fully maximize

ex parte data opportunities and process automation due to the extremely limited design and development period. Decisions will need to be made in incredibly compressed timelines, jeopardizing efficiency and forgoing opportunities for better system stability and functionality. DSS will not be able to conduct the regular level of systems testing or integration prior to go live. Data reporting and user interfaces are likely to be limited, further increasing risk. Training of staff and partners is likely to change and need to be redelivered, or be incomplete, increasing the risk of administrative and operational errors. Correspondence, including the wording on new notices and forms, could confuse members as operational processes will remain in flux depending on whether eligibility is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

21. If the Court were to vacate the Challenged Provisions, DSS anticipates that it would need at least six months to effectively reconfigure systems and avoid the improper disenrollment of eligible members.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 26th day of August 2026.

Peter Hadler

Digitally signed by Peter Hadler
DN: cn=Peter Hadler, o=DSS, ou=Deputy Commissioner, email=peter.hadler@ct.gov, c=US
Date: 2026.08.26 13:45:44 -04'00'

Peter Hadler
Deputy Commissioner

EXHIBIT 37

DELAWARE HEALTH
AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

OFFICE OF THE DIRECTOR

DECLARATION OF ANDREW WILSON

I, Andrew Wilson, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Delaware. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by Delaware's Department of Health and Social Services (DHSS) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DHSS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that DHSS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, DHSS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between late 2025 and June of 2026, DHSS was building a system based on claims data and diagnosis code to determine whether individuals were medically frail as defined in H.R. 1. In addition, DHSS was not planning for eligibility staff to determine medical frailty using documentation outside of claims data, diagnosis codes, self-declaration forms, and limited, if any provider documentation. DHSS was planning to go live with that system by the statutory implementation deadline. Due to this, DHSS did not staff nor budget for an eligibility workforce to accommodate the impact in decision making regarding medical frailty or budget for increased provider call center support for the provider community who is looking for documentation and definition guidance for their patients. This build out is now on a condensed timeframe that introduces risks full compliance and will inevitably add to future cost as issue are identified and corrected in the out years after initial implementation.

7. On June 1, 2026, DHSS was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our design, budget, and staffing structures, imperiling our ability to swiftly and correctly identify all allowed medical frailty exceptions. We are concerned about the ability to be in full compliance as we understand more guidance is coming our way. We are uncertain how this may impact our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DHSS must determine if an

individual falls within one of the five excluded categories established by Congress. And second, DHSS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, DHSS has had to design a system after IFR was published in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DHSS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DHSS first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If DHSS can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if DHSS cannot verify eligibility using available data does DHSS send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and DHSS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs onDHSS by allowing DHSS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible,

the applicable individual to submit additional information."). DHSS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DHSS would begin by *ex parte* consulting data available to DHSS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DHSS can determine whether the individual meets the criteria for medical frailty. The precise information DHSS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, DHSS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period DHSS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DHSS can rely upon when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If DHSS cannot rely on *ex parte* verification to determine medical frailty, or if DHSS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, Delaware Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DHSS will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, surely in the long run having a negative impact on Delawareans' health outcomes and placing additional financial burden on healthcare systems caring for more uninsured individuals.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026 and January 1, 2027 which DHSS has to create a new system for eligibility compliant with the IFR, we will be unable to take the appropriate time to ensure we are fully compliant with the IFR and any subsequent guidance lessening the usual systems design and testing we would do before going live. While we believe we will be ready by January 1, 2027, we know there is risk in Delawareans inappropriately losing coverage given the timeframe in which the changes are being made.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 21st day of August 2026

DocuSigned by:
Andrew Wilson
35F947C98C8B499...

Andrew Wilson
Deputy Secretary for Medicaid

EXHIBIT 38

DECLARATION OF MELISA BYRD

I, Melisa Byrd, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the District of Columbia. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Senior Deputy Director and Medicaid Director at the District of Columbia Department of Health Care Finance ("DHCF") of information and records gathered by DHCF staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DHCF has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that DHCF will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-

year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

THE DISTRICT'S WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, DHCF understood, based on the plain language of H.R. 1 and the December 8, 2025 CMS Information Bulletin[1] that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between fall of 2025 and June of 2026, DHCF was building analytics largely based on diagnosis codes, primarily from claims data, to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done, DHCF was planning to go live with a system that relied heavily on diagnoses by the statutory implementation deadline.

7. On June 1, 2026, DHCF was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our approach, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027. For example, DHCF is now investing substantial staff resources into the review of alternative claims data algorithms for assessing what might constitute a condition that "significantly impairs" and therefore would therefore pass muster as medically frail in the absence of clear guidance from CMS.

[1] CMS, State Requirements to Establish Medicaid Community Engagement Requirements (December 8, 2025), at 5-6, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DHCF must determine if an individual falls within one of the five excluded categories established by Congress. And second, DHCF must determine if that person's ability to work is significantly impaired because they may be medically frail or have a special medical need.

9. Accordingly, DHCF has to modify its approach in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned resource investment, including the use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DHCF to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DHCF first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If DHCF can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if DHCF cannot verify eligibility using available data does DHCF send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and DHCF and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on DHCF by allowing DHCF to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the State … without requiring, where possible, the applicable individual to submit additional information."). DHCF also understood, based on the plain language of H.R. 1 and the December 8, 2025 CMS Informational Bulletin, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DHCF would begin by *ex parte* consulting data available to DHCF to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DHCF can determine whether the individual meets the criteria for medical frailty. The precise information DHCF will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, DHCF is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine medical frailty.

16. If DHCF cannot rely on *ex parte* verification to determine medical frailty, or if DHCF is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR may lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices by their certification date. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

17. Beginning on January 1, 2027, DC Medicaid members who would be determined eligible but for the Challenged Provisions may be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DC Medicaid will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers. In turn, this could increase uncompensated care incurred by Medicaid-participating providers and negatively affect their ability to continue serving patients. It could also place financial pressure on the District if providers seek to offset their losses and sustain their existing operations through higher Medicaid payment rates for the population remaining enrolled.

THE DISTRICT'S EFFORTS GOING FORWARD

18. Given the limited time between June 1, 2026 and January 1, 2027, DHCF faces operational and technical challenges in designing, testing, and implementing system changes necessary to comply by the required effective date. The compressed timeframe materially limits DHCF's ability to follow its standard systems development lifecycle, which ordinarily includes requirements validation, system design, development, integration testing and so forth followed by operational readiness activities. The precise information DHCF will need to collect – and thus the

wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

Melisa Byrd
Senior Deputy Director and Medicaid Director
District of Columbia Department of Health Care Finance

EXHIBIT 39

DECLARATION OF EDIE MAYESHIRO

I, Edie Mayeshiro, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Hawai‘i. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as acting Assistant Administrator of the Med-QUEST Division of information and records gathered by Hawai‘i Department of Human Services and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

Professional and Agency Background

2. I am the acting Assistant Administrator for the Hawai‘i State Medicaid program and Children’s Health Insurance Program (CHIP) (known together in Hawai‘i as Med-QUEST).

3. The Hawai‘i Department of Human Services is the single state agency responsible for administering Med-QUEST. Med-QUEST provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Med-QUEST’s coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. Med-QUEST’s mission is to empower Hawai'i’s residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha.

4. Med-QUEST insures approximately 400,000 people, providing health coverage to children, families, and older adults—including some of the most vulnerable residents in the state, such as those experiencing homelessness, living with a disability, or who have a serious or complex medical condition.

5. Hawai‘i administers the Med-QUEST program pursuant to federal law and regulations as well as the terms of its federally approved State Plans and its Section 1115 Demonstration Project. Med-QUEST receives federal Medicaid and CHIP funding, known as “Federal Financial Participation” (FFP), which covers an average of 60 percent of Med-QUEST’s expenditures on eligible enrollees.

Medicaid Expansion in Hawai‘i

6. On January 1, 2014, Hawai‘i implemented Medicaid expansion under the Affordable Care Act (the “ACA”). This expansion extended federally funded comprehensive health insurance to low-income adults aged 19 to 64 with household incomes up to 133% of the Federal Poverty Level primarily through the Low Income Adult Expansion program.

7. Enrollees in the Low Income Adult Expansion program receive full, comprehensive benefits that include hospital care, prescription drugs, mental health services, and preventive care. Currently, eligibility for the Low Income Adult Expansion program requires that an individual (1) be a resident of the State of Hawai‘i between 19-64 years old; (2) be a citizen or qualified immigrant; and (3) have household income less than or equal to 133% of the Federal Poverty Level.

8. As of August 24, 2026, approximately 125,665 or 32 percent of Med-QUEST members are enrolled in the Low Income Adult Expansion program. For the current state fiscal year 2026, approximately 90% of Med-QUEST’s funding for the Low Income Adult Expansion program – that is, about $800 million –comes from federal Medicaid funds.

CMS’s Pre-IFR Guidance to Hawai‘i

9. I and my staff at Med-QUEST have been closely following the enactment and implementation of H.R. 1, in particular Section 71119, which imposes novel work or community engagement requirements for adults covered under the Medicaid expansion provisions of the ACA (the "community engagement requirements").

10. Prior to the enactment of H.R. 1, the Medicaid Act has never required financially eligible individuals to work, volunteer, or meet other community engagement requirements to establish Medicaid eligibility. Consequently, Med-QUEST does not have in place systems by which to verify work, volunteer, or other community engagement activities.

11. Since November 2025, CMS has been providing guidance on expected community engagement requirements policy. On November 19, 2025, CMS presented a slide deck on community engagement requirements, which was later provided to states on December 4, 2025. On December 5, 2025, CMS began a series of workgroups to provide guidance and conduct question-and-answer sessions with states on implementing community engagement. These workgroup calls took place once every other week from December 2025 through April 2026 and switched to a weekly cadence starting in May 2026.

12. These sorts of calls represent a long-held practice by CMS to provide guidance to states, outside of formal rulemaking, in complying with urgent and significant changes in federal Medicaid law. In the absence of regulations, Hawai‘i relied on CMS guidance from these calls, and the associated slide decks and other materials, to determine how to comply with new laws, implement operational, system, and process changes, and, ultimately, avoid financial penalties that those laws imposed for noncompliance.

13. States likewise relied on the guidance shared by CMS on these regular calls concerning H.R. 1. Regarding the definition of medical frailty, CMS indicated that it intended to

"use a definition … similar to that described in regulations at 42 CFR § 440.315(f)," which is a regulation whose language closely resembles the H.R. 1 language. Nov. 19, 2025 CMS Slide Deck, page 11. CMS also stated that it expected to allow verification of medical frailty through "medical claims data review or provider documentation, or completion of a screening tool." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data" or "medical screener").

14. At no point between the passage of H.R. 1 in July 2025 and the promulgation of the Interim Final Rule in June 2026 did CMS indicate that it would require "medically frail" individuals to have a significant impairment to their ability to comply with community engagement requirements. Nor did CMS indicate that states would need to verify that a member had such a significant impairment when determining eligibility for the medical frailty exclusion.

15. Regarding use of self-attestation to verify medical frailty, while initially CMS signaled that only limited use of self-attestation would be permitted, *see* Nov. 19, 2025 CMS Slide Deck pg. 16, CMS later indicated that self-attestation would be an acceptable verification method when data was not available.

16. In March 2026, CMS reiterated that states may use auditable self-attestation in the absence of claims data. CMS specifically noted that states could use such an auditable self-attestation "*to confirm ongoing medical frailty*" in addition to when a member newly identifies as medically frail. CMS also noted that States should be able to reassess individuals for medical frailty at redetermination, *even without extensive claims history*, based on new information such as a major life event. At no point did CMS indicate members would be limited to only one self-attestation per enrollment period, even if they developed multiple sequential medical frailty conditions.

17. On Friday, May 1, 2026, during the community engagement requirements workgroup call, CMS showed states a slide deck that included a definition of the medical frailty exclusion. These slides did not mention any requirement that an individual's medically frail condition would need to impair their ability to comply with community engagement requirements.

18. On or about Wednesday, May 6, 2026, CMS informed states that information conveyed on the Friday, May 1, 2026 call should not be acted upon, and was subject to change.

19. Beginning in November 2025 and continuing until the release of the IFR, Med-QUEST based its policy and system determination on the statutory language and the sub regulatory guidance provided by CMS, as detailed above. Based on this guidance, Med-QUEST has already done the following:

- Conducted statutory analysis of H.R. 1;
- Updated internal policies;
- Began designing new system specifications;
- Allocated budgets and personnel in anticipation of the changes;
- Created leadership teams to direct and oversee the necessary changes;
- Drafted new member notices and applications questions;
- Initiated public outreach;
- Engaged with vendors to design necessary changes; and
- Created new positions to focus on systems integration and community outreach related to H.R. 1.

20. With respect to implementing the medically frail exclusion in particular, Med-QUEST has worked extensively with clinical and systems personnel to build a process to identify individuals who could be considered "medically frail." This system is based largely on claims data,

in line with CMS guidance to "verify medical frailty" based on a "medical claims data review or provider documentation." Nov. 19, 2025 CMS Slide Deck, page 11; *see also* slide 17 ("medical frailty status … available through claims data").

21. Since the passage of H.R. 1, Med-QUEST has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

22. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that Med-QUEST will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

23. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specified excluded individual" under the exclusion for the medically frail.

Hawaii's Work to Date on the Medically Frail Exclusion

24. As to the Medically Frail exclusion, Med-QUEST understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May

2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

25. Based on this understanding, between fall of 2025 and June of 2026, Med-QUEST was designing a system based on claims data and diagnosis codes to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that system, Med-QUEST was striving to go live with that system by the statutory implementation deadline. The design process has been extremely time-consuming and costly. It has required, for example, up to 30 paid individuals meeting 20 hours or more per week over the past year.

26. On June 1, 2026, Med-QUEST was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

27. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, Med-QUEST must determine if an individual is "medically frail" by falling within one of the five categories established by Congress. If an individual is medically frail and not eligible in one of the other excluded groups, Med-QUEST must then *also* determine if that person's ability to comply with the Work Requirement is significantly impaired.

28. Accordingly, Med-QUEST has had to modify its system in order to determine whether someone meets the five congressionally established categories of medically frail

exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

Ex Parte Verification Process

29. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to Med-QUEST to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, Med-QUEST first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If Med-QUEST can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if Med-QUEST cannot verify eligibility using available data does Med-QUEST send the member a renewal form for the member to complete.

30. *Ex parte* verification reduces the burden on members and Med-QUEST and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

31. *Ex parte* verification also reduces administrative burdens and costs on Med-QUEST by allowing Med-QUEST to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

32. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the State … without requiring, where possible, the applicable individual to submit additional

information."). Med-QUEST also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

33. In practice, to verify medical frailty for the Work Requirement, Med-QUEST would begin by *ex parte* consulting data available to Med-QUEST to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), the individual will be provided a form that requests additional information through which Med-QUEST can determine whether the individual meets the criteria for medical frailty. The precise information Med-QUEST will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

34. Since the IFR was published, however, Med-QUEST is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

35. Additionally, the IFR limits the time period Med-QUEST can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which Med-QUEST can rely when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

36. If Med-QUEST cannot rely on *ex parte* verification to determine medical frailty, or if Med-QUEST is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

37. Beginning on January 1, 2027, Med-QUEST members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by Med-QUEST will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers. That will increase costs, increase the use of already overwhelmed emergency departments, increase burden and costs of administrative hearings filed by individuals who believe they have been wrongfully terminated, and lead to declining public health due to lack of access to care and preventive services, which in turn can impact the overall economy in Hawai‘i in many areas.

Hawaii's Efforts Going Forward

38. Given the limited time between June 1, 2026 and January 1, 2027 which Med-QUEST has to create a new system for eligibility compliant with the IFR, we will be unable to complete the extensive systems testing required to ensure the numerous and complex changes that are required to be in compliance with the IFR are properly vetted and confirmed to be operational. In addition to the many system changes, we are tasked with reeducating the community and stakeholders about the changed requirements detailed in the IFR. Based on these factors, Med-QUEST is unable to guarantee that the system will be ready by January 1, 2027. The precise

information Med-QUEST will need to collect to confirm eligibility – and thus the wording of all forms will vary depending on whether eligibility is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

39. In multiple meetings with CMS, Med-QUEST expressed that a good faith extension would provide the additional time needed to roll out H.R. 1 more successfully. CMS acknowledged our request but did not provide any assurances that such a request would be granted.

40. If the Court were to vacate the Challenged Provisions, Med-QUEST would need between 6–12 months to modify existing systems.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 28th day of August 2026.

Edie Mayeshiro
Acting Assistant Administrator

EXHIBIT 40

SUPPLEMENTAL DECLARATION OF KATHERINE YAGER

I, Katherine Yager, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Illinois. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Administrator of Medical Eligibility of information and records gathered by the Illinois Department of Healthcare and Family Services ("HFS") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, HFS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that HFS will first determine whether an individual is a specified excluded individual. If they are not determined to meet the eligibility requirements as a specified excluded individual, then they are considered to be an Applicable Individual and will need to demonstrate compliance with the Work Requirement.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

4. HFS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

5. Based on this understanding, between late 2025 and June 2026, HFS designed and began building a medical frailty evaluation methodology based on a validated set of diagnoses codes to pull from claims data to determine whether individuals were medically frail. HFS was planning to go live with that approach by the statutory implementation deadline. This system enhancement required extensive design and planning over a six-month period to develop within the state's Integrated Eligibility System ("IES"), as well as build the interface with the claims database, in coordination with multiple state agencies and the IES vendor. This enhancement is currently in the final phases of testing and is scheduled to go into production in September 2026.

6. On June 1, 2026, HFS was surprised to learn CMS had added criteria in the Interim Final Rule to the statutory definition of medically frail. In particular, the addition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system, impacting our ability to be considered fully ready to implement H.R. 1's Work Requirement on January 1, 2027, in accordance with the new requirements in the IFR. Because determining exclusions must be done as the first step in evaluating Work Requirement compliance, having to redesign and rebuild these system updates, especially in the absence of promised guidance, creates a meaningful obstacle to full implementation by the stated deadline.

7. As a result of this definition change, compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, HFS must determine if an individual falls within one of the five excluded categories established by Congress. And second, HFS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

8. Accordingly, HFS has assessed the systems updates already made under the guidelines outlined in H.R. 1 and begun to outline a revised methodology for determining both whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has required significant additional cost and staff time and cannot be fully completed until additional CMS guidance is provided.

EX PARTE VERIFICATION PROCESS

9. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to HFS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew customers' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a customer's eligibility renewal, HFS first attempts to use available data (such as data regarding income and residence) to determine whether the customer remains eligible. If HFS can verify a customer's eligibility using available data, then they find the customer eligible without requesting additional information from the customer. Only if HFS cannot verify eligibility using available data does HFS send the customer a renewal form for the customer to complete.

10. *Ex parte* verification reduces the burden on customers and HFS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible customers remain enrolled.

11. *Ex parte* verification also reduces administrative burdens and costs on HFS by allowing HFS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

12. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] ... the State shall ... establish processes and use reliable information available to the state ... without requiring, where possible, the applicable individual to submit additional information."). HFS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

13. However, since the IFR was published and added new criteria for medical frailty, HFS faces additional uncertainty around the use of *ex parte* verifications to validate this exclusion: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine medical frailty.

14. Despite stating that guidance would be coming, CMS has issued no new written guidance on how states can still use claims data for *ex parte* verification of medical frailty.

15. The IFR changes also impede the State's ability to design and implement required customer notifications on Work Requirements, particularly as it relates to medical frailty. Prior to the IFR, in order to verify medical frailty, HFS had planned to begin analysis of whether a customer is an Applicable Individual or a specified excluded individual by *ex parte* claims data. If the customer could not be *ex parte* verified as medically frail, HFS planned to provide them with a form, requesting additional information through which HFS can determine whether the customer meets an exclusion (including for medical frailty) or an exception, or is compliant.

16. Without further CMS guidance, HFS must build a customer notification process that lacks necessary details to effectively communicate how they can meet this exclusion. The

information HFS will need to collect to make this assessment– and thus the wording of the form – will vary depending on whether exclusions, specifically medical frailty, are governed by H.R. 1 or the added criteria from the IFR, for which additional guidance is needed. If additional changes are required for the newly updated forms, significant time and resources will be needed to reopen this work and make further enhancements to the system.

17. Additionally, adding complexity to the *ex parte* verification process as it was outlined in H.R. 1, limits the number of customers who are able to be verified by the state for medical frailty. A decreased ability to rely on *ex parte* verification will lead to additional customer burden, additional administrative burden on HFS, and result in fewer people having access to Medicaid.

18. To ensure that some form of *ex parte* verification of medical frailty including claims data is permitted, it is essential that CMS provide additional guidance on approved methodologies for medical frailty *ex parte* verification. We are aware of other states' proposals on alternative methodologies, which are currently awaiting a written response from CMS, and HFS would plan to use one of these methodologies.

CONSEQUENCES TO STATE MEDICAID CUSTOMERS

19. As stated previously, beginning January 1, 2027, Illinois Medical Assistance Program customers who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil, uncertainty, and additional barriers introduced by the Challenged Provisions increases the risk that customers formerly covered by the Illinois Medical Assistance Program will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, increasing strain on providers, particularly in rural and safety net hospitals, who will be called upon to provide

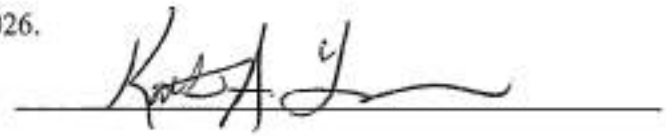
greater levels of uncompensated care. The "churn" involved with customers enrolling and disenrolling in the Illinois Medical Assistance Program due to the Challenged Provisions would raise costs for the program overall and decreases the health and quality of life for its customers.

STATE EFFORTS GOING FORWARD

20. HFS has made substantial efforts since late 2025 to implement the Work Requirements as outlined in H.R. 1. Since the IFR was issued on June 1, 2026, HFS has reviewed and assessed all of the changes included in the 378-page document. With a fast-approaching implementation deadline of January 1, 2027, Illinois has limited time in which to implement system enhancements to incorporate the new changes and requirements in the IFR, which will require substantial time and resources for design, coding, testing, and production. Introducing excessive volume or too many simultaneous or complex changes into a technical system can overwhelm its capacity and disrupt normal operations. When a system is pushed beyond its intended thresholds, the likelihood of defects, malfunction, or failure increases significantly. To maintain operational ability and ensure reliable performance, it is essential to manage change carefully and considered industry best practice to implement system updates in controlled, incremental phases. Implementing all new requirements in such an extremely compressed timeframe would compromise system integrity, putting the launch of the Work Requirements as a whole at risk, as well as leave inadequate time to educate and inform customers on the new requirements.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 18th day of August 2026.



Katherine Yager
Administrator of Medical Eligibility

EXHIBIT 41

DECLARATION OF LISA LEE

I, Lisa Lee, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of the Commonwealth of Kentucky. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Commissioner of the Kentucky Department for Medicaid Services (DMS) of information and records gathered by DMS staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Following the passage of H.R. 1 on July 4, 2025, DMS began efforts to implement H.R. 1's work requirement ("Work Requirement") by January 1, 2027. DMS has undertaken substantial and ongoing systems design, development and implementation work to operationalize the Work Requirement. The implementation effort has involved months of detailed requirements development, system design, technical analysis, configuration, interface development, testing and coordination across multiple systems and entities.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual definition. Congress identified a discrete category of "Specified Excluded Individuals," including, as relevant here, those who are medically frail or otherwise have special medical needs. Specified Excluded Individuals are not subject to the Work Requirement as a condition of eligibility. Practically speaking, this means that DMS will first determine whether an individual is a Specified Excluded Individual. Only if they are not a Specified Excluded Individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the Affordable Care Act (ACA) expansion would have to prove an exception, exclusion or exemption or demonstrate compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "Specified Excluded Individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they may be considered a "Specific Excluded Individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the medically frail exclusion, DMS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that medically frail individuals would fall within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between July 2025 and May 2026, DMS and its system partners conducted numerous Joint Application Design (JAD) sessions, Design, Development and Implementation (DDI) reviews, requirements discussions, technical meetings, and related systems-development activities to identify and resolve the detailed business and technical requirements necessary to implement the medically frail exclusion. These activities have included, among other things, determining how information already maintained in Medicaid and other state systems can be used to identify individuals who may satisfy the exclusion; determining what additional information must be collected or transmitted; establishing the data elements and business rules necessary to make an eligibility and compliance determination; and designing the interfaces and system processes necessary to support those determinations.

7. A significant portion of the systems work has involved identifying and evaluating the medical conditions, diagnoses, diagnosis codes, HCPCS codes, CPT codes, and other claims

and clinical information that may be used to identify individuals who meet the medically frail exclusion as described in H.R. 1. DMS has had to consider which codes and other data elements are sufficiently reliable and appropriate for this purpose, how those codes should be grouped or mapped to applicable policy categories, how frequently the information should be evaluated, and how changes in an individual's medical circumstances should be reflected in the eligibility system.

8. The implementation has required planning for extensive integration between the Medicaid Management Information System (MMIS) and the Integrated Eligibility and Enrollment System (IEES) and potentially other data sources. DMS has worked to determine what information must flow from the MMIS to the IEES, the format and timing of those data exchanges, the business rules that will govern the information, and how the IEES will use that information in determining if an individual is excluded due to being medically frail, all based on the language in H.R. 1 and CMS communications to date.

9. DMS was surprised by the changes to the interpretation of "medically frail" reflected in the Interim Final Rule issued in June 2025. CMS had added criteria to the statutory definition of medically frail, including a requirement that a condition "significantly impairs" an individual's ability to meet the Work Requirement. This additional language on the medically frail definition represents a material departure from both the text of H.R. 1 and the guidance CMS had provided for months preceding the issuance of the Interim Final Rule. The addition of this criterion was unexpected and DMS anticipates it will materially affect the policy and systems framework that has already been developed.

10. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirement as medically frail. First, DMS must determine if an individual falls within one of the five excluded categories established by Congress.

And second, DMS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

11. The significance of this change extends well beyond the wording of the eligibility policy. The definition of medically frail is foundational to the system design necessary to identify individuals who are excluded from or otherwise exempt from the Work Requirement. DMS has already invested substantial time and resources in translating the previously understood criteria into operational requirements, including determining the types of medical conditions and circumstances that may qualify an individual as medically frail; identifying and evaluating applicable diagnosis, HCPCS, and CPT codes; establishing business rules and data mappings; and determining how data from claims and other information will flow from the MMIS to the IEES and be used in the eligibility determination process.

12. The addition of a "significantly impairs" standard creates substantial implementation challenges because it may require DMS to reconsider not only which conditions and codes should be used to identify medically frail individuals, but also how the system can reliably determine whether a particular condition meets that additional standard. This potentially requires new policy decisions, system requirements, data sources, configurations, interfaces, testing, and cost that were not contemplated in the implementation work conducted to date.

13. DMS is particularly concerned about the timing of this change. The January 1, 2027 implementation date is a fixed federal deadline, and the systems-development process must proceed through requirements development, configuration, interface development, testing, user acceptance testing, implementation preparation, and other activities before the system can be placed into production. Changes to a fundamental eligibility concept such as medically frail, after substantial system design and development has occurred, significantly compress the time available

to make the necessary changes, test them, identify and correct defects, and validate that the system will accurately implement the revised requirements. While DMS has started the necessary work to implement the change in the federal interpretation of medically frail, particularly the addition of the "significantly impairs" criterion, it requires significant rework of systems and policy development already completed and could jeopardize the Department's ability to complete and adequately test the necessary systems changes before January 1, 2027. It also comes with additional cost and use of staff time.

EX PARTE VERIFICATION PROCESS

14. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DMS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DMS first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If DMS can verify a member's eligibility using available data, then they find the member eligible without requiring additional information from the member. Only if DMS cannot verify eligibility using available data does DMS send the member a renewal form for the member to complete the information that is missing and provide documentation if applicable.

15. *Ex parte* verification reduces the burden on members and DMS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

16. *Ex parte* verification also significantly reduces the administrative burdens and costs associated with processing Medicaid renewals. By allowing DMS to complete renewals without requiring the printing and mailing of renewal forms or the manually processing of returned renewal forms, *ex parte* verification conserves staff time and other administrative resources. Kentucky's *ex parte* rates are generally in the low- to mid-80 percent range, among the highest rates in the country, meaning that a substantial majority of renewals can be processed without these additional administrative steps, resulting in shorter processing times and more manageable workloads. Changes that limit DMS's ability to use *ex parte* verification would therefore be expected to reduce Kentucky's *ex parte* renewal rate and increase the number of renewals requiring manual processing, resulting in increased administrative workload, longer processing time, and higher associated costs.

17. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify the Work Requirement. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DMS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of the medically frail exclusion, were meant to be made on an *ex parte* basis, where possible.

18. In practice, to verify the medically frail exclusion for the Work Requirement by *ex parte*, DMS would begin by consulting data available to DMS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to have another exclusion or satisfy work requirements), they will be

provided a Notice of Noncompliance and a form requesting additional information needed to determine whether the individual meets the criteria for medical frailty or another exclusion, or meets the Work Requirement. The precise information DMS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

19. Since the IFR was published, however, DMS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine if an individual is medically frail.

20. Additionally, the IFR imposes a 12-month limitation on the claims and encounter data that DMS may use to verify medical frailty. 42 CFR 435.557(f)(1). However, it does not similarly limit the other six categories of data upon which DMS can rely upon when determining compliance with or exclusion from the Work Requirement. 42 CFR 435.557(a). The distinction is particularly concerning because limiting the use of claims and encounter data to the preceding 12 months may prevent DMS from identifying individuals whose medical conditions are documented in reliable historical data but who have not had a qualifying claim or encounter during that limited period. If CMS were to align claims and encounter data with the other categories, DMS could identify more individuals as medically frail through an ex parte process and reduce the number of individuals who must provide documentation solely because of limitation in the ability to access or use historical claims and encounter information. This would further the statutory objective of minimizing administrative burdens on individuals and reduce the risk that otherwise eligible individuals lose Medicaid coverage because they are unable to navigate an additional verification process.

21. If DMS cannot rely on *ex parte* verification to determine medical frailty, or if DMS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will result in fewer people having access to Medicaid. It will also lead to an increase in manual processing for those who do respond.

22. Beginning on January 1, 2027, Kentucky Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DMS will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, increasing the burden on those providers.

STATE EFFORTS GOING FORWARD

23. Given the limited period between June 1, 2026 and January 1, 2027, DMS has an extremely compressed timeframe in which to modify its eligibility system to implement the IFR. The changes reflected in the IFR require DMS to revisit significant portions of the system design and development work already completed, including eligibility rules, data requirements, system configurations, interfaces, and verification processes. As a result, DMS will not have the same amount of time ordinarily available to complete the full development, testing, user acceptance, and implementation activities necessary before placing a major eligibility-system change into production. The compressed timeframe creates substantial challenges and increases the risk that

DMS will be unable to complete all necessary development, testing and training activities before January 1, 2027, or identify and correct system defects before implementation.

24. The uncertainty regarding the applicable medically frail standard further compounds these challenges. The precise information DMS must collect from individuals, and, consequently, the content and wording of the forms used to collect that information, depends in significant part on whether DMS must implement the medically frail standard reflected in H.R. 1 or the additional criteria imposed by the IFR. If the IFR's additional criterion remain in place, DMS will need to develop system functionality and corresponding documentation capable of collecting and evaluating the information necessary to apply those criteria. If those criteria do not apply, much of that additional functionality and information collection may be unnecessary. DMS faces the difficult task of developing and testing systems and forms while the underlying federal requirements remain subject to significant uncertainty.

25. In addition to system development and testing, implementation requires substantial preparation of DMS's eligibility workforce and communication with Medicaid members and the public. Eligibility workers must be trained on the new Work Requirement policies, exemptions and exclusions, verification requirements, system functionality, and procedures for assisting individuals who may be subject to the requirement. DMS must also develop and distribute public and member education materials, notices, forms, website content, and other communication explaining the new requirements, applicable exemptions and exceptions, the information individuals may need to provide, and the consequences of failing to meet the applicable requirements. These materials and training cannot be finalized until the underlying policy and system requirements are sufficiently settled.

26. Ordinarily, DMS would use the time preceding a major eligibility-system implementation to conduct multiple rounds of system integration testing, user acceptance testing, and other validation activities; address issues identified through testing; train eligibility staff; finalize member and public communications; and provide workers and members sufficient time to understand and prepare for the changes. The significant compressed timeframe makes it difficult to complete these activities in the normal sequence and with the level of testing, training and public education that DMS would ordinarily undertake for a major change to Medicaid eligibility. DMS cannot responsibly represent that the system will be fully ready for production on January 1, 2027, if it is required to make substantial changes based on the IFR within the remaining implementation period. Doing so would require DMS to compress or potentially forgo portions of the ordinary development, testing, remediation, workforce training, and member education processes that are designed to ensure accurate eligibility determinations and successful implementation.

27. The Kentucky General Assembly passed a law in the 2026 legislative session that prohibits DMS from seeking a good faith extension. Therefore, the only remedy available is for the Court to vacate the Challenged Provisions.

28. If the Court were to vacate the Challenged Provisions, DMS would need a minimum of 7 months to perform the necessary coordinated process related to a change in the eligibility rules. From policy interpretation, business requirements development, system and technical design, data analysis, system configuration and coding, interface development, testing, defect remediation, forms and notice development, workforce training, member and public education, production preparation, and implementation, these activities are interdependent an iterative. Requirements must be sufficiently defined before they can be translated into system functionality; system functionality must be developed before comprehensive end-to-end testing

can occur; and sufficient time must remain after testing begins to identify, correct, and retest defects before the system is placed into production. The challenge presented by the IFR is not simply the amount of programming that must be completed. DMS must potentially revisit policy and system requirements that have already been developed, make corresponding changes to system design and configuration, modify data sources and interfaces, develop and test revised functionality, update forms and notices, train eligibility workers, and educate Medicaid members and the public, all within the period remaining before January 1, 2027. Compressing these interdependent activities into the remaining timeframe significantly reduces the opportunity for the iterative testing and remediation ordinarily necessary to ensure that a major eligibility-system change operates accurately before implementation.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 17th day of August 2026.

Lisa D. Lee
Commissioner

EXHIBIT 42

DECLARATION OF IAN YAFFE

I, Ian Yaffe, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Maine. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Director of the Office for Family Independence (OFI) within the Maine Department of Health and Human Services (DHHS), of information and records gathered by agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, Maine DHHS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that OFI will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-

year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

5. As to the Medically Frail exclusion, OFI understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that medically frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between September of 2025 and June of 2026, Maine DHHS was building a system based on claims and electronic health record data, including diagnosis codes, to determine whether individuals were medically frail as defined in H.R. 1. Maine DHHS was planning to go live with that system by the statutory implementation deadline.

7. On June 1, 2026, Maine DHHS learned that CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to the methodology for determining medical frailty, which impedes our ability to have a working technology system in place to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirement as medically frail. First, Maine DHHS must determine if an individual falls within one of the five excluded categories established by Congress. And second, Maine DHHS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, Maine DHHS has had to modify its system planning and establish new methodologies to determine whether someone meets the five congressionally established

categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to OFI to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR § 435.916(a)(2). Specifically, during a member's eligibility renewal, OFI first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If OFI can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if OFI cannot verify eligibility using available data does Maine DHHS send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and Maine DHHS, and it helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on Maine DHHS by allowing OFI to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). OFI also understood, based on the plain language of H.R. 1, and confirmed by

communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, OFI would begin by *ex parte* consulting data made available to OFI to determine if the individual qualifies as medically frail. If the individual cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which Maine DHHS can determine whether the individual meets the criteria for medical frailty. The precise information Maine DHHS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, Maine DHHS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine medical frailty.

16. Additionally, the IFR limits the time period Maine DHHS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which Maine DHHS can rely when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If Maine DHHS cannot rely on *ex parte* verification to determine medical frailty, or if Maine DHHS is only permitted to use a limited algorithm approach that *ex parte* verifies a

limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. As Maine DHHS was worked to implement the Work Requirement of H.R. 1, it has continued to refine its estimate of the impact from the Work Requirement. Those estimates continue to show that the more restrictive definition of medical frailty in the IFR will have a significant impact on the number of exclusions from the requirement and, as a result, potential disenrollments. However, modelling this effect has been challenging in the absence of critical guidance from CMS about the IFR.

19. Beginning on January 1, 2027, MaineCare members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by MaineCare will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers. The more restrictive IFR definition of medical frailty will result in a greater number of disenrollments among the MaineCare expansion population, and, as a result, will increase uncompensated and charity care costs across Maine hospitals and other providers, including Federally Qualified Health Centers and Certified Community Behavioral Health Clinics.

20. Given the limited time between June 1, 2026 and January 1, 2027, during which Maine DHHS has to create new system rules and other documents and procedures for eligibility compliance with the IFR, OFI lacks adequate time to make further changes prior to the required implementation date. The precise information Maine DHHS will need to collect – and thus the

wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

21. If the Court were to vacate the Challenged Provisions, OFI would need six months to reconfigure systems, notices, procedures, and documents.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 19th day of August 2026.

Ian Yaffe
Director, Office for Family Independence
Maine Department of Health and Human Services

EXHIBIT 43

DECLARATION OF PERRIE BRISKIN

I, Perrie Briskin, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Maryland. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as the Deputy Secretary of Health Care Financing and Medicaid Director for the Maryland Department of Health (the "Department" or "MDH") of information and records gathered by MDH and agency staff, of the matters set forth below. MDH is the single state agency responsible for administering Maryland Medicaid. I am the Director for the Maryland State Medicaid program and Children's Health Insurance Program (CHIP) (known together in Maryland as the "Maryland Medical Assistance Program" or "Maryland Medicaid"). If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, Maryland Medicaid has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that Maryland Medicaid will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to demonstrate that they are a specified

excluded individual, demonstrate a separate exception is applicable, or show compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, Maryland Medicaid understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between November of 2025 and June of 2026, Maryland Medicaid was building a system based on claims data and diagnosis codes to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that system, Maryland Medicaid was planning to go live with that system by the statutory implementation deadline. This build out was costly and time consuming, requiring investment of financial and personnel resources to support redesign of the Medicaid eligibility system and the state Health Information Exchange (HIE) interface.

7. On June 1, 2026, MDH was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system. Programming of the real time Application Program Interfaces (API) had to be paused for over 30 days after the publication of the IFR to assess the need for additional modifications. The

IFR has imperiled our ability to leverage existing data sources to support real time identification of applicants for exclusion from work requirements and effectively implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, Maryland Medicaid must determine if an individual falls within one of the five excluded categories established by Congress. Second, Maryland Medicaid must then determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, Maryland Medicaid has had to modify technical specifications for the state's eligibility and state HIE, which had been developed in consultation with MDH clinicians in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to Maryland Medicaid to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, Maryland Medicaid first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If Maryland Medicaid can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if Maryland Medicaid cannot verify eligibility

using available data does the member need to provide additional information to complete the renewal form.

11. *Ex parte* verification reduces the burden on members and Maryland Medicaid and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on Maryland Medicaid by allowing Maryland Medicaid to process renewals without the costs and resources, which would otherwise be necessary to support collection, processing, and review by caseworkers of requests for information, verification documentation, and other information necessary to process manual renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). Maryland Medicaid also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, Maryland Medicaid would begin by *ex parte* consulting data available to Maryland Medicaid to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they would need to self-attest and, beginning in 2028, they would need to submit a form providing additional information

through which Maryland Medicaid can determine whether the individual meets the criteria for medical frailty. The precise information Maryland Medicaid will need to collect – and thus the training materials for caseworkers reviewing self-attestation and the wording and questions on the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, Maryland Medicaid is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period Maryland Medicaid can use when relying on Claims and Encounter data to 12 months and does not take into account the fact that providers have 12 months from the date of service to submit claims data. Lags commonly occur between the time a given service is provided to a patient, the time the provider submits a claim, and the time needed for a claim to be processed and adjudicated. The IFR does not similarly limit the other six categories of data upon which Maryland Medicaid can rely upon when determining compliance with or exclusion from the Work Requirement. 42 C.F.R. § 435.557(a). If CMS were to extend the review period for Claims and Encounter data to align with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. Consistent with the IFR, when verifying an exclusion from the Work Requirement, some portion of Maryland Medicaid's process will utilize a system that reviews claims that have been adjudicated in the preceding 12 months and encounter data for the preceding 12 months. The system programming can be easily modified to include claims that go back for 2 years. The burden

of adding months, or even years, of claims and encounter data to a system that already has this capability is minimal. In contrast, the lookback limitations contemplated by the IFR will necessarily limit our ability to make *ex parte* determinations regarding medical frailty, and result in time consuming and costly process of additional member interaction to seek documentation to establish medical frailty.

18. If Maryland Medicaid cannot rely on *ex parte* verification to determine medical frailty, or if Maryland Medicaid is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

19. Maryland Medicaid originally projected that more than 320,000 adults would be subject to work and community engagement requirements and that 115,000 adults could lose coverage because of the H.R. 1 community engagement requirement. If the medical frailty changes in the IFR are implemented, Maryland Medicaid currently anticipates up to 152,000 eligible Marylanders could lose Medicaid coverage because of the new narrower medical frailty definition, administrative complexity, and operational barriers.

20. Beginning on January 1, 2027, Maryland Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by Maryland Medicaid will face challenges accessing primary and preventive care. Further, Maryland stands to lose $1.3 billion in Federal Financial Participation (FFP) due to the Challenged Provisions between state fiscal years 27 and 28.

STATE EFFORTS GOING FORWARD

21. Given the limited time between June 1, 2026 and January 1, 2027 in which Maryland Medicaid has to create a new system for eligibility compliant with the IFR, we will be unable to do the usual systems testing we would do before going live. Prior to issuance of the IFR, Maryland Medicaid had planned to complete iterative modular system testing, user acceptance testing in a closed environment, testing of system logic, and testing of interfaces with third party data sources, including those maintained by the federal government, by the end of September 2026. In addition Maryland Medicaid planned to complete at least two cycles of end-to-end testing and focus group user testing in fall 2026 so that any coding, workflow, processing or presentation errors could be identified and corrected prior to launch. Because of the changes required by the IFR, Maryland Medicaid's testing schedule is significantly delayed and we are unable to guarantee that the system will be ready to launch by January 1, 2027. The system complexity, performance, and risk for disenrollment errors will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

22. If the Court were to vacate the Challenged Provisions, Maryland Medicaid would need at least six months to reprogram workflows and reconfigure systems, including changes to coding, application logic, and file exchange interfaces.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 27 day of August 2026.

Perrie Briskin
Deputy Secretary of Health Care Financing,
Medicaid Director, Maryland Department of Health

EXHIBIT 44

DECLARATION OF RYAN SCHWARZ

I, Ryan Schwarz, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Massachusetts. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by MassHealth and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, MassHealth has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." *See* H.R. 1, Section 71119(a)(xx)(9)(A). Applicable Individuals are, in general, individuals enrolled or eligible to enroll in MassHealth under the ACA expansion. *See id.*, *see also* 42 CFR 435.551. However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special medical needs. If an individual is a specified excluded individual, they are not considered an Applicable individual and do not need to show compliance with the Work Requirement. Practically speaking, this means that MassHealth will determine whether an individual who would otherwise be an Applicable Individual is a specified excluded individual; only if they are not a specified excluded individual are they within the Applicable Individual category.

4. For example, based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exclusion or exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were

pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons and therefore would not be considered an Applicable Individual subject to the Work Requirement. If that 30-year-old had cerebral palsy, they potentially would be considered a "specific excluded individual" under the exclusion for the medically frail and therefore may not be an Applicable Individual subject to the Work Requirement.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, MassHealth understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(a)(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between the fall of 2025 and May of 2026, MassHealth devoted substantial clinical and operational resources to building an approach to identifying individuals qualifying for exclusion on the basis of "medical frailty" as defined by H.R.1. That approach was in testing and early implementation, in preparation to go live by the statutory deadline of January 1, 2027, when the IFR was released in June 2026. As a consequence of the new information and requirements in the IFR, MassHealth has had to substantially revise its approach, requiring allocation of additional resourcing to develop, test, and plan for rapid implementation of its new approach on a truncated timeline.

7. On June 1, 2026, CMS announced new criteria added to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system. Specifically, MassHealth has had to modify its system in order to determine whether someone

meets one of the five congressionally established categories of medically frail exclusions *and* that their condition significantly impairs their ability to meet the Work Requirement. This has required a shift in implementation design, forcing MassHealth to divert its limited resources away from other critical activities needed to administer MassHealth.

EX PARTE VERIFICATION PROCESS

8. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to MassHealth to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, MassHealth first attempts to use available data (such as data regarding income) to determine whether the member remains eligible. If MassHealth can verify a member's eligibility using available data, then it finds the member eligible without requiring input from the member. Only if MassHealth cannot verify eligibility using available data does MassHealth send the member a renewal form for the member to complete.

9. *Ex parte* verification reduces the burden on members and MassHealth and helps to ensure that fewer people are disenrolled due to administrative hurdles. MassHealth data shows that, in general, only about 40% of members under age 65 who receive a renewal form actually complete and send the renewal form back. Thus, *ex parte* verification is a critical process that helps ensure that eligible members remain enrolled.

10. *Ex parte* verification also reduces administrative burdens and costs for MassHealth by allowing MassHealth to process renewals without the resources necessary to print, mail, and manually process returned renewal forms and additional documentation.

11. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). MassHealth also understood, based on the plain language of H.R. 1 and communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

12. In practice, to verify medical frailty for the Work Requirement, MassHealth plans to begin by *ex parte* consulting data available to it to determine if an individual qualifies as medically frail. In 2027, if an individual cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy or be excluded from work requirements), the individual will first be asked certain medical frailty screening questions. If they answer in the affirmative, they will then be sent a Request for Information instructing them to share additional information through which MassHealth can determine whether they meet the criteria for medical frailty. The precise information MassHealth will need to collect – and thus the wording of MassHealth's medical frailty Request for Information – will vary depending on whether medical frailty is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

13. Since the IFR was published, however, MassHealth has been dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty. For example, in the preamble to the IFR, CMS stated: "Reading the statute to require automatic classification as medically frail or otherwise having special medical needs based solely on

diagnosis or condition would risk sweeping in individuals whose conditions do not significantly impair their functional capacity." 91 Fed. Reg. 33,373.

14. Additionally, the IFR limits the time period MassHealth can use when relying on claims and encounter data. However, it does not similarly limit the other six categories of data upon which MassHealth can rely when determining compliance with or exclusion from the Work Requirement. *See* 42 C.F.R. 435.557(a). If CMS were to remove the 12-month limitation on use of claims and encounter data and align it with CMS's approach to states' use of other data sources, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

15. Consistent with the IFR, when verifying an exclusion from the Work Requirement, MassHealth plans to utilize a system that reviews claims that have been adjudicated in the preceding 12 months and encounter data for the preceding 12 months. These systems can be easily modified to include data that goes back additional months beyond these 12. The burden of adding months, or even years, of claims and encounter data to a system that already has this capability is minimal. In contrast, the 12-month limitation contemplated by the IFR will necessarily limit our ability to make *ex parte* determinations regarding medical frailty, and result in time consuming and costly processes of additional member interaction to seek documentation to establish medical frailty.

16. The IFR's limitation on use of claims and encounter data will also likely lead to coverage loss for members and increased administrative burden on MassHealth for members or applicants who have lapses in claims data but who otherwise meet the parameters of medical frailty. For example, MassHealth may not be able to *ex parte* verify an individual with a permanent condition like quadriplegia who experiences a lapse in MassHealth coverage for over a year and

therefore has no claims or encounter data within the preceding 12 months, even if such data were available to MassHealth from the individual's prior enrollment period. Similarly, an individual who has a condition that, by its nature, limits their ability to seek care (such as schizophrenia, dementia, or major depressive disorder), may also not be *ex parte* verifiable as medically frail if they were not able to receive care in the prior 12 months. The IFR's time limitation on claims and encounter data will inhibit MassHealth's ability to conduct *ex parte* verification under the IFR, despite not being meaningfully related to the individual's condition or ability to work.

17. MassHealth expects that, if MassHealth cannot rely on *ex parte* verification to determine medical frailty, or if MassHealth is only permitted to use an algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. As stated above, renewal response rates show that many MassHealth members do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to MassHealth.

18. Beginning on January 1, 2027, MassHealth applicants and members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The coverage loss that will be precipitated by the IFR increases the risk that individuals formerly covered by MassHealth will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers. Moreover, each additional member that loses eligibility as a result of the Challenged Provisions results in average of $7,000 per year of lost federal financial participation for MassHealth.

STATE EFFORTS GOING FORWARD

19. If the Court were to vacate the Challenged Provisions, MassHealth would need to take numerous steps to ensure members were correctly evaluated for medical frailty. These steps

would include, but are not limited to, updating forms related to medical frailty, changing the processing of information from data sources, and updating staff training and member communication materials. MassHealth estimates that it would take at least six weeks to accomplish this change.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 24th day of August 2026.

Ryan Schwarz
Assistant Secretary for MassHealth
Executive Office of Health and Human Services

EXHIBIT 45

DECLARATION OF MEGHAN E. GROEN

I, Meghan E. Groen, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Michigan. I am over the age of 18 and have knowledge of all the facts stated herein, either personally or in consultation with staff at the Michigan Department of Health and Human Services (MDHHS) and/or based on documents that I have reviewed. If called as a witness, I could and would testify competently to the matters stated herein.

2. I am the Senior Chief Deputy Director for Health Services at MDHHS. In this role, I am Michigan's Medicaid Director.

3. H.R. 1 contains a work requirement (Work Requirement), which takes effect on January 1, 2027.

4. The Work Requirement applies only to those defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). Several discrete categories of individuals are specifically excluded from the definition of "Applicable Individuals," including those who are medically frail or otherwise have special needs.

5. Therefore, to determine whether a particular individual must comply with the Work Requirement, MDHHS must first determine whether that individual is specifically excluded from the definition of "Applicable Individuals."

MDHHS'S WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

6. As to the Medically Frail exclusion, H.R. 1 enumerates five categories of individuals who qualify. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

7. Following the passage of H.R. 1, MDHHS promptly began work to comply with the Work Requirement. Among other things, MDHHS worked with clinical and systems personnel

to build a process to identify individuals who could be considered "medically frail," leveraging claims data and other sources that reflect significant medical or functional vulnerabilities. MDHHS was planning to go live with that system by the statutory implementation deadline.

8. On June 1, 2026, CMS promulgated an Interim Final Rule (IFR) related to the Work Requirement, which imposed additional requirements, such as a more restrictive definition of "medically frail." To implement the IFR's new requirements, MDHHS's systems required significant changes, which MDHHS immediately began working to complete.

9. To determine whether an individual is excluded from the Work Requirements as medically frail, MDHHS must first determine whether the individual is, in fact, medically frail and, if so, whether that medical frailty "significantly impairs" the individual's ability to comply with the Work Requirement.

10. MDHHS has been working to configure its eligibility system to incorporate the significant impairment requirement into the eligibility factors for medical frailty. The design and development approach necessitated substantial departures from Michigan's previously adopted medically frail definition and the corresponding system configuration, which has required MDHHS to expend significant additional time and resources.

EX PARTE VERIFICATION PROCESS

11. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to MDHHS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations require that Medicaid agencies renew enrollees' eligibility using *ex parte* verification processes when possible. *See* 42 C.F.R. 435.916(a)(2). Specifically, during an enrollee's eligibility renewal, MDHHS first attempts to use available data (such as data regarding

income and residence) to determine whether the enrollee remains eligible. If MDHHS can verify an enrollee's eligibility using available data, then they find the enrollee eligible without requiring input from the enrollee. Only if MDHHS cannot verify eligibility using available data does MDHHS send the enrollee a renewal form for the enrollee to complete.

12. *Ex parte* verification reduces the burden on enrollees and helps to ensure that fewer eligible individuals are disenrolled due to administrative hurdles.

13. *Ex parte* verification also reduces administrative burdens and costs on MDHHS by allowing MDHHS to process renewals without the costs and resources necessary to print, mail, and manually process renewal forms.

14. H.R. 1 expresses a preference for utilizing *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information.").

15. To verify an individual's medical frailty for the Work Requirement on an *ex parte* basis, MDHHS would consult data available to MDHHS to determine if the individual qualifies as medically frail. If MDHHS could not verify medical frailty *ex parte* (and cannot otherwise verify satisfaction the Work Requirements or another exclusion *ex parte*), the individual will be required to provide, under penalty of perjury, additional written information through which MDHHS could determine whether the individual meets the criteria for medical frailty. The precise information MDHHS will need to collect—and thus the wording of the form—will vary depending on whether the IFR is operative.

16. However, the IFR has created additional uncertainty around the use of *ex parte* verifications to validate medical frailty. For instance, its preamble indicates that States cannot rely solely on diagnosis or condition codes to determine medical frailty.

17. If MDHHS cannot rely on *ex parte* verification to determine medical frailty, or if MDHHS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible enrollees losing Medicaid. Renewal response rates show that many Medicaid enrollees, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

STATE EFFORTS GOING FORWARD

18. Given the limited time between June 1, 2026, and January 1, 2027, in which MDHHS must modify its eligibility system to be compliant with the IFR, MDHHS will be unable to guarantee that the system can be fully configured in a compliant manner by January 1, 2027. The timeline requires MDHHS to complete policy decisions, system design, development, and testing within a significantly compressed window, and several critical dependencies remain outside MDHHS's control.

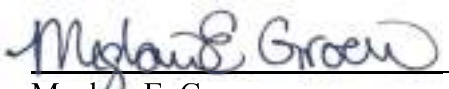
19. All policy and operational decisions must be finalized by August 31, 2026, in order to complete the required system work. This date is already far extended from MDHHS's original requirements and design due date, which had to be extended to account for the IFR release date. Because CMS has not yet issued the medical frailty guidance, MDHHS may be required to make assumptions in advance of receiving the federal parameters. If those assumptions do not align with the forthcoming guidance, the system may not fully reflect federal requirements on January 1, 2027, and additional corrective work would be necessary.

20. In addition, several required data feeds have not yet been made available to MDHHS. These include external data sources that must be integrated into the eligibility system to support IFR compliance. The timeline for receiving, testing, and operationalizing these feeds remains uncertain, and delays would directly affect MDHHS's ability to interface and complete system development to utilize the data. Further, the use of National Student Clearinghouse data requires beneficiary consent under federal law. Establishing, operationalizing, and verifying compliant consent workflows within the eligibility system presents additional complexity that will be challenging to accomplish quickly, limiting MDHHS's ability to utilize this data source as intended. MDHHS will continue to advance implementation activities to the greatest extent possible; however, given the timing, complexity, and reliance on yet-to-be-released federal guidance and data feeds, MDHHS cannot assure full compliance by January 1, 2027.

21. If the Court were to vacate the Challenged Provisions, MDHHS would need approximately three to six months to make the necessitated system updates.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 18th day of August, 2026 in Lansing, Michigan.



Meghan E. Groen
Senior Chief Deputy Director for Health Services

EXHIBIT 46

DECLARATION OF PAMELA WEINER

I, Pamela Weiner, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Minnesota. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Assistant Commissioner for Eligibility and Compliance of information and records gathered by the Minnesota Department of Human Services (DHS) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DHS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that DHS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour or $580 monthly income proxy Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion

for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, DHS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between fall of 2025 and June of 2026, DHS was developing a verification process based on claims data and diagnosis code to determine whether individuals were medically frail as defined in H.R. 1. In addition to developing the verification process, work was underway to update the online and paper application to reflect the medical frailty exclusion as were the educational tools needed to explain the new requirement to potential and current enrollees as well as the larger community supporting enrollees.

7. On June 1, 2026, DHS was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our proposed verification process, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DHS must determine if an individual falls within one of the five excluded categories established by Congress.

And second, DHS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, DHS will have to modify our verification process in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This will require significant additional unplanned resources.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DHS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DHS first attempts to use available data (such as data regarding income) to determine whether the member remains eligible. If DHS can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if DHS cannot verify eligibility using available data does DHS send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and DHS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on DHS by allowing DHS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DHS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DHS would begin by *ex parte* consulting data available to DHS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DHS can determine whether the individual meets the criteria for medical frailty. The precise information DHS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, DHS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period DHS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DHS can rely upon when determining compliance with or exclusion from the Work Requirement.

See 42 C.F.R. 435.557(a). If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If DHS cannot rely on *ex parte* verification to determine medical frailty, or if DHS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, Minnesota Medical Assistance members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DHS will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026 and January 1, 2027 which DHS has to revise our verification process for eligibility compliant with the IFR, we will be unable to guarantee we will be ready by January 1, 2027 . The precise information DHS will need to collect – and thus the wording on application/renewal forms, notices and other member communications – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

If the Court were to vacate the Challenged Provisions, DHS would need three to six months to switch systems and complete the administrative tasks necessary to adopt the revised requirements.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 27 day of August 2026.

/s/ Pamela J Weiner
Pamela J Weiner
Deputy Assistant Commissioner for Eligibility and Compliance
Minnesota Department of Human Services

EXHIBIT 47

DECLARATION OF GREGORY WOODS

I, Gregory Woods, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of New Jersey. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DMAHS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of "specified excluded individuals," including, as relevant here, those who are medically frail or otherwise have special medical needs. 42 U.S.C § 1396a(xx)(9)(A)(ii). Only Applicable Individuals need to show compliance with the Work Requirement. Specified excluded individuals, meaning an individual who meets at least one of the criteria described in subclauses (I) through (IX) under section 1902(xx)(9)(A)(ii) of the Social Security Act, are categorically exempt. Practically speaking, this means that DMAHS will first determine whether an individual is a specified excluded individual before assessing compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to: show that he or she satisfies an exclusion under the definition of "specified excluded individual", prove compliance with the Work

Requirement, or demonstrate that some exception to the Work Requirement applies. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons as outlined in H.R. 1. Based on the Work Requirement as outlined in H.R. 1, if that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, DMAHS understood, based on the plain language of H.R. 1, and supported by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include all individuals who fell within one of the five categories enumerated by Congress. 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between the passage of H.R. 1 and CMS's publication of the Interim Final Rule (IFR) on June 1, 2026, DMAHS worked to build a system based on claims data to determine whether individuals were medically frail as defined in H.R. 1. While additional work remained to finalize, validate and test that system, DMAHS was planning to go live with that system by the statutory implementation deadline. This build out required substantial time and effort from eligibility, clinical, data analysis, and other teams both within the agency and at the agency's contracted vendors.

7. On June 1, 2026, CMS promulgated regulations that added significant new criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system. These changes imperil our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require DMAHS to confirm that an individual meets two conditions to determine whether an individual is excluded from the Work Requirements as medically frail. First, an individual must fall within one of the five excluded categories established by Congress. And second, DMAHS must determine if that person's ability to comply with the Work Requirement is significantly impaired by their condition.

9. Accordingly, DMAHS needs to develop new standards and processes to confirm that an individual meets the two conditions required to establish medical frailty. Furthermore, DMAHS needs to validate this logic with eligibility, clinical, and data analysis, and other teams, both within the agency and at the agency's contracted vendors that helped to establish the medical frailty definition before the IFR was released. Once the logic is validated, further work is required to build and test its use in multiple eligibility systems. This has been a significant additional unplanned cost and use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DMAHS to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, DMAHS first attempts to use available data (such as data regarding income and immigration status) to determine whether the member remains eligible. If DMAHS can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if DMAHS cannot verify eligibility using available data does DMAHS send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members, DMAHS, and the County Social Service Agencies and Health Benefits Coordinator vendor that make or support eligibility determinations and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs for DMAHS by allowing DMAHS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* 42 U.S.C. § 1396a(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DMAHS also understood, based on the plain language of H.R. 1, and supported by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, DMAHS would begin by *ex parte* consulting data available to DMAHS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DMAHS can determine whether the individual meets the criteria for medical frailty. The precise information DMAHS will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional extra-statutory criteria from the IFR is operative. DMAHS and partner staff have dedicated substantial

time to rewording the medical frailty application and renewal questions that may be used for self-attestation in 2027, and in limited cases starting in 2028, since the IFR was released.

15. Since the IFR was published, however, DMAHS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period DMAHS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DMAHS can rely upon when determining compliance with or exclusion from the Work Requirement. 91 Fed. Reg. 33474 (defining eight categories of "reliable information" and limiting the time period for claims data and encounter data). Although the IFR limits consideration of claims and encounter data to only the preceding 12 months, it would pose very little administrative burden to DMAHS to have a longer lookback period. In fact, a longer lookback period would be beneficial to DMAHS in ensuring that Medicaid recipients eligible for exclusions from the Work Requirement are not denied coverage unnecessarily.

17. If DMAHS cannot rely on *ex parte* verification to determine medical frailty, or if DMAHS is only permitted to use an algorithm approach that includes a very limited definition of medical frailty, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, applicants and members of New Jersey's Medicaid program (called New Jersey FamilyCare) who would be determined eligible but for the Challenged

Provisions will be denied or terminated from coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DMAHS will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, creating greater strain for providers and poorer health outcomes for New Jerseyans.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026 and January 1, 2027 that DMAHS has to change substantial elements of its system to verify the Work Requirement, including to develop and stand up a new definition of medical frailty, we are unsure of our ability to ensure a complete and compliant implementation of Work Requirements and other eligibility changes on January 1, 2027. Significant policy, systems build, systems testing, eligibility worker training, and other work remains. As a result, DMAHS may choose to seek a good faith extension to implement the Work Requirement.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 31st day of August 2026.

/s/*Gregory Woods*
Gregory Woods
Director, Division of Medical Assistance and Health Services

EXHIBIT 48

DECLARATION OF SARAH GREGOSKY

I, Sarah Gregosky, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of North Carolina. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Assistant Secretary and Deputy Medicaid Director of information and records gathered by the North Carolina Department of Health and Human Services ("NC DHHS"), Division of Health Benefits ("DHB" or "NC Medicaid") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, NC Medicaid has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that NC Medicaid will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-

year-old had cerebral palsy, they would be considered a "specified excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, NC Medicaid understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between August 2025 and June of 2026, NC Medicaid was building a system based on claims and encounter data available through NC Medicaid's data warehouse and electronic health record data available through NC Health Information Exchange to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remains to be done on that system, NC Medicaid was planning to go live with that system by the statutory implementation deadline. This build out was costly and time-consuming as NC Medicaid had already done the following as of June 2026, and likely will have to re-do some of these tasks to address additional criteria identified in the IFR:

- Initiated internal workgroups with NC DHHS staff to develop work plan, policy and technology requirements, and external stakeholder engagement approach;
- Initiated internal workgroups with NC DHHS staff to develop medical frailty approach, which are having to be redone based on the IFR;
- Initiated workgroups with Managed Care Health Plan staff to review work plans, policy and technology requirements, and external stakeholder engagement approach;

- Initiated workgroups with eligibility and enrollment system (NCFAST) to review and implement policy and statutory requirements. As of June 2026, NC Medicaid had held 68 meetings with NCFAST staff and an additional 29 meetings with NC DHHS leadership to ensure cross program alignment with other economic service programs managed within NCFAST;
- Developed budget estimates to implement and operationalize community engagement requirements and sought state and federal budgetary authority to support the requirements;
- Developed stakeholder engagement materials and began stakeholder engagement, including website content, call scripting, and training presentations. As of June 2026, NC Medicaid had met with 63 external stakeholder groups, including community partner organizations and county Departments of Social Services staff;
- Analyzed existing eligibility policies to confirm necessary updates to support community engagement and began necessary updates;
- Began updating paper and electronic application aligned with community engagement requirements including development of the application appendices needed for H.R. 1. implementation;
- Initiated design and development of new data sources to support automation of community engagement requirements, including education data, work program data, NC Medicaid claims and encounter data, NC Health Information Exchange electronic medical record data, and veteran's disability rating data; and

- Initiated design and development of existing data sources to support automation of community engagement requirements, including wage data, incarceration data, and managed care eligibility data.

7. On June 1, 2026, NC Medicaid was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system and, as further discussed below, increases burden on beneficiaries to demonstrate an impairment and increases the volume of NC Medicaid eligibility determinations to be made[1] based on documentation manually submitted by beneficiaries where data to validate the additional "significant impairment" is not available, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027. That is because the IFR requirements add confusion, particularly given that notices to beneficiaries regarding the medically frail exception as set forth in H.R. 1 have been sent; increase complexity to the collection of information; require changes to the system rules already under development; and add additional burden on beneficiaries, eligibility caseworkers and providers for outreach/determinations of medical frailty.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, NC Medicaid must determine if an individual falls within one of the five excluded categories established by Congress. And second, NC Medicaid must determine if that person's ability to comply with the Work Requirement is significantly impaired.

[1] NC Medicaid eligibility determinations are made by county Department of Social Services caseworkers who are overseen by NC Medicaid ("eligibility caseworkers").

9. Accordingly, NC Medicaid has not only had to modify its system in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired, but anticipates that the additional medically frail criteria added by the IFR will require beneficiaries to manually provide documentation and evidence that the IFR criteria have been met, increasing the burden on beneficiaries and strain on eligibility caseworkers to conduct the unanticipated additional volume of manual reviews.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to NC Medicaid to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, NC Medicaid first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If NC Medicaid can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if NC Medicaid cannot verify eligibility using available data does NC Medicaid send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and NC Medicaid and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on NC Medicaid by allowing NC Medicaid to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). NC Medicaid also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, NC Medicaid would begin by *ex parte* consulting data available to NC Medicaid to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information and supporting documentation from a medical provider or attestation, to the extent permitted by the IFR when documentation is not reasonably available, through which eligibility caseworkers can determine whether the individual meets the criteria for medical frailty. NC Medicaid anticipates that a larger volume of individuals will be required to manually submit documentation to support medical frailty based on the limited definition and inclusion of significant impairment under the IFR. The precise information NC Medicaid will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, NC Medicaid is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to

the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period NC Medicaid can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which NC Medicaid can rely upon when determining compliance with or exclusion from the Work Requirement. 91 Fed. Reg. 33393, 33394 (June 3, 2026). If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If NC Medicaid cannot rely on *ex parte* verification to determine medical frailty, or if NC Medicaid is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then a larger volume of individuals will be required to manually submit documentation to demonstrate medical frailty based on requirements in the IFR, creating additional burden that will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. North Carolina anticipates that the more stringent medical frailty criteria under the IFR will cause 64,000 NC Medicaid beneficiaries to lose coverage in addition to the projected 30% of NC Medicaid expansion adult beneficiaries anticipated to lose coverage under the H.R. 1. Requirements and six month renewals.[2]

[2] P. Boozang et al, "CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034" Manatt Health, July 2026, https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/23b961e2-a654-4fd1-9358-1e3d42205358/Vital%20Signs%2050-State%20Tracking_CMS%20Medicaid%20Work%20Requirements%20Rule.pdf.

19. Beginning on January 1, 2027, NC Medicaid members who would be determined eligible but for the Challenged Provisions may be denied coverage if the Challenged Provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by NC Medicaid will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers. Before NC Medicaid expansion took effect in December 2023, uncompensated care in North Carolina in 2023 resulted in costs to North Carolina hospitals of roughly $2 billion, including $1.2 billion in charity care and $838 million in debt write-off in a single year.[3] Between 2005 and 2023, uncompensated care for uninsured patients contributed to twelve rural hospitals in North Carolina closing or ending inpatient care.[4]

STATE EFFORTS GOING FORWARD

20. Given the limited time between June 1, 2026 and January 1, 2027 which NC Medicaid has to create a new system for eligibility compliant with the IFR, absent additional time to implement necessary system changes, we are unable to guarantee that the system will be ready by January 1, 2027 based on the need for complex logic development that will not be implemented prior to January 1, 2027; expect a significant volume of beneficiaries will need to manually submit documentation to demonstrate compliance with the IFR criteria; and anticipate substantial delays in processing times due to the additional level of effort for eligibility caseworkers to process documentation submitted by beneficiaries to demonstrate criteria under the IFR has been met. The

[3] North Carolina Healthcare Association, Statement on medical debt and credit reporting, June 13, 2024 (2023 charity care and bad debt figures), https://www.ncha.org/ncha-statement-on-proposal-to-ban-medical-bills-from-credit-reports/.
[4] NC Health News, Mar. 5, 2025 (reporting on rural hospital closure data from Cecil G. Sheps Center for Health Services Research at UNC Chapel Hill), https://www.northcarolinahealthnews.org/2025/03/05/medicaid-expansion-at-risk/.

precise information NC Medicaid will need to collect from beneficiaries based on the IFR criteria will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

/s/ Sarah Gregosky
Sarah Gregosky, MSPH
Assistant Secretary and Deputy Medicaid Director
NC Department of Health and Human Services,
Division of Health Benefits (NC Medicaid)

EXHIBIT 49

DECLARATION OF VIVIAN LEVY

I, Vivian Levy, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Oregon. I am over the age of 18 and have personal knowledge, and knowledge based on review in my capacity as the interim State Medicaid Director of information and records gathered by the Oregon Health Authority (OHA) and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, OHA has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that OHA will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-

year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, OHA understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between July 1, 2025 and June 1, 2026, OHA was building a methodology based on diagnosis codes found in claims data to determine whether individuals were medically frail as defined in H.R. 1. As all claims necessarily are comprised of both a diagnosis code and a healthcare service, this methodology inherently included healthcare services utilization related to the qualifying diagnosis. While additional testing remained to be done on that system, OHA was planning to go live with that system by the statutory implementation deadline. This build-out was costly and time consuming, creating the need for urgent analysis and system requirement updates.

7. On June 1, 2026, OHA was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system, creating significant risk to our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, OHA must

determine if an individual falls within one of the five excluded categories established by Congress. And second, OHA must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, OHA has had to redesign its methodology for determining whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has resulted in significant additional unplanned cost and use of staff time. In addition, the very limited time to change methodology has precluded OHA from obtaining input and feedback on the proposed new methodology from internal and external partners, resulting in less review of the code list. Lastly, this change has threatened the timelines for adequate system testing prior to implementation.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to OHA to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, OHA first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If OHA can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if OHA cannot verify eligibility using available data does OHA send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and OHA and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on OHA by allowing OHA to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). OHA also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, OHA would begin by *ex parte* consulting data available to OHA to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which OHA can determine whether the individual meets the criteria for medical frailty. The precise information OHA will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, OHA is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period OHA can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which OHA can rely when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

17. If OHA cannot rely on *ex parte* verification to determine medical frailty, or if OHA is only permitted to use a limited algorithm approach that verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, Oregon Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by OHA will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers, increasing uncompensated care for Oregon hospitals, which was already $1.106B in 2025.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026 and January 1, 2027 which OHA has to make significant eligibility and enrollment system changes to be compliant with the IFR, we will be unable to sufficiently analyze and validate our methodology for identifying Medical Frailty and complete the usual systems testing we would do before going live by January 1, 2027. We are prioritizing systems testing, resulting in an expected need to further revise our methodology over the course of 2027. This will cause confusion for members, healthcare providers, and community partners, and increase the likelihood of eligible individuals not retaining Medicaid coverage.

20. If the Court were to vacate the Challenged Provisions, OHA would need at least six months to update IT systems and business processes

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 19th day of August 2026.

/s/ Vivian Levy
Vivian Levy
Interim Medicaid Director
Oregon Health Authority

EXHIBIT 50

DECLARATION OF HOA PHAM

I, Hoa Pham, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Pennsylvania. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as Deputy Secretary of the Pennsylvania Department of Human Services' ("DHS") Office of Income Maintenance of information and records gathered by DHS and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.
2. Since the passage of H.R. 1, DHS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.
3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special medical needs. Practically speaking, this means that DHS will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.
4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show an exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old is pregnant, they would be

considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the medically frail exclusion, DHS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that medically frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee) of the Social Security Act (codified at 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between February 2026 and June of 2026, DHS invested time and resources to build an automated system to evaluate Medicaid claim, diagnoses and provider encounter data to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that system, DHS was planning to go live with that system by the statutory implementation deadline. This system and data build was costly and time consuming. A substantial number of Commonwealth staff and resources were required to develop Pennsylvania's initial approach to medical frailty. The work involved data analysts, program managers and analysts, data engineers, eligibility and IT professionals, clinicians, and senior leadership across DHS. Two Special Advisors to the Secretary devoted significant time to leading and coordinating the policy, clinical, data, and implementation work.

7. DHS clinicians undertook detailed review and categorization of thousands of diagnosis codes, procedure codes, pharmacy codes, and other medical billing codes to determine

which conditions and health care services could support an automated medical frailty determination. This work required translating broad statutory concepts such as serious or complex medical conditions, disabling mental disorders, and functional impairment into specific, auditable criteria that could be implemented using administrative data.

8. At the same time, data and program staff had to develop expertise in data sources and fields that DHS had not previously used for Medicaid eligibility determinations. This data included finding lawful ways to access patient data and assessing how claims and encounter data, electronic health record information available through the Pennsylvania Patient and Provider Network (P3N), hospital admission and discharge information, managed care health assessments and case management information, and applicant-provided information could work together to identify individuals who qualify for an exemption.

9. Senior staff also convened and coordinated a broad group of internal and external stakeholders, including DHS program offices, clinicians, managed care organizations, Pennsylvania's health information exchange partners, IT teams and vendors, researchers, and peer states. This work required developing policy, clinical, analytic, and technical approaches in parallel while federal guidance was still evolving. In addition to policy development, DHS began significant systems discovery and design work to determine how medical frailty determinations could be incorporated into the Commonwealth's eligibility workflow rather than handled through a separate manual process.

10. On June 1, 2026, DHS was surprised to learn CMS had added criteria to the statutory definition of medically frail through its Interim Final Rule (IFR). In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of

June 1, 2026, but also requires significant changes to our system, imperiling our ability to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

11. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DHS must determine if an individual falls within one of the five excluded categories established by Congress. And second, DHS must determine if that person's ability to comply with the Work Requirement is significantly impaired.

12. Accordingly, DHS has had to substantially revise the medical frailty methodology and related system design that were already underway in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time. The IFR requires DHS not only to identify whether an individual falls within one of the five statutory categories, but also to evaluate whether the individual's condition significantly impairs the individual's ability to comply with the Work Requirement. That additional inquiry changes the information DHS must evaluate, the clinical judgments that must be translated into policy, and the business rules that must be programmed and tested.

13. To operationalize this additional inquiry, DHS developed a revised framework that distinguishes among: (1) severe or high-risk conditions that can support a medical frailty determination based on the condition itself; (2) chronic conditions that require additional evidence of severity, complexity, treatment burden, functional impairment, or overall worse health; and (3) significant acute or temporary conditions. For chronic conditions, DHS also had to develop measurable indicators of severity and complexity, such as high-

acuity utilization, repeated emergency care, intensive outpatient treatment, high-complexity treatment, durable medical equipment, and home health services.

14. This redesign required substantial additional clinical, policy, and analytic work. DHS clinicians had to re-review and reclassify thousands of diagnoses, procedure, pharmacy, and other codes under the revised framework. Policy and analytic staff had to review supporting medical literature, evaluate approaches developed by other states and researchers, determine appropriate definitions and thresholds, and assess how combinations of conditions and severity indicators should be applied consistently using administrative data.

15. The revised methodology also required changes to the data and systems work already underway. Data scientists, data engineers, and IT staff have had to identify additional data elements, develop new calculations and decision logic, revise the process for producing and transmitting medical frailty determinations to the eligibility system, and plan additional validation, testing, audit, and error-handling processes. This unplanned work has required significant additional staff time and resources and has reduced the time available to complete and test the revised process before January 1, 2027.

EX PARTE VERIFICATION PROCESS

16. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to DHS to determine whether an individual is eligible for Medicaid, without requesting further submission of information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR §

435.916(a)(2). Specifically, during a member's eligibility renewal, DHS first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If DHS can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if DHS cannot find the member eligible using available data, or it is not possible to do so, does DHS send the member a renewal form for the member to complete.

17. *Ex parte* verification was contemplated as a federal requirement to reduce the burden on members and DHS. It helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

18. *Ex parte* verification also reduces administrative burdens and costs on DHS by allowing DHS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

19. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). DHS also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, as well as specified exclusions, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

20. In practice, to verify medical frailty for the Work Requirement, DHS would begin by *ex parte* consulting data available to DHS to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which DHS can determine whether the individual meets the criteria for medical frailty. The precise information DHS will need to collect – and thus the exact wording of the form– will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.
21. Since the IFR was published, however, DHS is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.
22. On August 21, 2026, DHS sent a letter to CMS outlining DHS' approach to determining Medical Frailty, which DHS previously shared with CMS on July 2, 2026. In this letter, DHS respectfully requested that CMS authorize this method by September 4, 2026, which DHS shared previously with CMS on July 2, 2026. We have not yet received a response from CMS. DHS requires affirmation from CMS not only to confirm time-sensitive decisions to meet H.R.1's January 2027 implementation date, but to also provide assurances that DHS' approach does not run afoul of CMS' legal, policy and audit requirements.
23. Additionally, the IFR limits the time period DHS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DHS can rely upon when determining compliance with or exclusion from the Work

Requirement. *Medicaid Program; Community Engagement Requirement for Certain Individuals*, 91 Fed. Reg. 3334-33482 (June 3, 2026) (to be codified at 42 CFR Parts 431, 435, 438, 457, and 600). If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens, and DHS would avoid costs associated with mailing otherwise unnecessary Medicaid renewal forms and additional administrative staff processing.

24. If DHS cannot rely on *ex parte* verification to determine medical frailty, or if DHS is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. As stated above, renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

25. Beginning on January 1, 2027, Pennsylvania Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by DHS will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers.

STATE EFFORTS GOING FORWARD

26. Given the limited time between June 1, 2026, and January 1, 2027, which DHS has to create a new system for eligibility compliant with the IFR, we will be unable to do the usual systems testing we would do before going live and are therefore unable to guarantee

that the system will be ready by January 1, 2027, in order to function the way they must under the IFR.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

Hoa Pham
Deputy Secretary
Pennsylvania Department of Human Services
Office of Income Maintenance

EXHIBIT 51

DECLARATION OF KRISTIN PONO SOUSA

I, Kristin Pono Sousa, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Rhode Island. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by the Rhode Island State Medicaid Program and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, the Rhode Island State Medicaid Program and Children's Health Insurance Program (together, the "Rhode Island Medicaid Program") has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that the Rhode Island Medicaid Program will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement.

4. Based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the 80-hour Work Requirement. If that 30-year-old were pregnant, they would be

considered a "specified excluded individual" under the exclusion for pregnant persons. If that 30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, the Rhode Island Medicaid Program understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between fall of 2025 and June of 2026, the Rhode Island Medicaid Program was building a system based on claims data and diagnosis code to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that system, the Rhode Island Medicaid Program was planning to go live with that system by the statutory implementation deadline. This technical build was costly and time consuming, requiring significant commitment of time from full-time employees and contractors, including costly development of software across multiple platforms.

7. On June 1, 2026, the Rhode Island Medicaid Program learned CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our system, adding additional cost and resources to ensure we will be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, the Rhode Island Medicaid Program must determine if an individual falls within one of the five excluded categories established by Congress. And second, the Rhode Island Medicaid Program must determine whether the individual's condition significantly impairs the individual's ability to comply with the Work Requirements.

9. Accordingly, the Rhode Island Medicaid Program has had to modify and redesign its system in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time.

EX PARTE VERIFICATION PROCESS

10. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to the Rhode Island Medicaid Program to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, the Rhode Island Medicaid Program first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If the Rhode Island Medicaid Program can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if the Rhode Island Medicaid Program cannot verify eligibility using available data does it send the member a renewal form for the member to complete.

11. *Ex parte* verification reduces the burden on members and the Rhode Island Medicaid Program and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

12. *Ex parte* verification also reduces administrative burdens and costs on the Rhode Island Medicaid Program by allowing the agency to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

13. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). The Rhode Island Medicaid Program also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

14. In practice, to verify medical frailty for the Work Requirement, the Rhode Island Medicaid Program would begin by *ex parte* consulting data available to the Rhode Island Medicaid Program to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form, requesting additional information through which the Rhode Island Medicaid Program can determine whether the individual meets the criteria for medical frailty. The precise information the Rhode Island Medicaid Program will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

15. Since the IFR was published, however, the Rhode Island Medicaid Program is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

16. Additionally, the IFR limits the time period the Rhode Island Medicaid Program can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which the Rhode Island Medicaid Program can rely upon when determining compliance with or exclusion from the Work Requirement. 91 Fed. Reg. 33,393. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid eligibility simply because of administrative burdens.

17. If the Rhode Island Medicaid Program cannot rely on *ex parte* verification to determine medical frailty, or if the Rhode Island Medicaid Program is only permitted to use a limited algorithm approach that *ex parte* verifies a limited number of members, then the IFR will lead to more eligible members losing Medicaid. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid.

18. Beginning on January 1, 2027, Rhode Island Medicaid members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by the Rhode Island Medicaid Program will forgo all preventive care and present only if they are acutely ill at hospital emergency departments and community health centers,

increasing uncompensated care, exacerbating communicable and noncommunicable disease burden, and putting more strain on Rhode Island's public health infrastructure.

STATE EFFORTS GOING FORWARD

19. Given the limited time between June 1, 2026 and January 1, 2027 which the Rhode Island Medicaid Program has to create a new system for eligibility compliant with the IFR, the Rhode Island Medicaid agency will be unable to perform all the usual systems testing the agency would perform before going live and faces challenges to ensuring that the system will be ready by January 1, 2027. The precise information the Rhode Island Medicaid Program will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

20. If the Court were to vacate the Challenged Provisions, the Rhode Island Medicaid Program would need additional transition time to switch systems.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

Kristin Pono Sousa

Kristin Pono Sousa
Rhode Island Medicaid Director

EXHIBIT 52

DECLARATION OF STEVEN FORD

I, Steven Ford, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Virginia. I am over the age of 18 and have personal knowledge, or knowledge based on review in my capacity as State Medicaid Director of information and records gathered by Department of Medical Assistance Services ("DMAS") and agency staff, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, DMAS has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs.

4. Operationally, and as required by the CMS IFR, states must first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual are they within the Applicable Individual category. Only Applicable Individuals need to show compliance with the Work Requirement. For example, a 30-year-old who is covered by Medicaid under the Affordable Care Act (ACA) expansion would generally be subject to the Work Requirement unless they qualify for a specified exclusion under H.R. 1. If that 30-year-old were a disabled veteran (one of the other specified exclusions in the law), that individual would be considered a "specified excluded individual" and not subject to the Work Requirement. If that 30-

year-old qualified as medically frail, they would similarly be considered "specified excluded." If that 30-year-old did not qualify for an exclusion, they would need to show they met the Work Requirement (such as by working 80 hours during a month, enrolling as a student half-time, or meeting other criteria) in order to maintain health coverage.

STATE WORK PRIOR TO THE IFR ON THE MEDICALLY FRAIL EXCLUSION

5. As to the medically frail exclusion, DMAS understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that medically frail individuals would include individuals who had medical conditions that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee) (describing individuals who are medically frail as those who are blind or disabled, with a substance use disorder, with a physical, intellectual or developmental disability, or with a serious or complex medical condition).

6. Based on this understanding and guidance from CMS, between the fall of 2025 and before June 1, 2026 (when CMS issued its IFR), DMAS undertook a comprehensive effort to design and build an approach to determine whether individuals were medically frail as defined in H.R. 1. This effort included a comprehensive review and validation of thousands of diagnostic and clinical condition codes, procedure codes, and prescription drug codes to establish a clinically driven and robust framework for verifying this exclusion. DMAS analyses conducted before the IFR suggested that more than 200,000 individuals—about 37 percent of the Medicaid expansion population in Virginia—could be exempt based on medical frailty using this data-based approach. In addition, also based on guidance provided by CMS prior to the June 1, 2026, IFR, DMAS designed processes to verify medical frailty for individuals for whom data is unavailable by creating a screening tool for medical frailty that could be incorporated in the Medicaid application

and renewal form. This process required months of effort and collaboration with other states. DMAS was planning to go live with that system by the statutory implementation deadline.

7. On or about Wednesday, May 6, 2026, following a conversation in which CMS provided guidance to states on Medicaid work requirements implementation, CMS informed states that the information conveyed during the call should not be acted upon. In response to this and concerns that CMS would change its policy direction, DMAS sent a letter to CMS on May 28, 2026, conveying DMAS's concerns with limiting the definition of medically frail beyond the H.R. 1 statutory language.

8. On June 1, 2026, CMS issued an IFR that included a major departure from its prior guidance and the language of H.R. 1. The IFR required that, to be considered medically frail, an individual possess one of the conditions laid out in the statue, and that this condition "significantly impair" their ability to comply with the Work Requirement. This change conflicted with the statutory language, which only required individuals to meet the categories of conditions outlined in H.R. 1, and departed from the guidance CMS had provided for months ahead of June 1, 2026. In addition, this change has required significant changes to our system and implementation efforts, as outlined further below. The result is that the IFR has substantially impacted Virginia's ability to be ready to implement H.R. 1's Work Requirement by January 1, 2027.

9. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, DMAS must determine if an individual falls within one of the five excluded categories established by Congress. And second, DMAS must determine if that person's ability to comply with the Work Requirement is significantly impaired. In other words, per the IFR, having cancer or HIV/AIDS may or may not be enough to be deemed exempt from H.R. 1's work requirements; states will need

to determine whether the individual also is impaired in their ability to work or comply with the work requirement, using a process that remains unclear. 91 Fed. Reg. 33,373 (June 3, 2026). This new restriction means many Virginians with serious medical needs may need to navigate additional barriers to secure their health coverage—putting at risk access to critical health services.

10. Following the IFR, DMAS has had to significantly modify its approach to medical frailty to comply with the IFR and continues to face substantial uncertainty regarding how DMAS is expected to comply with these new requirements. This has generated additional unplanned costs, required additional staff time, and has generated significant uncertainty and concern among Medicaid members, health care providers, and community stakeholders across the Commonwealth.

EX PARTE (DATA-BASED) VERIFICATIONS OF MEDICAL FRAILTY

11. As a general matter, *ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. Federal regulations have long required that Medicaid agencies renew members' eligibility using *ex parte* verification processes—that is, data already available to the state—when possible. *See* 42 CFR 435.916(a)(2). This means that, during a member's eligibility renewal, DMAS must first attempt to use available data (such as data regarding income) to determine whether the member remains eligible. If DMAS can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Per *ex parte* requirements, only if DMAS cannot verify eligibility using available data does DMAS send the member a renewal form for the member to complete.

12. *Ex parte* verification reduces the burden on members and DMAS and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

13. *Ex parte* verification also reduces administrative burdens and costs on DMAS by allowing DMAS to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

14. In H.R. 1, Congress required states to use *ex parte* processes to verify work requirements to the extent possible. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). This requirement extends to determinations of medical frailty.

15. In practice, this *ex parte* requirement means DMAS must consult available data to determine if an individual qualifies as medically frail prior to requesting relevant information from an individual. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), the individual will be asked to provide additional information to the state (for example, through a form or by submitting information online or by telephone) so DMAS can determine whether the individual meets the criteria for medical frailty. The precise information DMAS will need to collect—and thus the wording of any request for additional information—will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

16. The IFR has created major disruptions as DMAS implements this *ex parte* requirement. Prior to the IFR, as noted above, DMAS planned to use a robust set of medical codes and relevant data to determine whether individuals had the medical conditions outlined in the statute, consistent with CMS's earlier guidance. Post IFR, DMAS now faces significant uncertainty because medical claims data do not, on their face, generally convey information about individuals' ability to work. The IFR noted this, indicating that in some circumstances a major medical

diagnosis such as cancer may not necessarily be enough to indicate medical frailty. Despite this fundamental limitation, CMS has not provided further guidance on how states are expected to meet both the IFR and their *ex parte* obligations.

17. Additionally, the IFR limits the time period DMAS can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which DMAS can rely upon when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and not be denied Medicaid simply because of administrative burdens.

18. Limitations in DMAS's ability to use data and *ex parte* processes for determining medical frailty could have significant implications for Virginians' access to coverage. *Ex parte* processes are essential in reducing administrative burdens for members, helping eligible people stay covered. Renewal response rates show that many Medicaid members, especially those who are most vulnerable, do not respond to renewal notices. As such, a decreased ability to rely on *ex parte* verification will likely result in more eligible Virginians losing Medicaid.

19. The consequences of these data limitations and uncertainty mean that, if the IFR's provisions take effect on January 1, 2027, more Virginians could lose access to health coverage—putting access to health care for individuals at risk, including individuals with severe medical needs. This raises the likelihood their medical conditions and health worsen over time, jeopardizing their well-being and increasing health care costs across the Commonwealth's medical system as hospitals take on more uncompensated care and treat individuals whose health has deteriorated.

OTHER IMPACTS TO MEMBERS, HEALTH PROVIDERS, AND THE COMMONWEALTH

20. There are other urgent operational consequences for DMAS beyond the data concerns described above. As noted, individuals for whom DMAS cannot use data to determine medical frailty will need to submit additional information to the state. For 2027, CMS's IFR indicates that individuals will be able to submit self-declarations (i.e., self-attestation) related to medical frailty, and that individuals can complete a medical frailty screener for this process. However, the form of this screener or self-attestation fundamentally depends on the definition of medical frailty—that is, whether someone is being asked whether their condition impacts their ability to work. This screener needs to be prepared and finalized well in advance of January 1, 2027 to be incorporated into our systems appropriately—for example, to ensure DMAS has an online application or other process by which individuals can upload information relevant to medical frailty. Clarity is also necessary to ensure DMAS's paper applications and renewal forms—which will include the medical frailty screener—accurately reflect federal requirements in time for January 1, 2027.

21. Additionally, as a general matter, DMAS will need to contract with a vendor to perform data entry and processing of manual paperwork, including medical frailty declarations and supporting information submitted by individuals. DMAS will need to establish vendor processes, staffing, training and quality controls, and data-transfer procedures well in advance of January 1, 2027. Any uncertainty or changes in federal requirements could require corresponding changes to vendor workflows, systems, and training on a compressed timeline, increasing the risk of processing delays, errors, and backlogs and further complicating DMAS's ability to implement the requirements accurately and timely by January 1, 2027.

22. In addition to these risks, the IFR's more narrow definition of medical frailty has generated significant concern and uncertainty among members and health care providers—underscoring why clarity regarding medical frailty's definition is urgently needed. Without clarity on whether the medical frailty exclusion is defined according to H.R. 1 or the IFR's narrower criteria, DMAS is severely limited in its ability to communicate requirements and expectations to Medicaid enrollees who will be navigating Work Requirements at the end of this year, including enrollees with cancer, HIV/AIDS, and other serious or complex conditions. Communicating clear instructions and expectations to individuals will be essential to help eligible individuals stay covered.

23. These implications also extend to health care providers, health plans, and other stakeholders across the Commonwealth, many of whom will be helping Medicaid members navigate these forthcoming changes.

STATE EFFORTS GOING FORWARD

24. DMAS is in the process of implementing the medical frailty definition based on our understanding of the IFR, though significant uncertainty remains and we continue to face the constraints described above.

25. The different definitions between H.R. 1 and the IFR will require different systems builds, systems testing, datasets, and communications and outreach to Medicaid enrollees, health providers, plans, and others.

26. This means that if the Court were to vacate the Challenged Provisions, DMAS would likely need additional time beyond January 1, 2027 to switch approaches to ensure compliance with federal requirements, develop and test a robust and functional data-driven approach, and effectively communicate to members and others across the Commonwealth.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

Steven Ford
Director, Department of Medical Assistance Services

EXHIBIT 53

DECLARATION OF JUDY ZERZAN-THUL

I, Judy Zerzan-Thul, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am a resident of Washington. I am over the age of 18 and have personal knowledge, or knowledge based on review of information and records gathered by the Washington State Health Care Authority (HCA) and agency staff in my capacity as Chief Medical Officer for Apple Health, which includes the Washington State Medicaid program, of the matters set forth below. If called as a witness, I could and would testify competently to the matters set forth below.

2. Since the passage of H.R. 1, HCA has worked to be ready to implement H.R. 1's work requirement ("Work Requirement") on January 1, 2027.

3. The Work Requirement applies to what Congress has defined as "Applicable Individuals." 42 U.S.C. § 1396a(xx)(9)(A). However, Congress excluded certain individuals from the Applicable Individual group. Congress identified several discrete categories of specified excluded individuals, including, as relevant here, those who are medically frail or otherwise have special needs. Practically speaking, this means that HCA will first determine whether an individual is a specified excluded individual. Only if they are not a specified excluded individual, and meet other definitional requirements, are they within the Applicable Individual category. Only Applicable Individuals must show compliance with the Work Requirement.

4. For example, based on the Work Requirement as outlined in H.R. 1, a 30-year-old who is covered by Medicaid under the ACA expansion would have to show a separate exception or prove compliance with the Work Requirement. If that 30-year-old were pregnant, they would be considered a "specified excluded individual" under the exclusion for pregnant persons. If that

30-year-old had cerebral palsy, they would be considered a "specific excluded individual" under the exclusion for the medically frail.

STATE WORK TO DATE ON THE MEDICALLY FRAIL EXCLUSION

5. As to the Medically Frail exclusion, HCA understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Medically Frail individuals would include individuals that fell within one of the five categories enumerated by Congress. Section 1902(xx)(9)(A)(ii)(V)(aa)-(ee).

6. Based on this understanding, between fall of 2025 and June of 2026, HCA worked to build a system based on diagnosis information identified from claims data to determine whether individuals were medically frail as defined in H.R. 1. While additional testing remained to be done on that system, HCA was planning to go live with that process by the statutory implementation deadline. This development was costly and time consuming, requiring many hours of dedicated planning time. A group of clinical, technical, and program staff collaboratively developed a draft code list and underlying methodology. The approach had been tested using claims data and it was made available for public comment. HCA was in the process of reviewing and addressing the public comments.

7. On June 1, 2026, HCA was surprised to learn CMS had added criteria to the statutory definition of medically frail. In particular, the imposition of the "significantly impairs" language on the medically frail definition not only contradicts the text of H.R. 1 and the guidance CMS had provided for months ahead of June 1, 2026, but also requires significant changes to our implementation approach and system design, making it more challenging to be ready to implement H.R. 1's Work Requirement on January 1, 2027.

8. Compliance with the IFR appears to require a two-step inquiry to determine whether an individual is excluded from the Work Requirements as medically frail. First, HCA must determine if an individual falls within one of the five excluded categories established by Congress. And second, HCA must determine if that person's ability to comply with the Work Requirement is significantly impaired.

9. Accordingly, HCA has had to reconfigure the entire clinical definition, and technical approach in order to determine whether someone meets the five congressionally established categories of medically frail exclusions *and* is significantly impaired. This has been a significant additional unplanned cost and use of staff time. The redesigning of the approach required reconvening the technical, clinical and program experts. It also required dedicated clinical staff time to reevaluate extensive code lists (ICD-10, CPT, and other medical codes). Overall we have a lack of dedicated resources including things like a lack of occupational medicine experts who have the training to verify disease severity in relation to a person's ability to work. The rebuilding has been hindered by complexities within the IFR requirements like SUD treatment provider type limitations.

10. The IFR limitations resulted in extensive changes to both short-term and longer-term technical solutions. The revised approach will necessitate infrastructure building to access new data sources (including electronic health records through a clinical data repository), which require investments in system modernization, clinical code set identification, and development of new data pipelines. The multi-year effort to obtain this data source will require extensive staff time, funding, technical development, and partnership with other organizations. It will also require outreach and training efforts to clients, providers and community partners on what constitutes eligibility for medical frailty.

EX PARTE VERIFICATION PROCESS

11. *Ex parte* verification of eligibility is an established part of the Medicaid eligibility verification process. It refers to using data available to HCA to determine whether an individual is eligible for Medicaid, without requiring further information from the individual. Federal regulations already require that Medicaid agencies renew members' eligibility using *ex parte* verification processes when possible. *See* 42 CFR 435.916(a)(2). Specifically, during a member's eligibility renewal, HCA first attempts to use available data (such as data regarding income and residence) to determine whether the member remains eligible. If HCA can verify a member's eligibility using available data, then they find the member eligible without requiring input from the member. Only if HCA cannot verify eligibility using available data does HCA send the member a renewal form for the member to complete.

12. *Ex parte* verification reduces the burden on members and HCA and helps to ensure that fewer people are disenrolled due to administrative hurdles. Thus, *ex parte* verification helps ensure that eligible members remain enrolled.

13. *Ex parte* verification also reduces administrative burdens and costs on HCA by allowing HCA to process renewals without the costs and resources necessary to print, mail, and manually process returned renewal forms.

14. Through H.R. 1, Congress expressed a preference for using *ex parte* verification to verify work requirements. *See* H.R. 1 § 71119(a)(xx)(5) ("For purposes of verifying [work requirements] … the State shall … establish processes and use reliable information available to the state … without requiring, where possible, the applicable individual to submit additional information."). HCA also understood, based on the plain language of H.R. 1, and confirmed by communications with CMS between July 2025 and May 2026, that Work Requirement

determinations, including determinations of medical frailty, were meant to be made on an *ex parte* basis, where possible.

15. In practice, to verify medical frailty for the Work Requirement, HCA would begin by *ex parte* consulting data available to HCA to determine if the individual qualifies as medically frail. If they cannot be *ex parte* verified as medically frail (and cannot otherwise be *ex parte* found to satisfy work requirements), they will be provided a form requesting additional information through which HCA can determine whether the individual meets the criteria for medical frailty. The precise information HCA will need to collect – and thus the wording of the form – will vary depending on whether it is governed by H.R. 1 or whether the additional criteria from the IFR is operative.

16. Since the IFR was published, however, HCA is dealing with additional uncertainty around the use of *ex parte* verifications to validate medical frailty: in the preamble to the IFR, CMS indicated that states cannot rely solely on diagnosis or condition codes to determine Medical Frailty.

17. Additionally, the IFR limits the time period HCA can use when relying on Claims and Encounter data. However, it does not similarly limit the other six categories of data upon which HCA can rely when determining compliance with or exclusion from the Work Requirement. If CMS were to align Claims and Encounter data with the other categories, more people would have their eligibility determined on an *ex parte* basis and fewer people would be denied Medicaid coverage simply because of administrative burdens.

18. If HCA cannot rely on *ex parte* verification to determine medical frailty, then the IFR will lead to more eligible members losing Medicaid coverage. Renewal response rates show that many Medicaid members, especially the most vulnerable, do not respond to renewal notices.

As such, a decreased ability to rely on *ex parte* verification will necessarily result in fewer people having access to Medicaid coverage.

19. Beginning on January 1, 2027, Apple Health members who would be determined eligible but for the Challenged Provisions will be denied coverage if the IFR provisions are imposed. The turmoil and uncertainty introduced by the IFR increases the risk that individuals formerly covered by HCA will forgo preventive care and present only if they are acutely ill at hospital emergency departments and community health centers.

STATE EFFORTS GOING FORWARD

20. Given the limited time between June 1, 2026, and January 1, 2027, which HCA has to create a new system for eligibility compliance with the IFR, we will be unable to do the usual systems testing we would do before going live. Thus, we are unable to guarantee that the system on January 1, 2027, will be error free, resulting in significantly more manual labor for HCA staff after the fact to reconcile incorrect eligibility determinations. Additionally, without clear implementation direction from CMS - outreach to clients and providers becomes increasingly challenging. We have to send the first federally required notices imminently. Without clear implementation direction, we risk sharing inaccurate information with clients and providers about how to prove they are medically frail.

21. If the Court were to vacate the Challenged Provisions, HCA would need approximately six months to switch systems.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed this 25th day of August 2026.

s/*Judy Zerzan-Thul*
Judy Zerzan-Thul, MD, MPH
Chief Medical Officer

EXHIBIT 54

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al.

Plaintiffs,

v.

MEHMET OZ, M.D., et al.

Defendants.

Case No. 1:26-cv-12962

DECLARATION OF ELIZABETH A. KAPLAN

I, Elizabeth Kaplan, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

1. I am the Director of Health Care Access and a Clinical Instructor in the Health Law and Policy Clinic at the Center for Health Law & Policy Innovation of Harvard Law School. An important part of our mission is to advocate for public policies that expand access to health care for people living with chronic conditions, particularly HIV.

2. I am also a co-chair of the Federal AIDS Policy Partnership's HIV Health Care Access Workgroup ("HHCAWG"). HHCAWG is a coalition of national and community-based organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV health care and support services.

I. Uninterrupted Access to Health Care is Critical for HIV Treatment and Prevention.

3. "HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. Without treatment, it can lead to AIDS (acquired immunodeficiency syndrome)," a life-threatening condition.[1]

4. As of 2019, more than 700,000 people with AIDS in the United States had died since the beginning of the epidemic.[2] In 2022, in the United States, "nearly 5,000 people died with HIV as the underlying cause of death, and about 8,000 died with HIV as a contributing cause of death."[3]

5. Today, treatment with antiretroviral therapy (ART) is recommended for all people living with HIV beginning as soon as possible after an HIV diagnosis.[4]

6. HIV is not curable and requires lifelong adherence to treatment, including regular medical monitoring to ensure that a person's ART regimen is working effectively.[5]

7. Most people living with HIV in the United States today take ART as a daily oral regimen, although long-acting injectable treatment is available for some individuals.[6]

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[1] *About HIV*, Centers for Disease Control and Prevention (Jan. 14, 2025), https://perma.cc/L8A4-Q9NW.
[2] *The HIV/AIDS Epidemic in the United States: The Basics*, KFF (Feb. 2019), https://files.kff.org/attachment/Fact-Sheet-HIV-AIDS-in-the-United-States-The-Basics.
[3] *The HIV/AIDS Epidemic in the United States: The Basics*, KFF (Aug. 16, 2024), https://www.kff.org/hiv-aids/the-hiv-aids-epidemic-in-the-united-states-the-basics/
[4] *See, e.g.*, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Initiation of Antiretroviral Therapy*, HIV.gov (Sept. 25, 2025), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/initiation-antiretroviral-therapy ("*Initiation of Antiretroviral Therapy*").
[5] *See HIV Treatment Adherence*, HIVinfo.NIH.gov (Jan. 13, 2025), https://perma.cc/8CL5-Q93K; *Initiation of Antiretroviral Therapy*, *supra* n.4.
[6] *See Taking Your HIV Medicine as Prescribed*, HIV.gov (last visited Aug. 18, 2026), https://perma.cc/V23R-2QUP; *FDA-Approved HIV Medicines*, HIVinfo.NIH.gov (June 8, 2026) https://perma.cc/QSH3-JYET; Deanna Kerrigan et al., *Factors Associated With Preference for Long-Acting Injectable Versus Daily Oral Antiretroviral Therapy Among People With HIV: Findings From the*

8. With regular access to ART and medical monitoring, people living with HIV can achieve viral suppression, which is defined as <200 copies/mL of HIV RNA.[7] People living with HIV whose HIV is virally suppressed can live long and healthy lives. They also cannot transmit HIV to others, making viral suppression an important tool to end the HIV epidemic.[8]

9. For people living with HIV, interruptions in access to health care can jeopardize viral suppression—sometimes within as few as three to six days of stopping treatment.[9] Viral rebound can threaten the immune system and lead to medication resistance, and it enables HIV transmission.[10]

II. Medicaid Is the Primary Source of Coverage for People Living with HIV in the United States.

10. Medicaid provides coverage for approximately 40% of nonelderly adults living with HIV in the United States.[11] In 2022, Medicaid contributed 45% of all federal funding for domestic HIV care and treatment.[12]

SELIGO Study, 101 J Acquired Immune Deficiency Syndrome 183, 189 (Feb. 1, 2026) (less than 3% of adults living with HIV who participated in survey reported being on long-acting injectable ART).

[7] *See, e.g.*, *Viral Suppression and an Undetectable Viral Load*, HIV.gov (last visited Aug. 18, 2026), https://perma.cc/N6PC-9A6Y; *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Antiretroviral Therapy to Prevent Sexual Transmission of HIV (Treatment as Prevention),* HIV.gov (Sept. 25, 2025), https://perma.cc/VSE4-4NWL ("*Antiretroviral Therapy to Prevent Sexual Transmission of HIV*").

[8] *See, e.g.*, *Initiation of Antiretroviral Therapy*, *supra* n.4; *Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n. 7; *HIV Treatment Prevention*, HIV.gov, https://perma.cc/RNB8-98QQ (last visited Aug. 18, 2026).

[9] *See Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n.7; UNAIDS, *Q&A on the impact of the interruption of treatment for people living with HIV* (May 15, 2025), https://www.unaids.org/sites/default/files/2025-05/20250520_QA-ART-Interruption_0.pdf.

[10] *See, e.g.*, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Management of People with HIV and Antiretroviral Therapy Experience*, HIV.gov (Sept. 12, 2024), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/virologic-failure; *Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n.7; Alexis Palmer et al., *Viral suppression and viral rebound among young adults living with HIV in Canada*, Medicine (Baltimore) (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6392935/pdf/medi-97-e10562.pdf ("Viral rebound increases vulnerability to illness, treatment failure, cART resistance, and the potential for HIV transmission.").

[11] Lindsey Dawson et al., *Medicaid and People with HIV*, KFF, (Mar. 27, 2023), https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/.

[12] *Id.*

11. Medicaid expansion is especially important, covering 60% of adult, nonelderly Medicaid enrollees with HIV in expansion states,[13] and offering these individuals full scope health insurance without them having to wait until they have become disabled due to advanced HIV.[14]

12. Under H.R. 1, to keep their Medicaid coverage, people living with HIV who access Medicaid through the expansion pathway must either show that they are meeting the community engagement requirement or that they qualify for an exception or exclusion.

13. More than half of people living with HIV are age 50 and older, a group that is more likely to experience comorbidities and HIV medication side effects.[15] These challenges can be compounded by barriers to work requirements compliance that impact older adults generally, including age discrimination that makes it difficult to find employment and caregiving responsibilities for spouses, parents, or adult children with disabilities.[16]

III. HIV is a "serious or complex medical condition" as defined in H.R. 1.

14. Congress in H.R. 1 excluded from Medicaid work requirements people who are "medically frail or otherwise [have] special medical needs," and defined that category by five conditions joined by "or": a disability as defined under the Social Security Act; a substance use disorder (SUD); a disabling mental disorder;

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[13] Lindsey Dawson & Jennifer Tolbert, *Medical Frailty and Medicaid Work Requirements: Challenges for People with HIV*, KFF (July 1, 2026), https://www.kff.org/medicaid/medical-frailty-and-medicaid-work-requirements-challenges-for-people-with-hiv/.
[14] Jennifer Kates & Lindsey Dawson, *Insurance Coverage Changes for People with HIV Under the ACA*, KFF, (Feb. 14, 2017), https://www.kff.org/affordable-care-act/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/#footnote-209018-4.
[15] *HIV and Older People*, HIVinfo.nih.gov (April 21, 2026), https://perma.cc/JY68-KJY4.
[16] Nari Rhee, *Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults*, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults.

a physical, intellectual, or developmental disability that significantly impairs activities of daily living; or a "serious or complex medical condition."[17]

15. HIV is a "serious or complex medical condition" because it requires consistent, continuous, lifelong treatment to prevent advancement to AIDS, a life-threatening condition.[18] People living with HIV are also at elevated risk for comorbidities such as cardiovascular disease.[19] Adding to HIV's seriousness, when not virally suppressed, HIV is infectious and transmissible to others.[20]

16. Recognizing the seriousness of HIV, the Centers for Medicare and Medicaid Services (CMS) identified HIV as a "serious chronic medical condition," suggesting that Medicaid members living with HIV should be exempt from rules requiring enrollment in an Alternative Benefit Plan (ABP).[21]

17. CMS has also recognized HIV as a "serious, high-risk" condition for which patient navigation and other more intensive services may be reasonable and necessary in the Medicare context.[22]

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[17] P.L. 119-21, § 71119(a)(9)(A)(ii)(V).
[18] *See* ¶¶ 3-9 *supra*.
[19] *See, e.g.*, Allison Webel et al., *A Review of Chronic Comorbidities in Adults Living with HIV: State of the Science*, 32 J. Assoc. Nurses in AIDS Care 322 (Feb. 4, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC8815414/
[20] *See Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, supra n.7; *How HIV Spreads*, Centers for Disease Control and Prevention (Nov. 25, 2024), https://perma.cc/SS9G-NJNY.
[21] *See* Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions.").
[22] *See* Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include, but are not limited to… HIV/ AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (July 24, 2025), https://perma.cc/G3NY-LB3M ("HIV is a single, serious condition, and/or a complex condition," such that a provider who has an ongoing relationship with a patient with HIV may use an "add-on" billing code to reflect the "inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

18. Several states recognized HIV diagnosis as qualifying an individual for exemption from state-based Medicaid work requirement proposals under the first Trump Administration.[23]

19. Several state policies implementing the ABP exemption rules also specifically acknowledge HIV diagnosis as qualifying an individual for exemption.[24]

20. Prior to publication of the Interim Final Rule (IFR) on June 3, 2026,[25] through my work as a co-chair of HHCAWG, I was aware of several states impacted by the Medicaid community engagement requirement that intended to acknowledge HIV as a "serious or complex medical condition" warranting exclusion from community engagement under P.L. 119-21, § 71119(a)(9)(A)(ii)(V)(ee). For example, HIV was included in Nebraska's published Medicaid Work Requirements: Medically Frail Exemption Conditions Index, which was made public before publication of the IFR.[26]

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[23] *See, e.g.*, Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 9 (Dec. 19, 2017), https://perma.cc/7A5M-RTV2 (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Section 1115 demonstration waiver request for Kentucky HEALTH, 26 (Aug. 24, 2016), https://perma.cc/J4JX-MEVN ("individuals otherwise eligible for Kentucky HEALTH who are … diagnosed with HIV/AIDs, … will automatically be determined medically frail upon verification of the qualifying condition"); Healthy Michigan Plan (HMP) § 1115 Demonstration Extension Application Amendment, Attachment K – Part 1, 6 (Sept. 10, 2018), https://perma.cc/YW3V-FMXW (agreeing with commenters that "beneficiaries with complex chronic conditions may have difficulty meeting the workforce engagement requirement" and adding HIV, cystic fibrosis, and several other conditions to Michigan's medically frail exemption list).

[24] *See, e.g.*, Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status"); Massachusetts State Plan Amendment: MA-23-0067, 6 (Feb. 9, 2024), https://perma.cc/8QQZ-AXF4.

[25] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33,348 (June 3, 2026).

[26] Nebraska Medicaid Work Requirements, Medically Frail Exemption Conditions Index, 4 https://perma.cc/T3TJ-49AV.

IV. The IFR's "Significant Impairment" Requirement Will Make It Harder for People Living with HIV to Keep their Coverage, Threatening Their Health.

21. Under the plain language of H.R. 1, a condition or diagnosis need only qualify as a "serious or complex condition" in order for a person with that diagnosis to be excluded from the community engagement requirements. Since HIV is a serious or complex condition—as states were already beginning to acknowledge[27]—HIV diagnosis alone should exempt a person from having to show that they meet these requirements.

22. The IFR adds a new requirement on top of the definition of "medically frail or [having] special medical needs," requiring that a qualifying condition—including a "serious or complex" condition—must *also* "significantly impair[]" a person's ability to meet the community engagement requirement.[28] Thus, someone who is living with HIV but is at least theoretically able to complete 80 hours per month of work or similar activities would no longer qualify for the medical needs exclusion, and would need to meet the community engagement requirements (or qualify for a different exemption) to retain Medicaid coverage.

23. Requiring people living with HIV to prove that they are too sick to work to protect them from loss of Medicaid puts coverage at risk for people whose health *depends* on continuous access to care. In other words, instead of encouraging and supporting people with a serious chronic condition to work, the IFR makes it so that a person with HIV who is deemed able to meet the community engagement requirements can be at risk of losing their Medicaid

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[27] *See* ¶ 20 *supra*. *See also* Louisiana Dep't of Health, *Medical Frailty Codes* (Preliminary and non-exhaustive. Updated as of Feb. 1, 2026), Administrative Record, Bates No. 004386, Serious + Complex Conditions: Immunodeficiency (including on Louisiana's list of qualifying conditions codes for "HIV disease" and "Asymptomatic HIV infection status"); Utah Dep't of Health & Human Servs., *Comprehensive ICD-10 Code List for Medical Frailty*, Administrative Record, Bates No. 004761 (including on Utah's list four HIV-related codes).

[28] 91 Fed. Reg. at 33,472.

coverage, jeopardizing their health. Paradoxically, once they become too sick to work, they would then qualify for the very exclusion that could have protected them from coverage loss in the first place.

24. The IFR's discussion of HIV is also ambiguous and vague. In the preamble to the IFR, CMS identifies "acuity" as relevant to significant impairment, but does not explain why this is an appropriate basis for that determination or how states should define or weigh it against other relevant considerations. CMS suggests that a person with lower "acuity" HIV is "less likely" to be significantly impaired, but does not explain what this means, or how it interacts with important factors such as the demands of ongoing treatment, comorbid mental health and other conditions, stigma-related barriers to care or employment, and other circumstances that could meaningfully affect a person with HIV's ability to comply with community engagement requirements.[29]

25. Depending on how it is interpreted, the IFR may also expose people living with HIV to privacy issues. For example, Medicaid enrollees may need to disclose private medical information (beyond what already appears in their Medicaid claims) to eligibility workers to prove they are "sick enough" to qualify for the exclusion.

[29] *See, e.g.*, *A qualitative study of barriers to employment experienced by people living with HIV in Toronto and Ottawa*, Int. J. Equity Health (Jan. 14, 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7807879/ (study participants reported common barriers in their efforts to obtain and maintain employment, including HIV stigma in the workplaces and mental health challenges); *An Insight Into Organizational HIV Stigma & Discrimination*, ViiV Healthcare U.S. (last visited Aug. 20, 2026), https://viivhealthcare.com/en-us/supporting-the-hiv-community/against-stigma/hiv-stories/organizational-stigma/.

V. The IFR's Limit on the Use of Self-attestation Further Threatens Coverage for People Living with HIV.

26. Importantly, the new requirement to do community engagement is not simply a requirement to complete 80 hours per month of qualifying activities—it is also a requirement to ensure that the state Medicaid agency can verify a person's completion of these activities. Thus, even people who are compliant with community engagement based on their activities or qualification for an exemption can still be vulnerable to losing their Medicaid coverage.[30] The IFR's limit on the use of self-attestation to verify medical frailty status increases the administrative burden of compliance on the population that can least afford to lose their coverage—those with elevated medical needs, including people living with HIV.

27. Many people with HIV may not have claims or encounters that document their HIV status. For example, a person who was recently diagnosed may not yet have a trusted provider who could provide this documentation, especially if the person was diagnosed outside of a traditional care setting.[31] Similarly, an individual who only recently gained Medicaid eligibility (because they were previously covered by an employer, moved from out of state, or recently became financially eligible) may have little or no relevant data available to the state.

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[30] *See* Matthew Buettgens et al., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations: National and State Estimates for 2028*, Urban Institute and Robert Wood Johnson Foundation, ix (March 25, 2026) https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html (estimating Medicaid expansion enrollment declines of 19-37% "among those who are working because some who are meeting the work requirement would be unable to manually verify compliance and because others are working less than 80 hours per month but do not have monthly income equivalent to 80 work hours at the federal minimum wage").

[31] HIV testing is performed in many locations, including "health care provider offices, health centers, community centers, health departments, pharmacies, and more"; there are also self-tests that a person can administer at home or in private. *HIV Testing Locations*, HIV.gov (last visited Aug. 20, 2026), https://perma.cc/4ZXS-T9HU.

28. Many people living with HIV face added barriers to compliance with administrative burdens. For example, people living with HIV are disproportionately impacted by homelessness and housing instability.[32] A person who is homeless may lack consistent access to mail, phones, or the internet, which can make it difficult for them to receive communications from their state Medicaid agency explaining what they need to do to keep their coverage; they may also lack a secure place to store documentation, or access to transportation.[33] These factors could make it harder for a person living with HIV who also experiences homelessness to provide documentation of their medical condition to the state Medicaid agency.

29. Administrative burdens have likely prevented access to exemption and accommodation processes for people with disabilities in similar work requirement programs. For example, Arkansas' medically frail exemption reached only 11% of beneficiaries subject to the work requirement, even though nearly 30% of those without an exemption who weren't working reported at least one serious health limitation.[34] Georgia's Pathways to Coverage program requires an eight-step accommodation process;[35] although it is unclear how

[32] *See, e.g.*, *Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection–Medical Monitoring Project, United States, 2023 Cycle (June 2023–May 2024)*, Centers for Disease Control and Prevention (March 16, 2026), https://perma.cc/YR5S-KBGZ (in 2023, 20% of people living with HIV reported unstable housing or homelessness).

[33] *See, e.g.*, Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion, Kaiser Commission on Medicaid and the Uninsured (Sept. 2012), https://www.kff.org/wp-content/uploads/2013/01/8355.pdf.

[34] *See Medicaid Work Requirements Don't Protect People With Disabilities*, Center on Budget & Policy Priorities (Nov. 14, 2018), https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities.

[35] *See How Medicaid Work Requirements Hurt People with Disabilities*, National Health Law Program (Dec. 2024), https://healthlaw.org/wp-content/uploads/2025/01/Machledt_NHeLP_WorkRequirementsandPeoplewithDisabilities_January-Update.pdf.

many people access the program through this process, overall, the program has enrolled only a small fraction of those estimated to be eligible.[36]

VI. The IFR's 12-Month Lookback Period Also Threatens Coverage for People Living with HIV.

30. The IFR limits states to a 12-month lookback period for claims and encounter data used to determine whether someone is medically frail or has special medical needs. This limitation harms people with ongoing conditions such as HIV where relevant claims fall outside the 12-month window.

31. Given that HIV is an incurable condition, older claims remain reliable evidence of a person's HIV status; requiring duplicative proof of that diagnosis merely because the relevant claims are more than 12 months old creates an unnecessary administrative burden for Medicaid enrollees, providers, and Medicaid agency staff.

32. With adherence to treatment, including attending regular medical appointments and adhering to an ART regimen, people living with HIV can achieve viral suppression.[37] However, many people living with HIV face barriers to adhering to regular HIV care, such as unmet socioeconomic needs, substance use, or serious mental health issues.[38] Housing instability, in particular, is a widely recognized barrier to HIV care retention.[39] People living with HIV who

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[36] *See* Leah Chan, Pathways to Coverage: Looking Back Two Years and Into the Future, Georgia Budget & Policy Institute (Oct. 13, 2025), https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/ ("About 8,077 Georgians were actively enrolled in the Pathways to Coverage program by the end of the first two years, which represents no more than 7% of uninsured, low-income adults from working households.").

[37] *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV: Limitations to Treatment Safety and Efficacy: Adherence to the Continuum of Care*, HIV.gov (Sept. 12, 2024), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care?view=full.

[38] *See id.*

[39] See, e.g., Angela Aidala, *Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review*, 106 Am. J. Public Health e1-e23 (Jan. 2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC4695926/pdf/AJPH.2015.302905.pdf.

experience socioeconomic and other barriers to care should not be denied access to Medicaid coverage simply because they do not have medical claims or encounter data from within the past 12 months that confirms their HIV status.

33. People living with HIV and other serious or complex conditions cannot afford to lose their coverage even temporarily due to administrative errors or unnecessarily complex red tape—as noted above, an HIV treatment lapse of even a few days or weeks may potentially lead to serious health consequences.[40]

VII. Due to the Importance of Maintaining Uninterrupted Access to Medicaid for People Living with HIV, HHCAWG and Others Provided Materials to CMS Before June 1, 2026, Regarding the Need to Exempt People Living with HIV from Community Engagement Requirements.

34. On October 28, 2025, the Center for Health Law and Policy Innovation, along with HHCAWG co-chairs The AIDS Institute and AIDS United, sent a letter to the Centers for Medicaid and CHIP Services (CMCS).[41] Members of these organizations and other groups affiliated with HHCAWG had a follow-up meeting on December 5, 2026, with Kirsten Jensen, Gene Coffey, and Martin Burian, staff at CMCS. During the meeting, the HHCAWG representatives reiterated the points in the letter and explained why HIV is unique, in the sense that people living with HIV can be virally suppressed and able to fully participate in community life, but continuous access to treatment is critical to avoid the risks of viral rebound, treatment resistance, and serious illness or death. The CMCS staff made no policy commitments but asked some granular questions about HIV, such as how soon after treatment interruption a person

[40] *See* ¶ 9, *supra* and sources cited.
[41] Letter from The AIDS Institute, AIDS United, and the Center for Health Law and Policy Innovation to Caprice Knapp, October 28, 2025 (attached as Exhibit A). *Accord* Administrative Record, Bates No. 003912 – 003914.

might experience HIV viral rebound, and how well the ABP regulations protect people with HIV.

35. On January 21, 2026, the HIV + Hepatitis Policy Institute sent a letter to CMS Administrator Dr. Mehmet Oz urging CMS to "include an explicit exemption for all people living with HIV" in federal guidance implementing the Medicaid community engagement requirement.[42]

36. On May 12, 2026, the HHCAWG co-chairs met with Phillip Pollman and Trenesha Fultz-Mimms, staff at the Office of Management and Budget (OMB), to discuss CMS's forthcoming IFR on Medicaid community engagement requirements.[43] In conjunction with the meeting, we provided the following documents further explaining how people living with HIV are covered under Medicaid and emphasizing the importance of recognizing HIV as a "serious or complex condition":

a. Lindsey Dawson, Priya Chidambaram, and Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, April 1, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/;[44]

b. The AIDS Institute, *Closing the Health Coverage Gap Is the Key to Ending the HIV and Hepatitis C Epidemics*, Oct. 25, 2021;[45]

c. The AIDS Institute, *7 Reasons to Exempt People with HIV from Medicaid's Community Engagement Requirement*, Oct. 2025,

[42] Letter from HIV+Hepatitis Policy Institute to Administrator Oz, Jan. 21, 2026, https://hivhep.org/wp-content/uploads/2026/01/HIV-Hep-Medicaid-Community-Engagement-for-HIV-1.21.26.pdf (attached as Exhibit B). *Accord* Administrative Record, Bates No. 004317.
[43] *See* EO 12866 Meeting 0938-AV98, Sept. 12, 2026 (screenshot attached as Exhibit C).
[44] Attached as Exhibit C(i).
[45] Attached as Exhibit C(ii).

https://www.theaidsinstitute.org/eliminating-hiv/fact-sheet-7-reasons-for-medicaid-requirement-exemptions-for-pwh;[46] and

d. Copy of the October 28, 2025, HHCAWG co-chairs letter to CMCS.[47]

37. On May 20, 2026, the HHCAWG co-chairs sent a follow-up letter to HHS Secretary Robert F. Kennedy, Jr., Administrator Oz, and OMB Director Russell Vought reiterating the importance of exempting people living with HIV from Medicaid community engagement.[48] We received no response to this letter.

38. The IFR and its preamble do not acknowledge or consider the points raised in the above letters and meetings.

DATED: August 28, 2026.

/s/ Elizabeth Kaplan

Elizabeth Kaplan, JD
Mass. BBO No. 568911
Harvard Law School
Center for Health Law & Policy Innovation
1607 Massachusetts Ave
Cambridge, MA 02138
Telephone: 617-496-1601
ekaplan@law.harvard.edu

[46] Attached as Exhibit C(iii).
[47] Exhibit A, *supra* n.41.
[48] Letter from HHCAWG to Secretary Kennedy et al., May 20, 2026 (attached as Exhibit D).

EXHIBIT A

October 28, 2025

Caprice Knapp, PhD
Deputy Administrator and Director (Acting)
Center for Medicaid and CHIP Services (CMCS)
7500 Security Boulevard
Room S3-14-07
Baltimore, MD 21244

Re: Medicaid Community Engagement Reporting Requirement

The AIDS Institute, AIDS United, and the Center for HIV Law and Policy Innovation are leading national organizations working to ensure access to care for people living with and vulnerable to HIV. Given the significant health risks and unique nature of HIV, we write to urge you to exempt people with HIV from the Medicaid community engagement requirement included in H.R. 1. We also request to meet with you to discuss how this exemption could be designed to minimize disruptive impact on access to HIV care and treatment.

In 2019, President Trump launched the Initiative to End the HIV Epidemic. His commitment to invest in innovative strategies to bring an end the HIV epidemic in the United States has helped to move our country closer to achieving that goal. Consistent access to health care coverage and treatment for people with HIV is crucial to continuing that progress and Medicaid is a critical source of that coverage.[1] Forty percent of adults living with HIV are covered by Medicaid, compared to just 15% of the general population.[2] Medicaid provides 45% of all federal funding for HIV treatment.[3] But people with HIV make up a very small share of Medicaid enrollees overall – less than one-half of a percent.[4]

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[1] *See* Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.
[2] *Id.*; Lindsey Dawson et al., *Medicaid and People with HIV*, KAISER FAM. FOUND. (Mar. 27, 2023), https://www.kff.org/hiv-aids/medicaid-and-people-with-hiv/.
[3] *Id.*; Lindsey Dawson et al., *Medicaid and People with HIV*, KAISER FAM. FOUND. (Mar. 27, 2023), https://www.kff.org/hiv-aids/medicaid-and-people-with-hiv/.
[4] Lindsey Dawson et al., *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.

Ensuring access to effective HIV care, treatment, and supports through the Medicaid program is important to the health of people living with HIV and to public health, broadly.[5] When HIV is effectively managed and individuals stay engaged in treatment and virally suppressed, people with HIV can live healthy lives and there is no risk of sexual transmission.[6]

HIV is a serious and complex chronic illness

H.R. 1 requires states to exempt people with "special medical needs" – including people with "serious or complex medical conditions" – from community engagement requirements.[7] HIV is the very definition of a serious and complex medical condition, requiring consistent, continuous, lifelong treatment to prevent advancement to AIDS. Continuous insurance coverage and access to care is critical to enabling people living with HIV to achieve viral suppression and positive health outcomes.[8] But because HIV is infectious, consistent management is also necessary to prevent others from acquiring it and to achieve an end to the epidemic.

As a result, CMS has historically recognized that HIV is a "serious chronic medical condition" warranting special treatment related to Medicaid eligibility and coverage,[9] as have several states.[10] We urge you to cement this recognition of the impact that HIV has on people and

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[5] *See* Dawson, Chidambaram & Mathers, *supra* note 1 (finding that "Medicaid is the primary payer for HIV care and treatment" but in 2022, federal Medicaid spending on HIV still represented less than 2% of total federal Medicaid spending).

[6] *See* Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, NEJM (2016); Robert W. Eisinger, Carl W. Dieffenbach & Anthony S. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451 (2019).

[7] *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72, 312; HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) SECTION 1115 DEMONSTRATION WAIVER APPLICATION, MONT. DEP'T PUB. HEALTH & HUM. SERV. 14 (2025) ("*Montana Waiver Proposal*").

[8] Lindsey Dawson and Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV*, 2018, KFF, (Sept. 4, 2020), https://www.kff.org/hiv-aids/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/.

[9] *E.g.*, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions."); Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include, but are not limited to… HIV/AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (Jan. 18, 2024) https://www.cms.gov/files/document/r12461cp.pdf ("[I]f the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., … HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

[10] *E.g.*, ARIZONA SECTION 1115 WAIVER AMENDMENT REQUEST: AHCCCS WORKS WAIVER, 9 (Dec. 19, 2017), https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration *or* a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status." (emphasis added)

communities by specifically exempting people with an HIV diagnosis from H.R. 1's community engagement requirement.

Community engagement requirements will disproportionately harm people with HIV

People living with HIV will be disproportionately challenged by the effects of this requirement. HIV can produce symptoms or disabilities that are not visible yet serve as impediments to steady employment.[11] For example, HIV can produce periods of inability to work due to medication side effects, periods of illness, or the need to attend many doctors' appointments; thus, employees with HIV may require flexible work arrangements that can be hard to find or keep.[12] More than half of people living with HIV are age 50 and older,[13] a group that is particularly likely to have difficulty complying with work requirements.[14] For people living with HIV, loss of Medicaid due to arbitrary denials and administrative red tape can lead to care disruptions that can pose enduring, costly, and complex health risks.[15]

We understand that implementing the community engagement requirement and other aspects of H.R. 1 is a complex job that requires balancing many different considerations. We look forward to working with you to ensure that these important decisions do not undermine the goal we share with President Trump: achieving once and for all an end to the HIV epidemic in the United States. Please reach out to Rachel Klein, Deputy Executive Director at The AIDS Institute at rklein@taimail.org or (202) 815-2973 to arrange a time to meet.

Sincerely,

Rachel Klein
Deputy Executive Director
The AIDS Institute

Leslie McGorman
Senior Director of Policy & Strategy
AIDS United

Liz Kaplan
Director of Health Care Access
Center for Health Law & Policy Innovation

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[11] Rachel Garfield, Robin Rudowitz & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, KAISER FAM. FOUND. (Jan. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-andWork.

[12] Catherine H. Maulsby et al., *A Scoping Review of Employment and HIV*, 24 AIDS BEHAV. 1, 5 (2020) https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.pdf ("Among employed individuals, those who have workplace accommodations are more likely to be adherent to HIV medications than those without an accommodation.").

[13] HIV.gov, Aging with HIV, (Sept. 8, 2025), https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

[14] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults/.

[15] Elizabeth Hamlyn et al., *Plasma HIV Viral Rebound Following Protocol-Indicated Cessation of ART Commenced in Primary and Chronic HIV Infection*, PLOSONE (2012); Gerald Friedland & Ann Williams, *Attaining Higher Goals in HIV Treatment: The Central Importance of Adherence*, 13 AIDS S61 (1999) ("Therefore, potent and continuous suppressive therapy for the duration of viral replicative capability is necessary for therapy to be effective.").

EXHIBIT B

HIV+HEP
POLICY INSTITUTE

January 21, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

RE: Medicaid Community Engagement Requirement and People Living with HIV

Dear Administrator Oz:

The **HIV+Hepatitis Policy Institute** is a leading national HIV and hepatitis policy advocacy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions.

We write to urge you to include an explicit exemption for all people living with HIV in upcoming federal guidance relating to the new Medicaid community engagement requirement mandated by HR 1.

People with HIV are living with a lifelong **serious and complex medical condition** and have **special medical needs**: they cannot stay healthy without *continuous* access to their lifesaving HIV treatment. Any gap in treatment risks serious health consequences, including failure of viral suppression and the risk of onward transmission. Longer treatment gaps are potentially disabling, allowing progression to AIDS, after which life expectancy is limited.

People with serious and complex medical conditions and special medical needs are statutorily exempt from the community engagement requirement; however, absent federal guidance, states can define which populations qualify. We urge CMS to explicitly state that all people living with HIV (both symptomatic and asymptomatic) have special medical needs and fall under this exemption.

This interpretation is consistent with long-standing federal precedents. For decades, Congress and Unites States DHHS have considered HIV (both symptomatic and asymptomatic) as a serious, life-threatening, and potentially disabling condition.[1]

We believe that all people living with HIV should be exempt from the community engagement automatically and not have to navigate cumbersome new procedures to document their status with each Medicaid recertification. Since HIV is a lifetime condition

[1] For example, 28 CFR 35.108(b)(2) or 78 FR 42233

that will not change over time, this assessment should only be carried out once.

Under statute, states are directed to maximize *ex parte* verification of eligibility in relation to the community engagement requirements. Automatic exemption through use of data already available to the Medicaid program (such as diagnostic codes and claims data) minimizes the burden on the enrollee. It also reduces the administrative burden on the state and on the health-care workforce providing care to people with HIV.

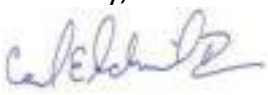
To put the onus on individuals living with HIV to navigate administratively cumbersome forms of verification of HIV status is unnecessary and puts their health at risk. In addition, since people with HIV face continuing stigma and discrimination, many are reluctant to disclose their HIV status in Medicaid enrollment and recertification paperwork, further amplifying the importance of using e*x parte* verification of HIV status.

Continuous access to Medicaid for people living with HIV is critical to sustaining our national progress towards ending the HIV epidemic and will directly support the goals of the *Ending the HIV Epidemic* initiative launched by President Trump in his first administration.

Approximately forty percent of people living with HIV nationwide are enrolled in Medicaid, making humane and clinically sound implementation of the new community engagement requirements of the highest importance to them, their clinical care teams, and communities.

We appreciate the opportunity to submit these comments and are ready to assist you in any way. Should you have questions or comments, please feel free to contact me at cschmid@hivhep.org or Kevin Herwig at kherwig@hivhep.org. Thank you very much.

Sincerely,



Carl E. Schmid II
Executive Director

cc: Mr. Daniel Brillman, Deputy Administrator and Director, Center for Medicaid and CHIP Services

EXHIBIT C

reginfo.gov/public/do/viewEO12866meeting?viewRule=true&rin=0938-AV98&meetingId=[illegible]&acronym=0938-HHS/CMS

View EO 12866 Meeting 0938-AV98

Title: Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social Security Act (CMS-2454)

Agency/Subagency: 0938-HHS/CMS

Stage of Rulemaking: Interim Final Rule Stage

Meeting Date/Time: 05/12/2026 01:30 PM

Requestor: The AIDS Institute **Requestor's Name:** Rachel Klein **Requestor's Client:** HIV Health Care Access Working Group

Documents:

List of Documents
5 Key Facts About Medicaid Coverage for People with HIV _ KFF
Coverage-Gap-Issue-Brief_draft-V7
7 Reasons to Exempt PWH from Medicaid Work Requirement
Exempting PWH from Medicaid Community Engagement Letter 10-25

Attendees:

List of Attendees	Participation
• Rachel Klein - The AIDS Institute	Teleconference
• Terri Wilder - SAGE	Teleconference
• Elizabeth Kaplan - Center for Health Law & Policy Innovation	Teleconference
• Leslie McGorman - AIDS United	Teleconference
• Dori Molozanov - NASTAD	Teleconference
• Phillip Pollman - OMB	Teleconference
• Trenesha Fultz-Mimms - OMB	Teleconference

EXHIBIT C(i)

KFF The independent source for health policy research, polling, and news.

5 Key Facts About Medicaid Coverage for People with HIV

Authors: Lindsey Dawson, Priya Chidambaram, and Jessica Mathers

Published: Apr 1, 2025

Medicaid is the primary source of insurance coverage for people with HIV, playing a key role in financing HIV care and prevention efforts. Despite the importance of Medicaid for people with HIV, they represent a very small share of program enrollees overall (less than one-half of a percent). Most Medicaid enrollees with HIV qualify for the program through the Affordable Care Act (ACA)'s Medicaid expansion and disability-related pathways.

Policy proposals being considered by Congress to reduce federal spending for the Medicaid program could have negative implications for people with HIV and those at risk. It is unclear what specific policies might be implemented to achieve federal reductions and a range of options are being considered, but reductions in federal Medicaid funding would shift costs to states and could result in coverage losses, reduction in benefits, cost-shifting to HIV safety-net programs, and/or reductions in payment rates to providers, if states do not offset federal dollars. Policies imposing Medicaid work requirements, which could happen through the Congressional budget process or via waiver approvals, would impact people with HIV as well, likely leading to coverage losses. Coverage losses among people with HIV would likely increase demand on the nation's HIV safety-net program, the Ryan White Program (which could also face cuts in Congress though the program's funding has already not kept pace with inflation or growing need). Loss of Medicaid coverage could result in

interruptions in HIV care and treatment, which could lead to increased morbidity and mortality as well as HIV transmission.

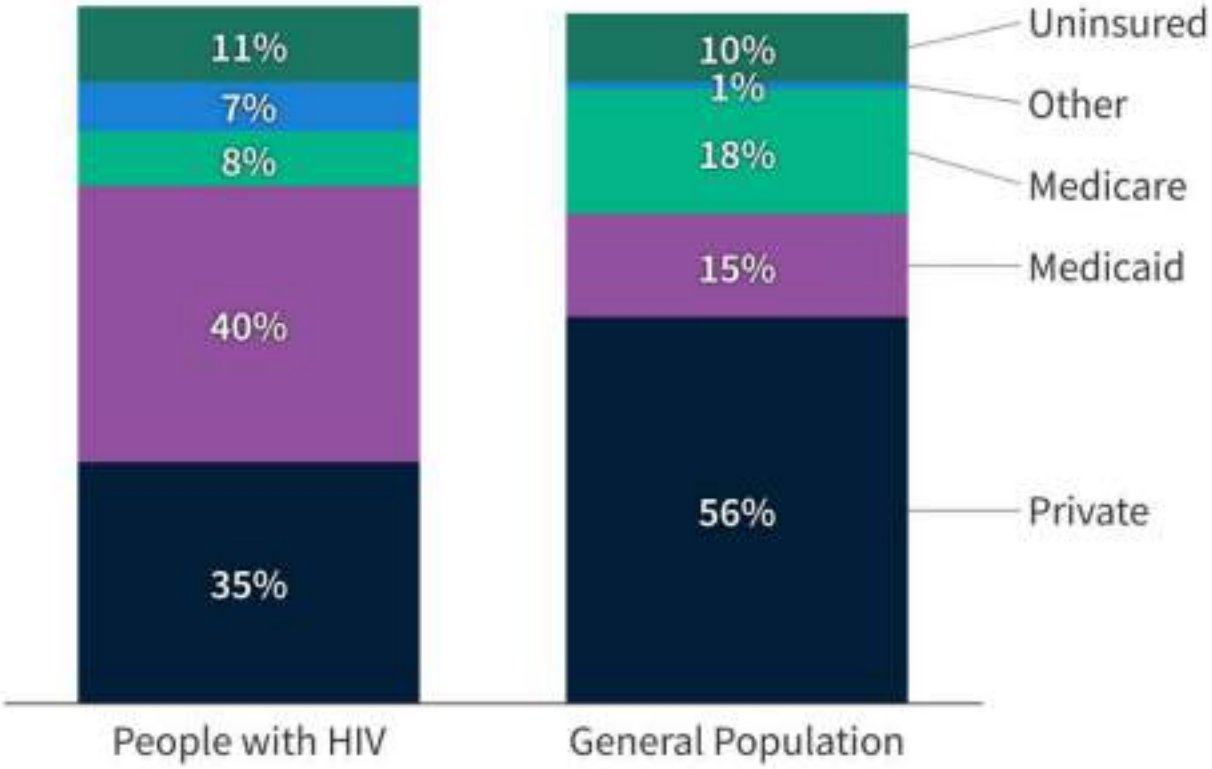
1. Medicaid is the primary source of insurance coverage for people with HIV.

Medicaid is the single largest source of coverage for adults with HIV in the U.S., with four in ten estimated to be covered by the program (40%). By comparison, only 15% of adults in the general population have Medicaid coverage (Figure 1). Medicaid has helped to provide HIV care since the HIV epidemic began in the early 1980s. Coverage and benefits have grown over time as people with HIV are living longer, new infections continue to occur, and due to the Medicaid program's expansion under the Affordable Care Act (ACA). Higher rates of Medicaid coverage reflect the fact that people with HIV have lower-incomes (33% of adults with HIV have incomes below 100% FPL compared to 11% of adults overall). Additionally, a large share of people with HIV have a disability (42%) and one in four (25%) people with HIV on Medicaid are dually eligible for Medicare, compared to 14% of enrollees without HIV.

Figure 1

Medicaid is the Primary Source of Insurance Coverage for People with HIV

Distribution of U.S. population by insurance coverage and HIV status



Note: Data sources are different for people with HIV and the general population and statistical testing was not performed.

Source: Data in both columns are from 2018 and from: KFF. Issue Brief. Insurance Coverage and Viral Suppression Among People with HIV, 2018 https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/

KFF

2. Medicaid is the primary payer for HIV care and treatment

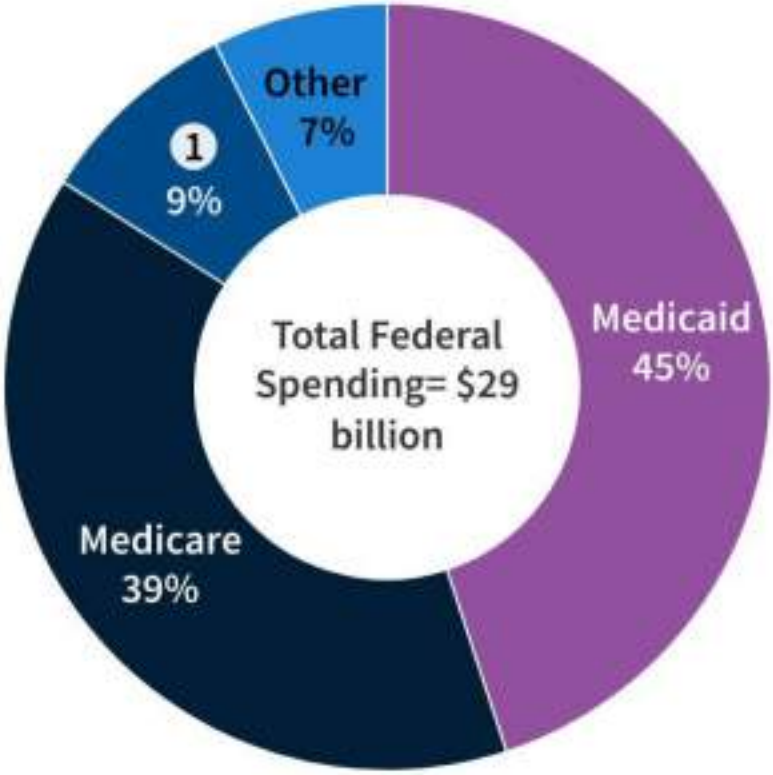
While Medicaid spending on people with HIV is a small share of all Medicaid spending, it accounts for an estimated 45% of all federal spending on HIV care and is the largest source of public financing for HIV care in the U.S, followed by Medicare.

Still, in FY 2022, CMS estimates federal Medicaid spending on HIV represented less than 2% of total federal Medicaid spending. In addition, states also contribute to Medicaid spending on HIV (Medicaid is jointly financed by state and federal governments). Medicaid spending on HIV has increased over time, reflecting growing numbers of enrollees with HIV and the rising costs of care and treatment. In this way, it differs from the Ryan White Program, which is dependent on Congressional appropriations and funding levels do not automatically adjust to meet the needs of a growing population and increasing medical costs.

Figure 2

Medicaid is the Primary Payer for HIV Care and Treatment

Distribution of U.S. federal spending on HIV by program, FY 2022



1 Ryan White

Note: Total Medicaid funding includes only federal spending. A small amount of VA prevention funding is included in "other" as it was not possible disaggregate care and prevention funding for that account. Several accounts in the "other" category are estimates carried forward from FY17.

Source: Calculation based on KFF review of Congressional Budget Justifications, other budget documents, and personal agency correspondence

KFF

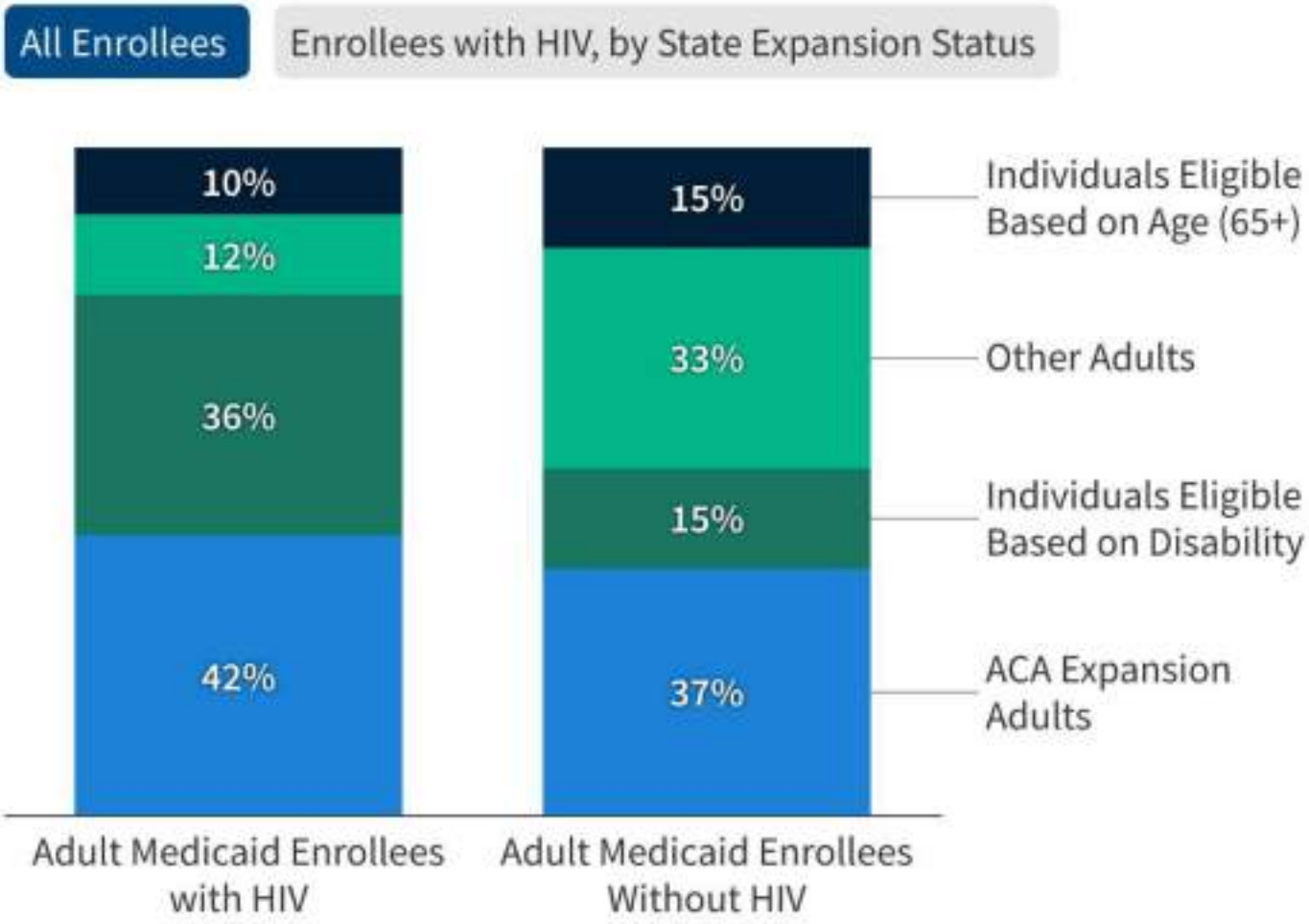
3. Medicaid expansion is the most common pathway to program eligibility for people with HIV.

Over four in ten (42%) Medicaid enrollees with HIV have coverage through the ACA's Medicaid expansion, making it the primary pathway to Medicaid eligibility for this population. In Medicaid expansion states, over half (51%) of adults with HIV have coverage through the expansion. This pathway was created under the ACA to provide coverage to low-income adults on the basis of income without other categorical requirements like disability or pregnancy. Individuals with HIV who qualify through the expansion pathway may be able to access early treatment that could help stave off disability and significantly improve health outcomes. However, not all states offer the expansion pathway and today over one-third (35%) of people with HIV live in one of ten states that has not opted to expand Medicaid. Medicaid enrollees with HIV continue to enroll through the disability pathway at much higher rates than those without HIV (36% v 15%) and it remains the primary entry point to coverage for adults with HIV in non-expansion states, two-thirds (66%) of whom have disability-related coverage (compared to 30% in expansion states).

Figure 3

Medicaid Expansion is the Most Common Pathway to Program Eligibility for Adults with HIV

Distribution of adult Medicaid enrollees by eligibility group, by HIV status, 2021



Note: This analysis reflect enrollees 18 and older (348,000 enrollees with HIV and 59.7 million enrollees without HIV). 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. For Medicaid enrollees without HIV, the "Other Adults" category includes 2% of enrollees who are 19 but qualified via the children's pathway.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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4. Medicaid enrollees with HIV are more likely to have substance use disorders,

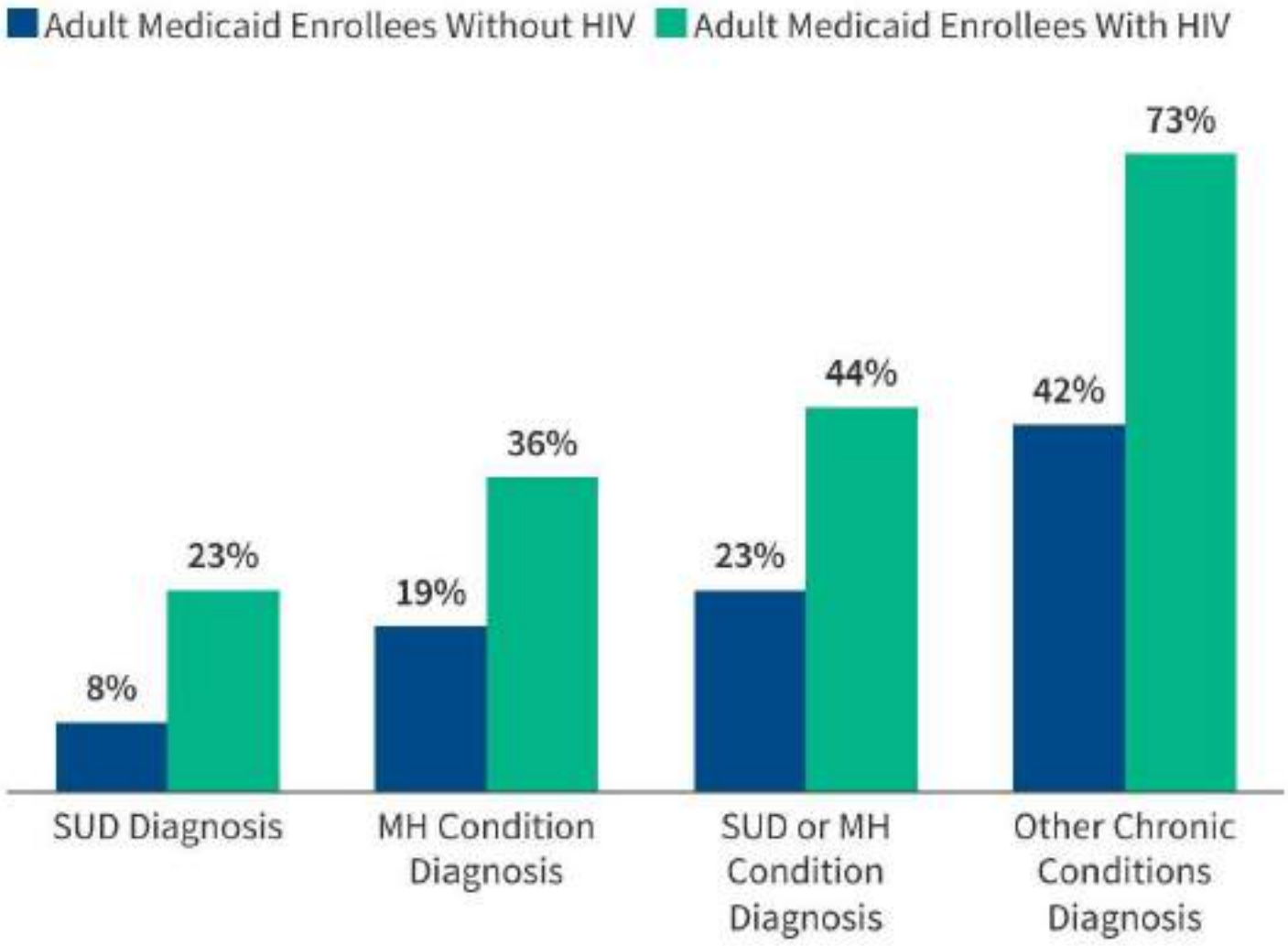
mental health conditions, and other chronic conditions relative to those without HIV.

Medicaid enrollees with HIV experience comorbidities at higher rates than those without HIV, including those related to mental health and substance use disorders. Nearly three-quarters (73%) of Medicaid enrollees with HIV have one of 34 other chronic conditions, compared to 42% of enrollees without HIV (see Figure 4 notes for details). Enrollees with HIV are more than twice as likely to be medically complex than enrollees without HIV, with about one-third (32%) having three or more chronic conditions in addition to HIV, compared to 13% of enrollees without HIV (data not shown). Adult enrollees with HIV are also twice as likely to have either a substance use disorder or mental health condition diagnosis (44% v 23%) compared to those without HIV. Enrollees with HIV are nearly ten times more likely than enrollees without HIV to have a hepatitis diagnosis. However, likely reflecting curative treatments now available, that share has declined from 14% of enrollees in 2013 to 6% in 2021 (data not shown). These differences between enrollees with HIV and without HIV likely reflect a range of both medical and social factors that combine to increase the risk and prevalence of these co-occurring conditions.

Figure 4

Adult Medicaid Enrollees with HIV are More Likely Than Those Without HIV to Have Substance Use Disorder, a Mental Health Condition, and Other Chronic Conditions.

Rate of chronic conditions among adult Medicaid enrollees, by HIV status, 2021



Note: SUD = Substance Use Disorder. MH = Mental Health condition. This analysis reflect enrollees 18 and older who had no Medicare coverage in 2021 (260,000 enrollees with HIV and 46.3 million without HIV). Enrollees who had at least one month of Medicare coverage in 2021 were excluded from these calculations since these enrollees may not have sufficient claims in T-MSIS to identify chronic conditions. 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. There are a total of 34 non-HIV chronic conditions captured in this analysis. This includes 29 conditions from the Chronic Condition Warehouse algorithm (excluding mental health); KFF's definition of obesity and hepatitis; Urban Institute's Behavioral Health Services Algorithm (BHSA) for definitions of SUD and Mental Health; and ASPE's definition of I/DD.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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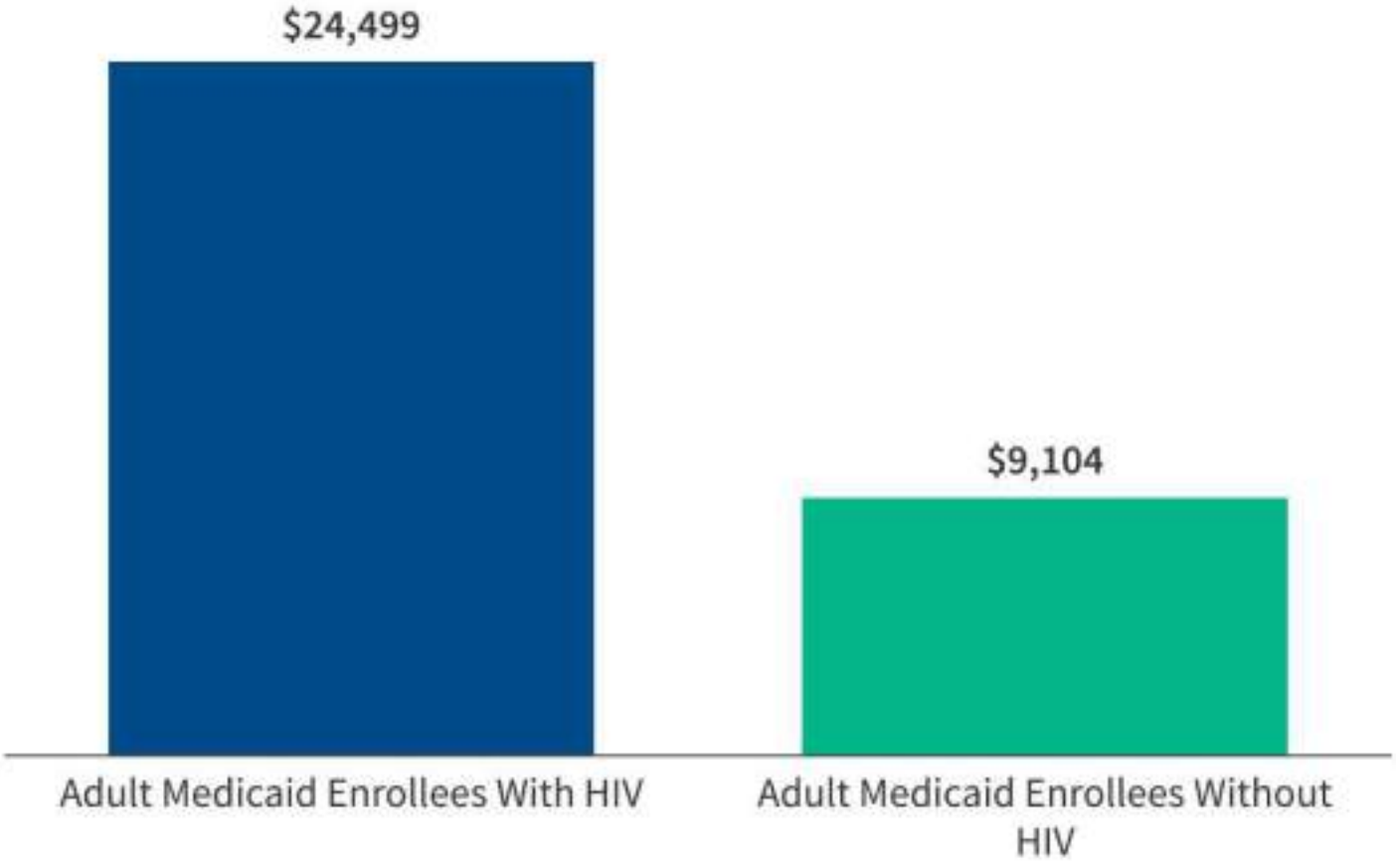
5. Spending for Medicaid enrollees with HIV is nearly three times higher than spending for those without HIV.

Spending on people with HIV enrolled in Medicaid is substantially higher than on those without HIV, reflecting higher health needs and costs of care. Average Medicaid spending per adult enrollee with HIV was about $24,000 in 2021, nearly three times that of adult Medicaid enrollees without HIV (about $9,000 per enrollee). While spending on enrollees with HIV was higher across all spending categories, the difference was especially marked in the drug/treatment category reflecting the relatively high cost of HIV medications (though notably, the drug spending data reflects pre-rebate amounts). Still, because people with HIV represent less than one-half of a percent of Medicaid enrollees overall, the net impact on Medicaid spending is small (less than 2%, see point 2 above).

Figure 5

Spending for Adult Medicaid Enrollees with HIV is Nearly Three Times Higher Than Spending for Those Without HIV

Average annual per capita spending for adult Medicaid enrollees by HIV status, 2021



Note: This analysis reflect enrollees 18 and older (348,000 enrollees with HIV and 59.7 million enrollees without HIV). 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. Average annual per capita spending calculations include fee-for-service spending, payments to managed care plans, and payments to Medicare.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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Methods

Medicaid Claims Data: Figures 3-5 in this analysis use the 2021 T-MSIS Research Identifiable Demographic-Eligibility and Claims Files (T-MSIS data) to identify Medicaid

enrollees with HIV.

Identifying HIV in Medicaid Claims Data: Enrollees with HIV were flagged if they had a relevant ICD 9 or ICD 10 code, any drug claims for a single tablet regiment (STR), or two or more other non-STR ARVs. A list of diagnosis and drug codes that were used for this analysis are available upon request.

Enrollee Inclusion Criteria: Enrollees were included if they were ages 18 or older and had at least one month of Medicaid coverage. Figure 4, which identifies rates of chronic conditions among those with and without HIV, also excludes those who had at least one month of Medicare coverage. These enrollees were excluded from these calculations since they may not have had sufficient claims in T-MSIS to identify chronic conditions.

State Inclusion Criteria in Medicaid Claims Data: To assess the usability of states' data, the analysis examined quality assessments from the DQ Atlas for service users in the "Other Services" and Drug files for 2021. 49 states and D.C. were included in this analysis. Mississippi was excluded since it received an "Unusable" rating on these measures.

Defining Chronic Conditions (Figure 4): This analysis used the CCW algorithm for identifying chronic conditions (updated in 2020), excluding its definition for mental illness, which was pulled from a different source. This analysis also included in its definition of chronic conditions substance use disorder, mental illness, obesity, hepatitis C, and intellectual and developmental disabilities (ASPE definition).

Calculating Spending (Figure 5): Average annual per capita spending calculations include fee-for-service spending, payments to managed care plans, and payments to Medicare. Spending was calculated by summing the total spending of all claims per enrollee in the T-MSIS claims files and manually adds Medicare premiums for those who are also enrolled in Medicare. Estimates here do not include prescription drug rebates and most supplemental payments to providers.

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EXHIBIT C(ii)

THE AIDS INSTITUTE

TAI Policy Brief: October 25, 2021

Closing the Health Coverage Gap Is the Key to Ending the HIV and Hepatitis C Epidemics

HIV and hepatitis C are at epidemic levels in the United States. Over more than 40 years, these diseases have ravaged the country, killing hundreds of thousands of people, devastating families and communities, and costing billions in health care costs. Thanks to revolutionary new medicines, people with either disease can be successfully treated and live long, healthy lives. Treatment also helps ensure that people living with HIV and hepatitis C cannot transmit these infectious diseases to others, stopping the epidemics in their tracks. But without health coverage, many low-income people living with HIV and hepatitis C cannot access or afford treatment and prevention. Health coverage is the key to health care, and ultimately ending the HIV and hepatitis C epidemics.

Health insurance remains out of reach for millions of Americans who live in states that have not taken advantage of the opportunity to expand Medicaid to all low-income adults. As a result, approximately two million low-income people remain uninsured in states – mostly in the South – that also have very high rates of HIV and hepatitis C. Improving access to health care will increase access to testing, prevention, care and treatment for these focus populations. If Congress closes the health coverage gap in those states, it can save lives, lessen health disparities, reduce the burden on our already strained health care system, and save the country billions of dollars.

The first step to ending the HIV and hepatitis C epidemics is to make sure that people have access to health coverage. Health coverage opens the door to prevention, care, and treatment, all of which are needed to reduce the transmission of HIV and hepatitis C and prevent new cases.

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HIV and Hepatitis C Can Be Prevented and Cured – if People Have Access to Groundbreaking Medicines

Thanks to innovations in drug development and groundbreaking advancements in preventive measures, neither HIV nor hepatitis C is considered a death sentence today.

> **HIV**: When patients with HIV strictly adhere to their treatment regimens, not only can they live longer, healthier lives, but their HIV viral loads can be reduced to undetectable levels. This makes HIV untransmissible. And with the advent of pre-exposure prophylaxis (PrEP), a once-daily pill that prevents HIV infection, new cases can be avoided for people who are at a higher risk for contracting HIV.
>
> **Hepatitis C**: As with HIV, major advancements have been made in treating hepatitis C. Since these new treatments first came on the market in the 1990s, patients can now be cured in as little as eight weeks.

However, there are many people living with, and at risk for, HIV and hepatitis C who do not have access to these curative, life-saving treatments. Treatment costs are estimated to be between $1,500 and $4,500 each month for an HIV patient, depending on the medication or medications that are most appropriate; and hepatitis C treatment can be as high as $28,000 per month for a three-month course.[1,2] Most patients cannot afford these medicines without health insurance, but they cannot afford the kind of insurance they need due to the health coverage gap in their states.

Why Is There a Coverage Gap?

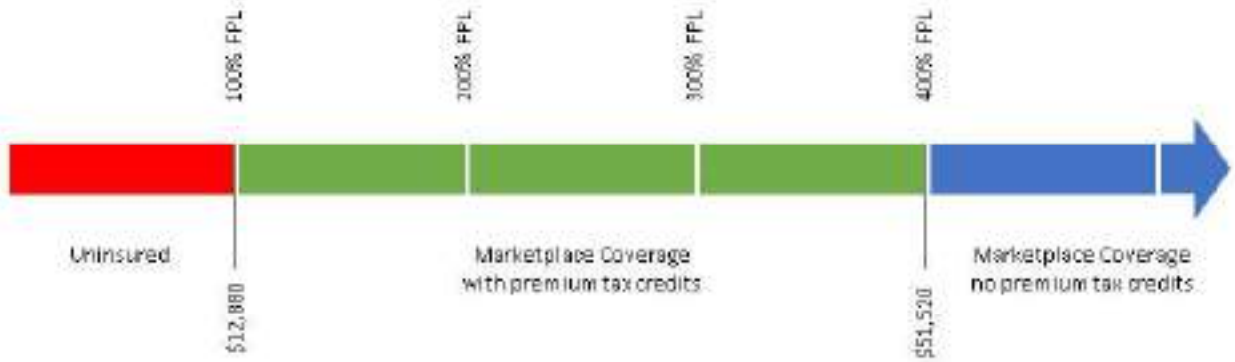
The Supreme Court ruled in 2012 that the ACA's Medicaid expansion was optional for states, creating an unforeseen problem for low-income people in some states who needed health coverage. The ACA intended for states to expand their Medicaid programs by offering coverage to all residents with incomes up to at least 138% of the federal poverty level (FPL, which is $17,774 for an individual and $16,500 for a family of four).[3] Then the federal government would offer premium tax credits to people with incomes between 138-400% FPL (between $17,774-$51,520 for individuals) who bought coverage through the health insurance marketplaces. This would ensure that coverage was affordable and accessible for Americans at every income level.

However, the ACA did not account for what would happen in states that opted not to expand Medicaid (non-expansion states). In those states, premium tax credits are available only to people with incomes at or above 100% FPL. Residents with incomes below 100% FPL but above their state's Medicaid eligibility level cannot get insurance through Medicaid or get help through premium tax credits. Without tax credits, monthly premiums for private insurance in these states can range from $325-$485 – amounts that are well beyond the budget of people making $12,880 or less per year. This leaves 2 million people without access to health care.

Figure 1.

Health Insurance Coverage by Income, Medicaid Expansion State

Health Insurance Coverage by Income, Coverage Gap State



Which States Have This Coverage Gap, and Who Does It Affect?

To date, 12 states have yet to expand Medicaid: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Many of these non-expansion states are at the nexus of the HIV and hepatitis C epidemics: The majority of these states are in the South, which is also home to a disproportionate share of people living with HIV and hepatitis C.

- The HIV epidemic continues to rage in the South: Southern states represent only 38% of the nation's population, but 53% of all new HIV diagnoses occurred in those states (according to the most recent data).[4]
- The ongoing opioid crisis has fueled the hepatitis C epidemic among younger adults aged 20-39, causing a 350% increase in new cases between 2010-2018.[5] Many of the states that have yet to expand Medicaid are among those hit hardest by the opioid epidemic[6]

Medicaid is a lifeline for people with these diseases, in the South and across the country.

HIV: Medicaid is the largest source of health coverage for people living with HIV, playing a critical role in preventing and treating the disease. However, an analysis by Kaiser Family Foundation found that Medicaid coverage for this group varies significantly across states. In non-expansion states, 20% of people living with HIV are uninsured, compared to 6% of people in states that have expanded Medicaid.[7] This has left nearly 86,000 people who have HIV without access to vital health coverage across the non-expansion states.[8]

Hepatitis C: People with hepatitis C are more likely to have Medicaid or be uninsured compared to people who don't have hepatitis C; those without insurance tend to have lower incomes.[9] A solution to close the coverage gap would provide a critical link to health care and treatment for this group.

Medicaid eligibility requirements in non-expansion states exclude many people who are not caregivers or disabled. This leaves a total of 2 million low-income residents without access to health insurance, including tens of thousands of people living with HIV and hepatitis C.[10] Low-income people of color are also overrepresented in the coverage gap population. And Black and Latino men and women have higher rates of new HIV diagnoses compared to people of other races and ethnicities.

Closing the coverage gap could give many low-income people access to much-needed health care, especially in the south where many barriers to health care exist such as poverty and rural landscapes. It could also help reduce persisting racial and ethnic disparities in health and health care. Ending these epidemics is possible if Congress expands health insurance and closes the coverage gap.

Four Reasons Why Closing the Coverage Gap Is Essential

- It would help end the HIV and hepatitis C epidemics, saving thousands of lives
- It would reduce inequities in health and health care
- It would relieve the burden on the health care system
- It would save billions of dollars in health care spending

Helping End the HIV and Hepatitis C Epidemics and Saving Lives

Several national plans have been developed that outline strategic goals and objectives with specific measures to end these epidemics. The more recent Ending the HIV Epidemic: A Plan for America (EHE initiative) is complimentary to the long-established HIV National Strategic Plan (the National Plan): The EHE initiative provides a focused strategy for targeted jurisdictions with disproportionately high rates of HIV, whereas the National Plan is a broader approach to addressing HIV across the United States. Both the HIV National Strategic Plan and the Viral Hepatitis National Strategic Plan cite lack of health insurance as a barrier to improving health outcomes and ending these epidemics.[11,12] The coverage gap presents a challenge to the ambitious goals of reducing new infections and reducing HIV and hepatitis C

disparities set out by these strategic plans, preventing an effective response. Without a solution that addresses the coverage gap, the decades of advocacy, billions of dollars in research, and public health resources that have been devoted to eradicating these diseases will be in vain.

To end the epidemics, additional funding to supplement existing state and federal resources is needed, program capacity must be expanded, and the cracks in the foundation of our health care system must be filled. The coronavirus pandemic made painfully clear our health care system is not a solid base to build upon. Temporary solutions had to be issued by the federal government to help fill the gaps during the emergency: Expanding access to premium tax credits, relaxing Medicaid eligibility criteria, waiving fees for testing and vaccinations.[13] Health care systems in states across the nation have been strained to their breaking point, including many of the 12 non-expansion states.

The four pillars of the EHE initiative are: diagnosis, treatment, prevention, and response.[14] But without access to insurance, our system of health care cannot provide any of these services to people with HIV or hepatitis C.

HIV: Consistent access and adherence to a prescription drug regimen is key to achieving viral suppression among people living with HIV. According to the Centers for Disease Control and Prevention (CDC), sustained viral suppression at levels that are undetectable makes it impossible to transmit HIV to others. Medicaid is crucial in this regard because it increases access to HIV treatment and prevention through coverage of prescription drugs, resulting in reduced transmission.[15] States that have expanded Medicaid, like Louisiana, have seen a significant reduction in HIV transmission.[16]

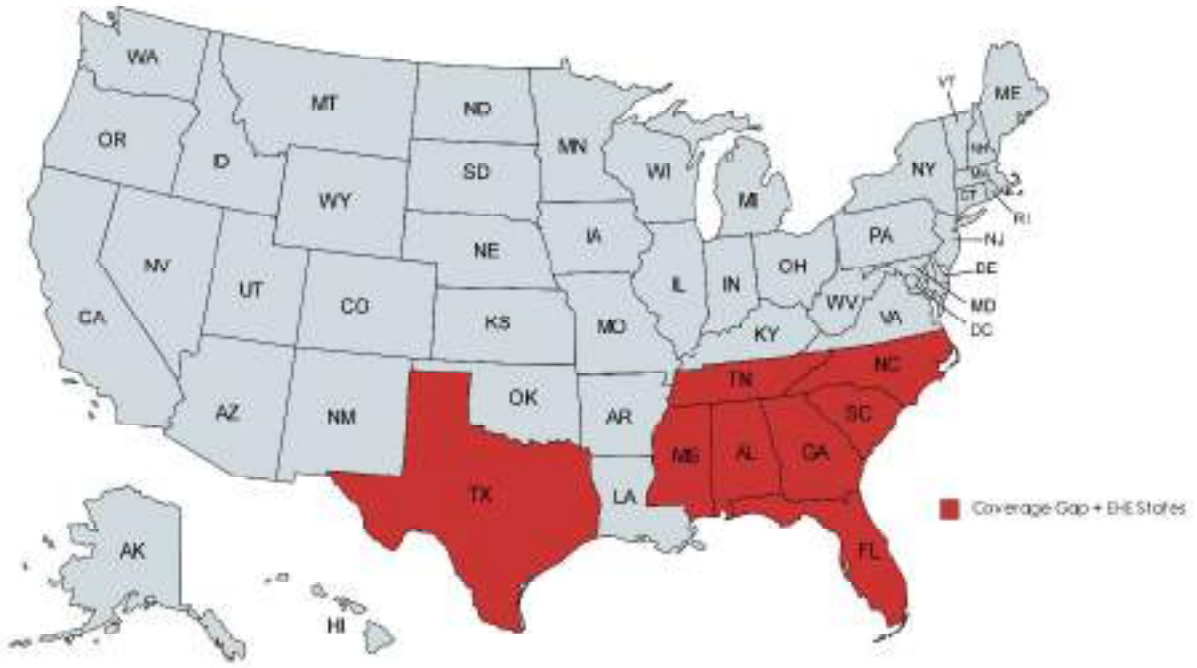
Another key factor in ending the HIV epidemic is improving access to PrEP to prevent the transmission of HIV. As a result of a decision by the U.S. Preventive Services Task Force, beginning this year, PrEP must be offered at no cost to beneficiaries in Medicaid expansion states.

Hepatitis C: The medical miracle of hepatitis C is that in a mere 25 years after the virus was discovered, a cure was developed. Today, there are several medications on the market that can cure a patient in eight weeks. In addition, the Task Force recommends that all adults aged 18-79 be screened for hepatitis C without having to pay any cost-sharing (they'll have no out-of-pocket costs). This will undoubtedly lead to more people being diagnosed, treated and cured.

By covering the costs of screening, diagnosis and treatment, Medicaid can play a role in eliminating this curable disease that silently kills if not treated. However, these best practices are available only to those enrolled in health insurance, which excludes people in non-expansion states. Ending these epidemics starts with improving access to health care by closing the coverage gap.

Figure 2.

The Map shows an overlap of states that have a coverage gap and were identified in the Ending the HIV Epidemic Initiative as priority jurisdictions. The HIV epidemic has disproportionately burdened southern states, where access to coverage has remained a challenge.



Reducing Disparities in Health and Health Care and Improving Health Equity

Improving access to health coverage is inextricably linked to reducing racial and ethnic disparities in health and health care. This is especially true for patients with HIV or hepatitis C. Black Americans are disproportionately burdened by HIV and hepatitis C. They make up only 13% of the population, but they account for 42% of new HIV diagnosis.[17,18] And they are 2.3 times more likely than their white counterparts to have hepatitis C.[19]

Overall, 60% of all people who fall into the coverage gap are people of color, though they represent only 33% of the population of non-expansion states.[20] In states that have expanded Medicaid, Black and Hispanic residents have seen the greatest declines in uninsured rates.[21]

To end these epidemics, racial disparities in health, health care, and health coverage must be acknowledged and addressed. Closing the coverage gap is imperative to achieving health equity.

Relieving the Burden on the Health Care System

The coverage gap affects not only people's health and the nation's ability to end these epidemics, but it also puts a strain on the health care system overall. Without health insurance,

a patient diagnosed with HIV or hepatitis C can't obtain routine care and treatment. Instead, that person may delay care until their condition worsens, or use emergency services as their primary source of care, burdening already strained health care systems. In 2020, community hospitals provided $41.61 billion in uncompensated care, much of that going to uninsured patients.[22] Uncompensated care costs are closely tied to the rate of uninsured people. States that have expanded Medicaid have seen a significant decline in uncompensated care: Uncompensated care costs fell 45% between 2013 and 2017 in those states, compared to 2% in non-expansion states.[23]

Coverage expansion has also alleviated the burden on safety net programs like the Ryan White HIV/AIDS Program. As a "payer of last resort," the Ryan White Program is intended to supplement other forms of health insurance. The program's funds cannot be used for services that are eligible for coverage by federal or state health insurance programs or by private insurance. In states that have expanded Medicaid, Ryan White Program dollars can go further because Medicaid pays for the majority of patients' care and treatment.

Texas has shown the stress that safety net programs, like the Ryan White Program can experience when states decide not to expand Medicaid. This year, Texas revealed that it was experiencing a $104 million budget crisis with its AIDS Drug Assistance Program,[24] which is an integral part of its Ryan White Program. This budget crisis is threatening access to medication for more than 21,000 people living with HIV.[25]

People enrolled in the Ryan White program have higher rates of viral suppression compared to the national average of people living with HIV.[26] The scaling up the success of the program to reach more people living with HIV hinges on health coverage also being expanded. Closing the coverage gap could help relieve the burden that state Ryan White HIV/AIDS Programs experience when they are forced to serve as the primary source of insurance rather than the safety net they were intended to be.

Expanding Access to Health Insurance Makes Financial Sense

Expanding Medicaid eligibility to include people with incomes below 100% FPL could save states money, even if expansion meant more people enrolled in the program. Health insurance and access to health care improve health outcomes and prevent disability. Providing long-term or specialized medical care for a seriously ill patient who has experienced extensive, irreversible disease progression as a result of delayed care is far more costly than providing preventive care

Hepatitis C: If left untreated, hepatitis C causes liver damage, liver disease, cancer and even death. It also contributes to or exacerbates other serious and chronic health conditions, which in turn increases costs for the entire health care system. The average cost of treating a patient with hepatitis C is a one-time investment of $19,051, while the average cost to care for that person's accompanying health conditions and overall declining health is $205,760 over a lifetime.[27]

HIV: The lifetime treatment cost for a person with HIV is estimated to be over $350,000.[28] Compare this figure to the lifetime cost of preventing a person at high risk from getting infected at $96,700, saving $253,300 to prevent a single HIV infection.[29] These figures demonstrate the value of investing in treatment and prevention. Closing the coverage gap is the most fiscally responsible option for all states.

Conclusion

There are many proposed policy solutions to close the coverage gap. States that have not yet expanded Medicaid could choose to expand their programs' eligibility criteria, and take advantage of enhanced federal funding to support the transition.[30] Congress has the opportunity to close the coverage gap by passing legislation. Some of the proposals build off of existing infrastructure, such as expanding eligibility for premium tax credits for people with incomes below 100% FPL.[31] Other options suggest offering a federally-run program that mirrors the state Medicaid programs, or a public option similar to Medicare.[32] It is imperative that Congress members or state leaders act now to close the coverage gap, regardless which option they choose. The AIDS Institute urges policy makers to find a way to close the coverage gap, ensuring the thousands of people living with HIV and hepatitis C who are currently without affordable health coverage can get the care they need. Closing the coverage gap will not only bring health insurance to millions of low-income people, reduce health disparities, and saving money; closing the coverage gap will save the lives of thousands of people with HIV and hepatitis who will have access to life-saving care and treatment. Closing the coverage gap is the key to ending the HIV and hepatitis epidemics.

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[27] F. Hood, *Treating Hepatitis C Saves Lives and Money* (The AIDS Institute, August 2021), https://aidsinstitute.net/documents/Fact-Sheet---Treating-Hepatitis-C-Saves-Lives-and-Money.pdf

[28] Centers for Disease Control & Prevention, HIV Cost-Effectiveness https://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html#:~:text=Currently%2C%20the%20lifetime%20treatment%20cost,than%20%24379%2C668%20per%20infection%20averted.

[29] B. Schackman, J. Fleishman, A. Su, B. Berkowitz, R. Moore, R. Walensky, J. Becker, C. Voss, A.D. Paltiel, M. Weinstein, K. Freedberg, K. Gebo, E. Losina, *The Lifetime Medical Cost Savings from Preventing HIV in the United States.* (Med Care, April 2015)

[30] E. Gee, N. Rapfogel, *Closing the edicaid Coverage Gap Would Save 7,000 Lives Each Year,* (Center for American Progress, September 10, 2021), https://www.americanprogress.org/issues/healthcare/news/2021/09/10/503687/closing-medicaid-coverage-gap-save-7000-lives-year/#:~:text=The%20most%20straightforward%20solution%20to,%2C%20evictions%2C%20and%20medical%20debt.

[31] Center for Health Law & Policy Innovation, *Filling the Medicaid Coverage Gap: A Federal Policy Priority for People Living with HIV,* (Harvard Law School, June 2021), https://www.chlpi.org/wp-content/uploads/2013/12/Filling-the-Medicaid-Coverage-Gap.pdf

[32] J. Holahan, M. Simpson, *Filling the Medicaid Gap with a Public Option,* (Urban Institute, July 14, 2021) https://www.urban.org/research/publication/filling-medicaid-gap-public-option

EXHIBIT C(iii)

THE AIDS INSTITUTE

October 2025

7 Reasons to Exempt People with HIV from Medicaid's Community Engagement Requirement

Beginning January 1, 2027, Medicaid expansion programs will have a new "community engagement" requirement that means people must show that they completed at least 80 hours of work, school, or a qualifying volunteer activity per month, ***unless they are exempt****. States will soon be making decisions about how this requirement will work, including who is exempt from it. The law requires states to exempt people with "special medical needs," (including people who have a serious or complex chronic illness) from the requirement. Advocates should urge their state Medicaid agency and/or state legislatures to include people with HIV in that exempted group.*

Here are 7 reasons that states should exempt people with HIV from the community engagement requirement:

1) HIV is a serious and complex chronic condition that requires consistent and continuous treatment, medical monitoring, and care coordination to achieve "viral suppression" and stay healthy and able to work. CMS and states have already agreed that HIV is a serious and complex chronic illness in other contexts.[1]
2) HIV treatment is HIV prevention: People with an undetectable viral load cannot transmit HIV to others. Keeping people with HIV in treatment helps prevent the spread of HIV.[2]
3) Medicaid enrollees with HIV are more than twice as likely to have multiple chronic conditions (in addition to HIV) than enrollees without HIV (32% vs 13%).[3] Moreover, people with HIV are twice as likely to have either a substance use disorder or mental health condition (44% vs 23%),[4] which are also reasons to be exempted from the community engagement requirement. Managing HIV, multiple chronic conditions, and the red tape of community engagement requirements is difficult, so these populations should be exempt.
4) HIV can make it more difficult for people to adhere to a regular work schedule because of medication side effects, periods of illness, and the need to attend many doctors' appointments.[5] Employees with HIV may require flexible work arrangements that can be hard to find or keep. It is cruel to penalize people in this situation by removing access to lifesaving treatment.
5) Medicaid is a work support for people with HIV, because it provides consistent and continuous access to treatment that keeps people with HIV healthy. Disruption of care due to administrative reporting requirements undermine the ability of people to work and can lead to long term unemployment.[6]

6) Half of people with HIV enrolled in Medicaid are age 45-64,[7] and therefore face significant challenges entering the workforce if they are not already employed due to age discrimination and HIV stigma.[8] People aging with HIV face the early onset of aging-related health issues, making it even more important for older people with HIV to remain in continuous care.[9]

7) If people with HIV lose access to Medicaid, they are likely to look to Ryan White Care programs. These programs have not received any increase in federal funding in well over a decade and lack the resources to serve everyone with HIV. This will lead to benefit reductions, eligibility cuts, and wait lists, compromising care for all Ryan White clients, or require state budgets to supplement federal Ryan White program funding.

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[1] CMS has acknowledged that HIV and viral hepatitis are serious chronic illnesses in regulations regarding Medicaid benefits, Medicare payment and claims policies. AZ and IN exempted people with HIV from work requirement waiver programs.
[2] HIV.gov, "Viral Suppression and an Undetectable Viral Load," October 24, 2025. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression
[3] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, Apr. 1, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.
[4] Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.
[5] Ibid: Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.
[6] Ibid: Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.
[7] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, Apr. 1, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.
[8] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults/
[9] HIV.gov, *Aging with HIV*, September 8, 2025. https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

The AIDS Institute is a national non-partisan, nonprofit organization that promotes action for social change through public policy, research, advocacy and education. For more information and to become involved, visit www.TheAIDSInstitute.org or write to us at info@taimail.org, and follow The AIDS Institute on X @AIDSAdvocacy, Facebook at www.facebook.com/The-AIDS-Institute, and LinkedIn @the-aids-institute.

This fact sheet was authored by: Rachel Klein, The AIDS Institute

EXHIBIT D

FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

May 20, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Russell Vought
Director, Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Re: Medicaid Community Engagement Requirement

Dear Secretary Kennedy, Dr. Oz, and Director Vought:

On behalf of the HIV Health Care Access Working Group (HHCAWG)—comprised of organizations working to advance policies that ensure the millions of people living with HIV have consistent access to comprehensive care and treatment—we write to urge you to adopt a definition of medical frailty or special medical needs that gives full meaning to the category of people with a "serious or complex condition," which should include people living with HIV. Such a definition honors the language and intent of H.R. 1, ensuring that people who rely on Medicaid to manage serious, complex illnesses that do not meet the standard for disability are able to maintain their connection to ongoing medical care.

Medicaid is the cornerstone of President Trump's initiative to End the HIV Epidemic, which he announced in the State of the Union address in 2019. Medicaid is a crucial program for people with HIV, providing 45% of all federal funding for HIV treatment and providing access to care for 40% of all people living with HIV in the United States. In Medicaid expansion states, more than half of people with HIV who are enrolled in Medicaid are in the adult expansion group.

I. "Serious or Complex Medical Condition" Does Not Require a Showing of Disability

The budget reconciliation act of 2025 (P.L. 119-21) or H.R. 1, the One Big Beautiful Bill Act, established for the first time national community engagement requirements for people who

access Medicaid through the expansion pathway. Recognizing the importance of Medicaid to people who are living with chronic illnesses and disabilities—including many people who are enrolled in Medicaid expansion, rather than traditional Medicaid[1]—Congress included a mandatory exemption from the community engagement requirement for people who are "medically frail or otherwise [have] special medical needs."[2] That broad category includes five statutorily mandated subcategories separated by the word "or," indicating that a person who falls into any *one* of the five subcategories qualifies as medically frail or having special medical needs.

Three of the five subcategories of people with special medical needs are people with disabilities: those who are blind or disabled under the Social Security Act definition of disability, those who have a "disabling mental disorder," and those with a "physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living." The other two subcategories—those with a "serious or complex medical condition" and those with a "substance use disorder"—by their plain terms do not require a showing of disability or inability to work. Had Congress wanted all five subcategories to require a showing of disability or physical or mental inability to work, it could have specified as much (as evidenced by the language that describes the other three categories), but Congress did not do so. The logical interpretation of this omission is that Congress recognized the importance of uninterrupted access to care for people living with serious or complex conditions, including HIV, and for people living with substance use disorders. The Centers for Medicare and Medicaid Services (CMS) should adopt an interpretation of "serious or complex medical condition" that adheres to Congress's plain intent and does not require a showing of disability.

Moreover, the federal government has elsewhere defined a "serious and complex condition" for the purpose of avoiding disruptions in access to health care. This common-sense definition should be applied to the Medicaid community engagement mandatory exemptions, where continuity of access to care is just as critical. At 26 USC § 9818(b)(2), the Internal Revenue Service defines a "serious and complex condition" as one that, in the case of a chronic condition, is "life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time." This definition does not require evidence that a person is already disabled; rather, the emphasis is on the potential for life-threatening or disabling consequences and the need for ongoing access to care.

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[1] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/; Sara Rosenbaum et al., *Implementing Medicaid Work Reporting Requirements: Defining A 'Serious or Complex Medical Condition'*, Health Affairs Forefront (Jan. 12, 2026) https://www.healthaffairs.org/content/forefront/implementing-medicaid-work-reporting-requirements-defining-serious-complex-medical (finding high percentages of adults on Medicaid who are over 50 but under 65 who do not have known limitations in their ability to perform activities of daily living but who have two or more chronic conditions that make uninterrupted access to care critical).

[2] P.L. 119-21 § 71119(a)(9)(A)(ii)(V).

II. HIV is a serious and complex chronic medical condition that qualifies a person for the medically frail or special medical needs exemption under H.R. 1

HIV is a serious and complex medical condition under the H.R. 1 definition because HIV requires consistent, continuous, lifelong treatment to prevent debilitating illness, potential drug resistance, and ultimately, the advancement to AIDS. Ensuring access to effective HIV care, treatment, and supports through the Medicaid program is important to the health of people living with HIV and to public health, broadly. When HIV is effectively managed and individuals stay engaged in treatment, and achieve and maintain viral suppression, people with HIV can live healthy lives—including engaging in work, education, or other pursuits—and there is no risk of sexual transmission or community spread.[3] These outcomes require continuous access to HIV medications and related care, which in turn require uninterrupted insurance coverage.[4]

We are concerned that requiring people living with HIV to comply with the new work reporting requirements will create administrative barriers that will lead to improper terminations and lost access to crucial healthcare, even for people who are working. For people living with HIV, loss of Medicaid due to erroneous denials and administrative red tape could lead to care disruptions that can pose enduring, costly, and complex health risks such as the development of drug-resistant HIV.[5] Additionally, more than half of people living with HIV are age 50 and older,[6] a group that is particularly likely to have difficulty complying with work requirements due a variety of factors, including comorbidities that often lead to challenges maintaining employment, age discrimination that makes it difficult to find employment, or caregiving responsibilities for spouses, parents, or adult children with disabilities.[7]

Accordingly, the Centers for Medicare and Medicaid Services (CMS) has repeatedly recognized HIV as a "serious chronic medical condition" warranting special treatment related to Medicaid eligibility and coverage.[8] Several states have also recognized people living with HIV as

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[3] Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, NEJM, 2016; Robert W. Eisinger, Carl W. Dieffenbach & Anthony S. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451, 2019.

[4] Lindsey Dawson and Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV*, 2018, KFF, Sept. 4, 2020, https://www.kff.org/hiv-aids/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/ ("*Insurance Coverage and Viral Suppression*").

[5] Elizabeth Hamlyn et al., *Plasma HIV Viral Rebound Following Protocol-Indicated Cessation of ART Commenced in Primary and Chronic HIV Infection*, PLOSOne, 2012; Gerald Friedland & Ann Williams, *Attaining Higher Goals in HIV Treatment: The Central Importance of Adherence*, 13 AIDS S61, 1999.

[6] HIV.gov, *Aging with HIV*, Sept. 8, 2025. https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

[7] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center, June 23, 2025., https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults

[8] *E.g.*, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions."); Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include,

"medically frail" under previous work requirement proposals or exemptions to the Medicaid Alternative Benefit Plan rules.[9] Most recently, Nebraska has included HIV on its list of diagnosis codes that will trigger eligibility for the serious or complex condition exemption to the work requirement under H.R. 1.[10] We understand that numerous other states have planned for that, as well.

We therefore urge you to adopt a definition of the "serious or complex medical condition" subcategory of medical frailty or special medical needs that encompasses all people living with HIV. It is a medical condition that lasts for a lifetime and requires consistent, uninterrupted access to care.

III. Many People with HIV Qualify for Medicaid Only Through Medicaid Expansion

Medicaid expansion has been a lifeline for many people living with HIV. Prior to Congress's passage of Medicaid expansion, eligibility for Medicaid was limited to those who met financial eligibility requirements and fell into one of the traditional Medicaid categories, such as people with disabilities, people over the age of 65, children, and pregnant people. Low-income people living with HIV could not qualify for Medicaid unless they met one of the existing eligibility categories or had already developed advanced disease due to HIV. This created a "catch-22" for many people with HIV, whereby they could not access comprehensive health insurance—which could help them stave off severe disease—until after their health had substantially deteriorated.[11] Many people with HIV in states that have not expanded Medicaid remain uninsured for this reason.[12]

Today, 42 percent of people living with HIV who are enrolled in Medicaid access the program through Medicaid expansion.[13] These individuals may not qualify for any of the categorical

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but are not limited to… HIV/ AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (Jan. 18, 2024) https://www.cms.gov/files/document/r12461cp.pdf ("[I]f the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., … HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

[9] *E.g.*, ARIZONA SECTION 1115 WAIVER AMENDMENT REQUEST: AHCCCS WORKS WAIVER, 9 (Dec. 19, 2017), https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration *or* a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status" (emphasis added).

[10] Nebraska Medicaid Work Requirements, Medically Frail Exemption Conditions Index, p. 4, https://dhhs.ne.gov/Documents/Nebraska%20Medicaid%20Work%20Requirements%20-%20Medically%20Frail%20and%20SUD%20Conditions.pdf.

[11] Jennifer Kates and Lindsay Dawson, *Insurance Coverage Changes for People with HIV Under the ACA*, KFF (Feb. 14, 2017), https://www.kff.org/affordable-care-act/insurance-coverage-changes-for-people-with-hiv-under-the-aca/.

[12] *See Insurance Coverage and Viral Suppression*, supra note 4.

[13] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/

eligibility pathways for traditional Medicaid, including eligibility for people who are disabled. That is because Medicaid based on disability generally requires a person to meet the Supplemental Security Income (SSI) definition of disability, which requires significant impairment in an individual's ability to work.[14] Many people living with HIV do not meet this definition *because* the treatment they are able to get through Medicaid keeps them healthy enough to avoid worsening illness or disability. For them, continuous health coverage and access to care is an essential support that helps them maintain their health so that they can continue to work or otherwise participate in their communities.

IV. Allowing Verifiable Self-Attestation of Serious or Complex Chronic Illness is Necessary

Congress recognized the importance of continuous coverage for people living with HIV and other serious or complex conditions when it incorporated the "serious or complex medical condition" exemption subcategory into H.R. 1 *in addition* to people with disabilities and other concerns. We urge the federal government to fully implement this exemption in its forthcoming guidance and to permit verifiable self-attestation as a sufficient basis for the exemption. Because H.R. 1 does not require states to verify exemption status, states can and should accept self-attestation integrated directly into the Medicaid application—without requiring separate forms or affidavits.[15]

We understand that implementing the community engagement requirement and other aspects of H.R. 1 is a complex job that requires balancing many different considerations. We look forward to working with you to ensure that these important decisions do not undermine the goal we share with President Trump: achieving once and for all an end to the HIV epidemic in the United States. Please reach out to Rachel Klein, Deputy Executive Director at The AIDS Institute at rklein@taimail.org or (202) 815-2973 to arrange a time to meet.

Sincerely,

Elizabeth Kaplan, Director of Health Care Access, Center for Health Law and Policy Innovation
Rachel Klein, Deputy Executive Director, The AIDS Institute
Dori Molozanov, Senior Manager of Health Systems Integration, NASTAD
Leslie McGorman, Senior Director of Policy and Strategy, AIDS United
Terri Wilder, Manager of Health & Economic Security Policy, SAGE

[14] MACPAC, *People with disabilities* (July 30, 2025), https://www.macpac.gov/subtopic/people-with-disabilities/.

[15] National Alliance on Mental Illness (NAMI) and Legal Action Center. *Work Reporting Requirements and Mental Health: Recommendations to Protect Individuals with Mental Health Conditions from Losing Medicaid.* November 2025. Available at: https://www.nami.org/wp-content/uploads/2025/11/2025-Work-Reporting-Requirements-and-Mental-Health.pdf.

EXHIBIT 55

ROB BONTA
ATTORNEY GENERAL

ANDREA JOY CAMPBELL
ATTORNEY GENERAL

JENNIFER DAVENPORT
ATTORNEY GENERAL

July 31, 2026

Via Federal eRulemaking Portal

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

The Honorable Robert F. Kennedy, Jr.
Secretary
United States Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Objection to CMS Medicaid Work Requirement Interim Final Rule (June 3, 2026), RIN 0938-AV98, File Code No. CMS-2454-IFC, Document ID CMS-2026-2047-0002, Federal Register No. 2026-11094

Dear Administrator Oz and Secretary Kennedy:

We, the Attorneys General for California, Massachusetts, New Jersey, Arizona, Colorado, Connecticut, Delaware, the District of Columbia, Hawai'i, Illinois, the Governor of the Commonwealth of Kentucky, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, Oregon, Rhode Island, the Secretary of the Pennsylvania Department of Health, Vermont, Virginia, Washington, and Wisconsin (the "States") submit this Comment in opposition to portions of the interim final rulemaking by the Centers for Medicare & Medicaid Services ("CMS") and United States Department of Health & Human Services ("HHS") titled *Medicaid Community Engagement Requirement for Certain Individuals* Interim Final Rule, RIN 0938-AV98 [File Code No. CMS-2454-IFC, Document ID CMS-2026-2047-0002, Federal Register No. 2026-11094 (the "Interim Final Rule" or "IFR").[1]

The purpose of Medicaid is to enable States "to furnish [] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical

[1] The States also incorporate by reference to this comment letter, all pleadings and supporting documentation filed in *Massachusetts, et al. v. Oz, et al.*, Case No. 1:26-cv-12962 (D. Mass). The lawsuit, in which all the undersigned States are Plaintiffs, challenges portions of the IFR.

services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C.A. § 1396-1. In 2025, H.R. 1 imposed new requirements for certain individuals receiving Medicaid benefits by requiring work or "community engagement" (Work Requirements). H.R. 1 explicitly excluded several categories of individuals from the Work Requirements, including those who are "medically frail or otherwise have special medical needs." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).

Federal law has long required prioritizing "simplicity of administration and the best interests of recipients" in the administration of Medicaid. 42 U.S.C. §1396a(a)(19). And it bars HHS from promulgating regulations that create "unreasonable barriers" to access to medical care. *Id*. at §18114. Yet the IFR issued on June 1, 2026 makes it harder for recipients to access the coverage and care they are eligible for.

Rather than assist the States in implementing the Work Requirements, the IFR instead contains specific provisions that impermissibly narrow the statutory exemptions to the Work Requirements—in violation of the plain language of H.R. 1—and impose onerous requirements on States to verify compliance. In sum, the IFR requires the States to spend more money to cover fewer people—a misplaced set of priorities.

Among other things, the IFR narrows the definition of medical frailty by stating that an individual is medically frail *only* if their ability to comply with the Work Requirements is significantly impaired because of their physical, mental, or behavioral health condition. This unworkable definition contradicts the statute, is extremely narrow and limiting, was not discussed in any of the public-facing documents prepared by CMS prior to the IFR, and places unnecessary burdens on state Medicaid agencies.

These narrowed exceptions and the red tape created by the IFR will result in the loss of Medicaid coverage for millions of individuals who are otherwise eligible for an exclusion. Not only does the IFR make it difficult for the States to comply with the imminent deadlines imposed by H.R. 1, but it will also result in increases in uncompensated care costs borne by the States and providers.

The States urge CMS and HHS to withdraw the portions of the IFR identified below in promulgating a Final Rule.

I. BACKGROUND

Medicaid is a cooperative federal-state program that provides medical services to low-income individuals and individuals with disabilities. *See* 42 U.S.C. §§ 1396 *et seq*.; *Harris v. McRae*, 448 U.S. 297, 308 (1980). In 2010, Congress enacted the Affordable Care Act (ACA), which expanded access to Medicaid to low-income, working age individuals (Expansion Population), and adopted new methods for determining financial eligibility that allow for greater automation of such determinations and align with ACA marketplace coverage. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14). States that expanded access to Medicaid, including most of the undersigned States, have enjoyed reduced rates of uninsurance, increased healthcare

affordability, improvements in health access and outcomes, and economic benefits for medical providers and Medicaid members. Medicaid expansion has been shown to be associated with increased early-stage cancer diagnosis, improved disease management, and lower mortality rates for many chronic conditions.[2]

In 2025, Congress passed H.R. 1 which established an 80-hour-per month community engagement or work requirement for the Expansion Population. 42 U.S.C. § 1396a(xx)(9)(A)(i). The law carved out certain populations as excluded from the Work Requirements, including those who are medically frail. 42 U.S.C. § 1396a(xx)(9)(A)(i-ii). During the months when individuals satisfy the medical frailty criteria, they are exempt from the H.R. 1 Work Requirements. *Id*. These individuals must satisfy the terms of their exclusion both upon initial application and at renewal. 42 U.S.C. § 1396a(e)(14)(L).

Congress specified five subcategories of medical frailty, including an individual: (aa) who is blind or disabled (as defined in [42 U.S.C § 1382c, which provides the standard for eligibility for Supplemental Security Income]); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition. 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).

II. MEDICAID IN GENERAL

A. Importance of Medicaid Coverage

Well-established public health literature has shown that loss of Medicaid coverage is catastrophic, and the addition of work requirements leads to loss of coverage for individuals who are either already working, or are eligible for exceptions, creating a sicker population that incurs greater health costs borne by the state.[3] Therefore, it is critical that any new rules imposed by CMS minimize these losses by ensuring that States can offer clear and straightforward instructions to Medicaid enrollees so they can maintain coverage. The IFR fails to do that. And CMS fails to directly address publicly available studies or evidence provided to CMS in advance of the publication of the IFR. Further, the IFR does not grapple with the fact that the additional administrative burdens imposed by the IFR will result in coverage loss and further harms as a result of that loss of coverage.

Studies show that the majority of individuals receiving Medicaid are employed, and those in better health, with more education, and without disabilities are more likely to be working.[4] Among Medicaid-enrolled adults, particularly those at the older end of the working age

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[2] *Massachusetts, et al. v. Oz, et al.*, Case No. 1:26-cv-12962 (D. Mass), ECF No. 89, Amicus Brief filed by American Medical Association, Massachusetts Medical Society in Support of Plaintiffs' Motion for a Preliminary Injunction.
[3] Elizabeth Hinton &Robin Rudowitz, *5 Key Facts About Medicaid Work Requirements*, KFF, Feb. 18, 2015, https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/.
[4] *Id*.

spectrum, many have serious and complex health problems that limit their ability to work but do not rise to the level of a "physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living."[5] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). More than 40 percent of Medicaid working-age adults ages 40 through 64 face serious health limitations but do not receive Social Security Act benefits through the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs.[6] In other words, many Medicaid members are living with "substantial health problems that demand regular, ongoing access to health care."[7] As such, it is critical for such individuals to maintain their Medicaid coverage so that they can continue to work.

For those individuals who face health limitations and then lose coverage for not meeting work requirements, many experience adverse consequences, including incurring medical debt, delaying care, or forgoing medications.[8]

There is considerable evidence in states that have previously imposed work requirements that individuals with serious health needs who should have been eligible for exemptions lost coverage or were at risk of losing coverage due to red tape.[9] When Arkansas instituted work requirements, around 25% of Medicaid-enrolled adults lost coverage in the first seven months of implementation.[10] In New Hampshire, almost 17,000 enrollees, or about 40 percent of those subject to the requirement were set to lose Medicaid before the requirement was suspended.[11] In Michigan, some 80,000 enrollees, around one-third of those subject to the work requirements were set to lose coverage before the court vacated the state's work requirements policy.[12]

In Arkansas, for those individuals who lost coverage, it was determined that lacking a comprehensive system to provide modifications to protect people with disabilities, such as modifying the hourly requirement or providing support to help people meet the reporting requirement led to loss of coverage.[13] Losing coverage is particularly harmful to people with disabilities who rely on regular care to manage their conditions. And coverage loss can lead to job loss—making sick people even sicker.[14]

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[5] Sara Rosenbaum, et al., *Medical Frailty Rule Contravenes HR 1, Burdens The Health Care System, And Threatens Public Health*, Health Affairs, June 12, 2026, https://www.healthaffairs.org/content/forefront/medical-frailty-rule-contravenes-hr-1-burdens-health-care-system-and-threatens-public.
[6] *Id.*
[7] *Id.*
[8] Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements*, Ctr. on Budget & Policy Priorities, Nov. 18, 2020, https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements.
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*

B. Coverage Loss As a Result of the IFR

The IFR is likely to increase coverage loss significantly beyond what would have occurred under a plain-language reading of the statute.

The Congressional Budget Office (CBO) estimated that the Work Requirements imposed by H.R. 1 would lead to 5.3 million people losing Medicaid coverage by 2034.[15] It made this determination based upon "research and data from states that have implemented community engagement demonstrations, as well as an analysis of the phaseout of continuous enrollment during the coronavirus public health emergency."[16]

The IFR instead claims that only 3.3 million people will lose coverage as a result of H.R. 1 and the IFR, lower than the CBO's estimate, and it disregards past state experiences by making the conclusory claim that "there is no direct historical experience from which to derive empirical estimates of how many enrollees will not meet the requirement, the community engagement implementation policies States will adopt, or how verification systems will perform in practice." 91 Fed Reg. 33454. The IFR does not explain why it disregards the CBO's analysis or why it disregards past state experiences.

Further, expert analyses of the IFR have found that the IFR's narrow definitions will cause a greater coverage loss of up to 8.2 million between 2027-2034, well beyond the IFR's 3.3 million estimate.[17] The IFR alone will lead to an increase of 1.8 million people losing coverage, nearly 1 in 10 Medicaid enrollees nationwide.[18] Based upon past state experiences, an expert analysis determined that there will be an additional 10% disenrollment (on top of the disenrollment due to H.R. 1 alone) due the IFR's restrictive definitions.[19]

Any loss of coverage causes harm to the States. It strains safety net providers, leads to more uncompensated care, raises costs associated with newly uninsured residents, is likely to lead to rural hospitals shuttering, and can lead to an increase in the transmission of communicable diseases.

C. Concerns for Individuals with Chronic Conditions

The IFR also ignores comments from organizations that advocate for individuals with chronic and complex conditions, like sickle cell anemia. Such organizations submitted letters to CMS seeking blanket exclusions for certain illnesses, which CMS offered little explanation for

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[15] Congressional Budget Office, *Supplemental Cost Estimate, Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid*, Oct. 28, 2025, https://perma.cc/6J7Y-8CG4.
[16] *Id.*
[17] Patti Boozang, et al., *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses*, FFY 2027–2034, Manatt, July 2026, https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/23b961e2-a654-4fd1-9358-1e3d42205358/Vital%20Signs%2050-State%20Tracking_CMS%20Medicaid%20Work%20Requirements%20Rule.pdf.
[18] *Id.*
[19] *Id.*

disregarding.[20] For example, CMS was given information that chronic diseases like sickle cell anemia cause unpredictable flareups which can lead to missed work or even hospitalization.[21] As a result, even if a person wants to work, there are months where they are physically unable to do so, and it is unpredictable which months those are, which is why an exemption is critical to ensure that coverage loss does not occur when a person is unpredictably ill.

Further, Medicaid is the largest source of insurance coverage for people with HIV, and in 2023, 60% of adults under age 65 with HIV in expansion states had coverage through the expansion pathway and would be subject to work requirements.[22] Loss of Medicaid coverage is catastrophic for these individuals, because if people with HIV lose access to Medicaid due to CMS's narrow definition of medical frailty, including failure to navigate reporting rules, they may develop more severe conditions.[23] As such, deviating from the text of H.R. 1 will harm HIV positive individuals and treatment exclusions can also lead to antiretroviral resistance. The IFR's failure to carve out certain diseases, and failure to permit States to carve out certain diseases, means that individuals who need coverage most could lose coverage, leading to an increase in crisis frequency

As such, it is critical that any new criteria must be clear, straight forward, and place an emphasis on maintaining coverage. The IFR acknowledges this and states, "beneficiary awareness, clarity of requirements, and the accessibility of reporting mechanisms, as well as overall administrative complexity, can influence participation and compliance." 91 Fed. Reg. 33350. But the IFR never discusses how to limit the number of Medicaid members who would be disenrolled by the procedural hurdles created by the IFR. Likewise, the IFR does not weigh any purported benefits from its limitations on exemptions to the Work Requirements against this loss in Medicaid coverage. And CMS also failed to address the follow-on consequences of this broad coverage loss—a surge in uncompensated care costs incurred by doctors, hospitals, and States.

III. MANY IFR PROVISIONS CONTRADICT CMS'S PREVIOUS REPRESENTATIONS TO THE STATES

A. CMS's Previous Communications to the States

The IFR fails to account for the States' reliance on CMS's previous pronouncements on how the States could comply with the Work Requirements. The States have devoted significant

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[20] *[National Organization for Rare Disorders] Joins Coalition of 48 Patient Advocacy Organizations Expressing Concerns Over Coverage Loss Under Final CMS Medicaid Work Requirement*, June 3, 2026, https://rarediseases.org/nord-joins-coalition-of-48-patient-advocacy-organizations-expressing-concerns-over-coverage-loss-under-final-cms-medicaid-work-requirement/.

[21] *Commonwealth of Massachusetts, et al. v. Oz, et al.*, Case No. 1:26-cv-12962 (D. Mass), ECF No. 6, Exhibit 30 to Declaration of Nita K. Klunder, Sickle Cell Disease Partnership letter to Administrator Oz dated October 22, 2025.

[22] Lindsey Dawson & Jennifer Tolbert, *Medical Frailty and Medicaid Work Requirements: Challenges for People with HIV*, KFF, July 1, 2026, https://www.kff.org/medicaid/medical-frailty-and-medicaid-work-requirements-challenges-for-people-with-hiv/.

[23] *Id.*

resources to developing implementation plans based on CMS's assurances about how the Work Requirements could be applied—which never included the significant limitations in the IFR.

First, in November 2025, CMS presented a slide deck titled "Implementing Section 71119 of the Working Families Tax Cut Legislation: Key Requirements and Preliminary Policy Direction from CMS." The slide deck confirmed that it "intend[ed] to require states to use a definition of medical frailty similar to that described in regulations at 42 C.F.R. § 440.315(f)," which do not define "medically frail" in relation to an individual's ability to work. CMS further highlighted its expectation that State Medicaid agencies would use reliable data sources and minimize requests for information from applicants and members, consistent with existing Medicaid regulations. It also implied that State Medicaid agencies would be able to categorically exclude people with certain conditions/diagnosis codes from the Work Requirements.

The next month, in December 2025, CMS released an Informational Bulletin listing among the "persons" who are "specified excluded individuals," "[a]n individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a physical, mental, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition."[24] The Bulletin added no other qualification or test to this categorical exclusion. During this time, CMS also began a series of workgroup calls with the States that continued on a biweekly basis through April 2026. During these calls, CMS continued to inform State Medicaid agencies that it intended to define the exclusion for individuals who are "medically frail or otherwise ha[ve] special medical needs" consistent with 42 C.F.R. § 440.315(f). CMS also continued to indicate the viability of using claims data and screener tools for evaluating applicability of the exception. Indeed, in one call, CMS pointed to Louisiana as an example for implementing the "medically frail" exclusion where the State Medicaid officials had proposed using available data from claims and encounters, including medical billing codes, to identify members who are categorically excluded from the work requirements as "medically frail." And CMS also recommended the State Medicaid agencies identify individuals with chronic conditions using CMS's Chronic Conditions Data Warehouse, suggesting those individuals would categorically qualify as "medically frail," thus again suggesting that diagnoses alone could be sufficient to verify an individual as "medically frail."

Until the issuance of the IFR, CMS did not indicate that the medically frail exclusion would include a requirement that the condition significantly impair the individual's ability to comply with the Work Requirements, nor did CMS indicate that States may need to conduct inquiries into applicants or enrollees' ability to work. The States relied on CMS's representations.

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[24] Dan Brillman, Deputy Administrator CMS, Section 71119 of the "Working Families Tax Cut" Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals, CMCS Information Bulletin, Dec. 8, 2025, https://perma.cc/HJ39-HEXP.

B. Early Implementation in Nebraska

The IFR further contradicts CMS's own actions in approving Nebraska's work requirements program.

Nebraska, in coordination with CMS, implemented work requirements early on May 1, 2026. Nebraska's Department of Health and Human Services (DHHS) directed applicants and enrollees seeking renewal to report "job-skills or training program hours," "volunteer hours," "school or an apprenticeship," and certain exemptions through an "individual declaration form."[25]

CMS Administrator, Mehmet Oz, M.D. appeared at the December 2025 press conference announcing Nebraska's rollout. Oz stated, "Nebraska is leading the way as the first state to launch its community engagement requirements, and we congratulate Governor Pillen and his team… CMS will be working together with Nebraska… to ensure every program is implemented smoothly, responsibly, and in compliance with federal law."[26] Among the "exemptions" noted in the press release are "people who are medically frail" with no reference to their ability to comply with the Work Requirement.

Consistent with CMS preliminary guidance, in state guidance addressing the "Medically Frail and [Substance Use Disorder] Treatment Program Exceptions," Nebraska's Department of Health and Human Services provided a nearly-300-page list of diagnosis and procedure codes identifying qualifying medical conditions.[27] The Nebraska DHHS guidance stated that, for existing enrollees, "[i]f qualifying medical conditions or treatment indicators are identified" based on those codes, "the individual will be treated as exempt without needing to take additional action." It permitted new applicants to "self-declare that they are medically frail or enrolled in an SUD treatment program," and required no additional documentation.

In the context of its guidance on the "medically frail" exclusion, it did not preview future prohibitions on self-attestation. It also did not link its determination of whether an individual is "medically frail" or has "special medical needs" to a consideration of that individual's ability to comply with the work requirements.

The IFR fails to acknowledge, let alone explain, its changes in position between CMS's subregulatory guidance, exemplified by Nebraska's rollout, and the IFR. CMS departed from guidance it provided the States less than a month before the IFR was issued and the IFR fails to account for the nearly impossible burden the IFR's modified work requirements have placed on the States that relied upon the earlier guidance. States began time-consuming and costly efforts to

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[25] Nebraska Medicaid Work Requirements Frequently Asked Questions, Medicaid Work Requirements, Department of Health and Human Services Nebraska, April 2026, https://perma.cc/AV74-PYQJ.
[26] *Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements*, Nebraska Office of the Governor, Dec. 17, 2025 https://governor.nebraska.gov/gov-pillen-dr-oz-announce-nebraska-first-nation-pursue-medicaid-work-requirements.
[27] Nebraska Medicaid Work Requirements, Medically Frail and SUD Treatment Program Exemptions, Nebraska Dept. of Health & Human Servs., May 1, 2026, https://perma.cc/2U9CFF93.

implement H.R. 1's work requirements, based upon CMS's representations, and the IFR does not address those reliance interests.

IV. MANY PARTS OF THE IFR MUST BE REVISED

A. The Definition of Medical Frailty Is Unworkable

The IFR's definition of medically frail is unnecessarily narrow. First, the IFR narrows the statutory exclusion of those "who [are] medically frail or otherwise ha[ve] special medical needs" to cover only those individuals whose "physical, mental, or other behavioral health condition significantly impairs [their] ability to comply with the community engagement requirement" ("Medically Frail Definition"). 42 C.F.R. §435.554(c)(5)(i).

Further, the IFR unnecessarily narrows the definition of "serious or complex medical condition." Consistent with State prerogatives to determine which Medicaid services are medically necessary, CMS should allow States Medicaid programs to determine what qualifies as a "serious or complex medical condition" for purposes of determining medical frailty.

Finally, the IFR departs from the language of H.R. 1's "medically frail" exclusion with respect to the subcategory for individuals "with a substance use disorder" by carving out individuals "in stable recovery," which it defines as individuals "in recovery for 5 or more years." 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb); 91 Fed. Reg. 33374.

These definitions require a more stringent showing than the showing of impairment required to qualify for disability benefits.[28] These definitions are impermissible in at least two ways, as they violate the plain language of H.R. 1 and they are arbitrary and capricious.

1. The IFR is Contrary to H.R. 1

The IFR is contrary to the plain language of H.R. 1 and must be revised. Congress excluded individuals:

> who [are] medically frail or otherwise ha[ve] special medical needs (as defined by the Secretary), ***including*** an individual—(aa) who is blind or disabled (as defined in section 1382c of this title); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition.

42 U.S.C. §1396a(xx)(9)(A)(ii)(V).

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[28] Sara Rosenbaum, et al., *Medical Frailty Rule Contravenes HR 1, Burdens The Health Care System, And Threatens Public Health*, *supra* n. 5.

Congress explicitly did not tie the definition of medical frailty to the ability to comply with the Work Requirements. While Congress gave the Secretary some discretion to define medical frailty, it also determined that the resulting definition must "includ[e]," at a minimum, individuals who have one of the five enumerated conditions—without any qualification. Far from being the "best reading" of the statute, as the IFR implausibly asserts, 91 Fed. Reg. 33373, CMS's decision to radically shrink the medically frail exclusion contravenes the "plain meaning" of the statute's text.

Moreover, it is entirely reasonable that Congress did not want to tether the medical frailty exclusions overall to an individual's ability to work. Allowing individuals who have serious medical conditions to maintain Medicaid eligibility regardless of their ability to work ensures continuity of care for individuals with especially significant health care needs. Indeed, that would be consistent with other exclusions, such as for pregnant individuals—who are not per se precluded from working, but for whom timely and uninterrupted access to care is critical. See 42 U.S.C. §1396a(xx)(9)(A)(ii)(IX).

Congress further did not carve out any temporal restrictions on individuals in stable recovery from substance use disorders, and the IFR improperly creates limitations on who can qualify as exempt from work requirements.

H.R. 1's broad statutory exclusions exist for good reason. People with disabilities, patients in the middle of cancer treatment, or those struggling with another serious or complex health condition, shouldn't be at risk of losing the care that helps maintain their health. As the American Medical Association stated, "studies show what any practicing clinician can readily observe: when people with serious conditions lack health coverage, they are more likely to get sicker faster and die sooner."[29]

2. The Medical Frailty Definition is Arbitrary and Capricious

The medical frailty definition and the definition of "serious and complex condition" are arbitrary and capricious.

First, the IFR does not consider the administrative burdens created by the provisions. The medical frailty definition in the IFR requires States to verify, and individuals to establish, not only that an enrollee has a serious medical condition, but that the condition significantly impairs their ability to work—an unprecedented and costly process that could require resource-intensive medical visits and reviews for thousands of enrollees. Indeed, CMS itself estimates that establishing compliance with the Work Requirements—including establishing entitlement to a specified exclusion such as "medical frailty"—will impose an aggregate burden of more than 32 million hours per year on members. 91 Fed. Reg. 33434.

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[29] *Commonwealth of Massachusetts, et al. v. Oz, et al.*, Amicus Brief of American Medical Association, Massachusetts Medical Society, *supra* n. 2.

Second, the IFR also offers inadequate guidance to the States as to how to implement the restrictive definition of medical frailty. First, a state Medicaid agency must determine whether an individual's condition appears on the list the State has created. 91 Fed. Reg. 33472. For individuals whose condition does not appear on the list, the State must create a separate process and establish criteria for that individual to "request consideration for" the "medically frail" exclusion. *Id*. Second, if an individual's condition appears on the State's list, or is otherwise accepted under the "medically frail" exclusion, the State must somehow further evaluate, in a manner not contemplated by the statute, whether that individual's experience with the condition "significantly impairs" their ability to comply with the Work Requirements. *Id*.

CMS has not explained what constitutes significant impairment for purposes of complying with Work Requirements—it has not provided guidelines or a standard of proof for making this determination and it has not explained, to name but a few examples, whether the determination changes based on the jobs available to a particular individual, the physical and mental capabilities a job requires, or the individual's location or issues with access to work via reliable and appropriate transportation. Nor has CMS explained whether or how evaluating significant impairment changes depending on which of the means of complying with "community engagement"—work, community service, or education, for example—a state is evaluating.

The States and their Medicaid agencies are not disability determination agencies; they do not employ occupational medicine experts with the expertise and training to ascertain severity in relationship to ability to work. Some States will have to hire case workers to review Medicaid applications and renewals. Hiring such staff would be yet another unreasonable cost to States.[30] For other programs that use work requirements, the individualized determinations about ability to work, like those made for SSI disability eligibility, are initially made by a network of local Social Security administration field offices and State agencies that specialize in such disability determinations.[31] They rely on extensive guidance from the Social Security Administration with extensive details about what constitutes a disability and relevant factors for adjudicators to consider, including functional limitations and residual functional abilities, relative to prior job experience.[32] The IFR provides nothing comparable.

CMS also had information that Medicaid providers were reticent and often unwilling to make determinations regarding ability to work. CMS received a letter in November 2025 citing a study that showed that providers were confused about and frequently unwilling to sign paperwork relating to work requirements, yet did not incorporate any of that analysis in promulgating the IFR.[33] The American Medical Society also submitted a letter stating that

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[30] *Id*.
[31] *Disability Determination Process,* Social Security, https://www.ssa.gov/disability/determination.htm
[32] *Disability Benefits, How Does Someone Become Eligible*, Social Security, https://www.ssa.gov/benefits/disability/qualify.html#anchor1; *Disability Evaluation Under Social Security*, Social Security, Medical/ Professional Relations, Social Security, https://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm.
[33] Ian Hill, et al., *New Hampshire's Experience with Medicaid Work Requirements*, Urban Institute, Feb. 2020, https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf.

requiring physicians to make determinations about ability to work "interferes with the patient-physician relationship by eroding trust."[34]

The Final Rule should address and rectify doctors' concerns about making determinations about medical frailty.[35] Doctors say they are not trained to accurately assess whether someone's health keeps them from working—as it requires an assessment of what kind of employment a person is qualified to do (desk job versus manual labor), what kinds of jobs are available in an individual's county, and a long term determination of how an individuals condition would intersect with their ability to work over a six month to 1 year period.[36] This is well outside the scope of most medical doctors' training.

Further, many physicians lack the time to handle another administrative task that keeps them from patient care, and "being involved in whether someone gains access to a public benefit undermines the doctor-patient relationship."[37] Doctors are also concerned about potential repercussions if they incorrectly assess whether someone is sick to work.[38]

Third, the IFR, as discussed in Section II.B, fails to grapple with how many Medicaid members will be disenrolled from Medicaid as a result of the narrow medical frailty definition.

Fourth, the IFR does not address or discuss the States' legitimate reliance upon CMS's previous assertions, as discussed in Section III.

As such, the States recommend that CMS revise the medical frailty definition to be unlinked to any individualized determination of ability to work. The States further suggest the definition of "serious or complex medical condition" be revised to be broad, consistent with the statute. Finally, as discussed below in Section IV.B, the States suggest that CMS permit the States to exclude categories of individuals and use diagnoses to determine medical frailty.

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[34] American Medical Association letter to Dr. Oz, May 21, 2026, https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfm.zip/2026-5-21-Letter-to-Oz-re-Medicaid-Community-Engagement-v2.pdf.

[35] Sam Whitehead, *Doctors 'Cringe' at Possibility of Documenting Which Medicaid Enrollees Too Sick To Work*, KFF Health News, July 20, 2026, https://kffhealthnews.org/medicaid/medicaid-work-requirements-medical-frailty-documentation-doctors/.

[36] *Medicaid Work Rules Surprise States*, What The Health? From KFF Health News, June 4, 2026, https://kffhealthnews.org/podcast/what-the-health-449-medicaid-work-rules-exemptions-june-4-2026/#transcript.

[37] Sam Whitehead, *Doctors 'Cringe' at Possibility of Documenting Which Medicaid Enrollees Too Sick To Work, supra* n. 35.

[38] *Id.*

B. The IFR Should Explicitly Permit States To Use Diagnoses or Conditions To Determine Frailty

Language in the IFR appears to contemplate further limitations on States by stating that in no case can States base their determinations of whether an individual is "medically frail" solely on their records that an individual has a "particular diagnosis or condition," 91 Fed. Reg. 33373.

Such guidance is contrary to law and inconsistent with other CMS regulations. Congress has directed that States, when verifying exclusions, should not "requir[e], where possible, the applicable individual to submit additional information." 42 U.S.C. §1396a(xx)(5). Indeed, such records are exactly the kind of "reliable information available to the state" that would enable States to verify eligibility without additional information from an enrollee in accordance with other terms of the IFR, 42 C.F.R. §§435.557, 435.558(a)(i), and established Medicaid regulations on eligibility redeterminations, *id*. at §435.916(a)(2) and (b).[39] In the IFR, CMS never acknowledges nor attempts to reconcile its apparent expectations of individualized ability to work determinations with these other regulatory and statutory provisions.

Further, as discussed in Section III, this bar on use of diagnosis and conditions data is contrary to previous communications between CMS and the States, and the IFR fails to acknowledge the administrative burden upon the States to make such individualized determinations.

For many conditions, including HIV, cancer, and chronic illnesses, an individual is able to work, go to school, or volunteer *because* they are receiving care for their condition. Loss of coverage if they are unable to meet administrative requirements due to the IFR will result in an inability to comply with Work Requirements because their condition will worsen. The Final Rule should permit the state to exclude certain conditions from the Work Requirements.

C. The IFR Imposes Burdensome and Contradictory Guidance Regarding *Ex Parte* Determinations

The IFR provides burdensome and contradictory guidance that limits the States' ability to rely on information available to the States.

Medicaid regulations require States in the first instance to conduct *ex parte* renewals for all Medicaid members, based on reliable information that is available to the State Medicaid agency, without requiring information of the individual. 42 C.F.R. §§ 435.916(a)(2) and (b), § 57.380(h).

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[39] The IFR notes that states have proposed using "algorithms using administrative claims data that assign acuity scores to individuals" or an "approach that relies on lists of qualifying diagnosis codes combined with utilization data and other factors, such as severity of conditions," to determine medical frailty. 91 Fed. Reg. 33406. This is consistent with preexisting regulations requiring an *ex parte* eligibility determination process for Medicaid members at renewal. *See* 42 C.F.R. §435.916(a)(2) and (b). However, CMS does not provide guidance on what administrative claims and data fields are permissible for review.

This includes, but is not limited to, information accessed through electronic data sources available to the state. *See, e.g.*, 42 C.F.R. §§ 435.948, 435.949, 457.380.

As standard practice, when a state Medicaid agency cannot verify a member's eligibility on an *ex parte* basis, the state Medicaid agency sends to the member a pre-populated renewal form to complete. As the IFR notes, States typically begin their renewal process and send this form, as needed, approximately 60 to 90 days before a member's renewal is due. *See* 91 Fed. Reg. 33390. In the IFR, CMS explains that, when a State cannot certify compliance with the Work Requirements on an *ex parte* basis, the State may either send a "notice of noncompliance" with the renewal form or as a follow-up to a completed renewal form if the State still cannot verify compliance. 91 Fed. Reg. 33411–12. H.R. 1 mandates that this "notice of noncompliance" must allow members only 30 days to respond, after which the State must disenroll an individual no later than "the end of the month following the month in which" the 30-day period ends, if the state cannot verify compliance. 42 U.S.C. § 1396a(xx)(6).

This structure requires that States evaluate members for compliance with work requirements up to several months *before* the end of the time period in which they are entitled to show compliance. For example, a State that starts a renewal process 90 days before a member's renewal period expires will send a renewal form and notice of noncompliance at that time. The member then has only 30 days to demonstrate compliance, depriving the member of two months during which they could demonstrate their compliance under H.R. 1's framework. For example, a member whose eligibility period began on January 1 and ends on June 30 and who is asked on April 1 whether they have met the requirements would be required to respond by May 1, before May and June have passed. Thus, that member would be considered noncompliant if they did not fulfill the work requirement in the months of January through April, even though the member may have secured seasonal work during May and June and thus would be fully compliant under the regime set by Congress in H.R. 1.

Though States have some flexibility to send a notice of noncompliance later in the renewal process, CMS explained that States must "complete the entire renewal process, including the noncompliance procedures, by the end of the beneficiary's eligibility period." 91 Fed. Reg. 33412. This means that, at a minimum, States must send the notice of noncompliance early enough that they can receive and process the response, and provide the member with notice and hearing rights, before the end of the member's eligibility period. As a result, members will necessarily be asked to report on how they have complied with the Work Requirements *before* the time period for them to comply with the Work Requirements has expired.

Further, if this *ex parte* verification that the States use to verify eligibility is not sufficient to meet CMS' vague standards, then States must create a system to manually verify the significant-impairment limitation it has imposed on the medical frailty definition, which would result in significant long-term costs and expenses.

The IFR does not offer States a meaningful solution or explain how it reached its interpretation despite these issues. 91 Fed. Reg. 33390. Instead, CMS directs the States to

"consider [their] abilit[ies] to access timely data to verify compliance with community engagement and otherwise renew eligibility" when "electing the number of months during the review period for which a beneficiary must demonstrate community engagement at renewal." *Id*. CMS also requires that States "act on" any information received "after the timeframe provided by the State, but prior to the end of an individual's eligibility period" by "promptly redetermining eligibility." *Id*. at 33412. In effect, CMS thus arbitrarily requires the States to both require members to report on compliant activities before the 30-day time period expires *and* act on any information provided after such expiration. *See* 91 Fed. Reg. 33412.

The IFR should be revised to ensure that States can conduct *ex parte* verifications—instead of an individualized inquiry, and the IFR should be revised to give the States enough time to verify compliance after the time period ends.

D. The IFR's Self Attestation Limitations Are Impermissible

The IFR's limitations on self-attestation should be revised.

The IFR takes two distinct approaches to self-attestation: one for the "medically frail or otherwise ha[ving] special medical needs" exclusion, and one for compliance with the Work Requirements and for all other exceptions.

With respect to the "medically frail" categorical exclusion, the IFR requires that a state first attempt to use "reliable information available to the state" to verify that an individual qualifies for the exception. If such information is not available—as it is unlikely to be with respect to determining whether a condition "significantly impairs" an individual's ability to comply—a State "may require documentation or accept a statement or other information under penalty of perjury" to verify eligibility for the exception *only in 2027*. 91 Fed. Reg. 33476.

In 2028, the States must again significantly change their approach. Beginning on January 1, 2028, the States may accept "a statement or other information provided under penalty of perjury" only once during a member's period of enrollment. *Id*. The "once-per-enrollment" cap, like the "period of enrollment," are concepts introduced for the first time in the IFR. "Period of enrollment" is defined to mean "a continuous period of enrollment" without an individual being disenrolled. *Id*. at 33474. It is not time-limited and could extend as long as an individual successfully navigates their eligibility redeterminations. *Id*. But applicability of the "medically frail" exclusion must be redetermined at least every 12 months; a state that accepts self-attestation from an individual after January 1, 2028 to verify that they qualify as "medically frail" would then be foreclosed from accepting self-attestations from that individual as to their continuing condition or any new conditions in the future, even if that individual maintains enrollment for years.

For example, a 50-year-old Medicaid recipient who self-attests on January 1, 2028 that she has a malignant melanoma that impairs her ability to comply with the Work Requirements could not on January 1, 2033 self-attest at age 55 that she has just developed breast cancer that impairs her ability to comply with the Work Requirements, if she has been continuously enrolled

between ages 50 and 55. Nor could she self- attest on January 1, 2029, that the same malignant melanoma continues to impair her ability to comply with the Work Requirements.

The IFR thus creates an arbitrary loophole for enrollees seeking a "medically frail" exclusion. It provides no lockout period or other prohibition on reapplying for Medicaid after an individual has been disenrolled for failure to verify compliance with or exception or exclusion from the Work Requirements. An individual who is prohibited from self-attesting to qualifying as "medically frail" for a second time in a period of enrollment and is subsequently terminated, can reapply after being disenrolled and again submit a self-declaration at the start of a new period of enrollment. The IFR has the potential to create unnecessary churn in the Medicaid population, which can increase administrative costs and complexity and disrupt an individual's continuity of healthcare.

For compliance with the Work Requirements or eligibility for exclusions other than the "medically frail" exclusion, the IFR also permits self-attestation in 2027. But beginning January 1, 2028, when a state is not able to verify eligibility using available data, it must require documentation from an individual, "whenever documentation is reasonably available." *Id*. Only when such documentation is not "reasonably available" can a state accept self-attestation. *Id*. at 33475. States risk penalties if CMS determines that the State accepted a self-attestation when CMS later determines documentation was "reasonably available."

The IFR thus irrationally permits self-attestation in some instances, but bars it in others, and otherwise significantly limits States' abilities to conduct verifications using auditable self-declarations, limiting flexibility that H.R. 1 explicitly preserved for the States.

The Final Rule should broadly permit individuals to self-attest to their compliance with the Work Requirements or their exception or exclusion therefrom.

E. The IFR Places Impermissible and Illogical Limitations on States' Use of Claims Data

The IFR requires State Medicaid agencies to "establish processes to use reliable information available to the State" to verify compliance with or exclusion from the community engagement requirements, and to look to that "reliable information" first when determining eligibility for coverage. 91 Fed. Reg. 33474. The IFR defines "reliable information available to the State" to include adjudicated claims, but it arbitrarily limits the lookback period to claims adjudicated in the preceding 12 months. *Id*. at 33475.

This limitation ignores an important issue: the realities of Medicaid claims processing. For many States, there may be a significant lag between the time a given service is provided to a patient, the time when a provider submits a claim for payment, and the time a State Medicaid agency processes and pays a claim for that service.

For example, if an individual has a medical condition that would designate them as medically frail and they go to the physician for care, the physician has up to 12 months to submit that claim for payment to the state or the Medicaid managed care plan.[40] 42 C.F.R. § 447.45 (d)(1). Then, while the State typically pays clean claims within 30-90 days, the agency has up to twelve months to process and pay claims. 42 C.F.R. § 447.45 (d). This means there can be a lag of up to 24 months before the State has information before it that would allow it to determine that an individual should be excluded due to medical frailty. Limiting the look back period to only twelve months of claims data could result in individuals losing coverage when they should be excluded from the Work Requirements.

Further, other individuals may have permanent disabling conditions, such as quadriplegia, or chronic conditions, for which they do not require ongoing treatment. The claims data for the preceding 12 months may not reflect their condition. Thus, when a State Medicaid agency seeks to redetermine eligibility for a member under the IFR, despite best efforts, it is possible that adjudicated claims data from the preceding 12 months will fail to fully reflect both the services that the member received during that time and their condition. For example, if a person with quadriplegia does not need to see a physician for twelve months or if they only see a physician for a minor ailment like an ear infection, there might not be any claims data that affirms that the permanent disabling condition is still present. Expanding the lookback period increases the likelihood that the claims that the States are reviewing establish the basis for an exclusion.

Studies which have attempted to design algorithms to fully identify all medically frail adults have noted that the shorter the lookback period, the less accurate claims data is in identifying eligible medically frail adults because individuals who have lower healthcare utilization are less likely to have claims within the 12-month window.[41] One of those studies was before CMS, which determined that shortening the lookback from two years to one could strip automatic exclusions from roughly 1.6 million medically frail enrollees.[42] That study further determined that excluded Medicaid members were substantially sicker than non-excluded members, with markedly higher hospital, emergency department, and a higher mortality rate.

CMS acknowledged this reality in the preamble to the IFR. It stated, "reliable information available to the State includes, but is not limited to, adjudicated claims and encounter data as relevant to the individual for the preceding 12 months (as applicable). However, States may not have these data available, or there may be a lag in receipt of such data." 91 Fed. Reg. 33409. But CMS failed to grapple with this issue, simply basing its limitation on the incomplete view that "older information may not reflect the individual's current condition." *Id*. at 33405.

The IFR should be revised to expand States' ability to rely on claims data.

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[40] Some states have statutes or policies requiring a shorter time frame for claims submissions.
[41] Sanjay Basu & Seth A. Berkowitz, *Redesigning Medicaid frailty algorithms: improved identification of medically frail adults under community engagement*, Health Affairs Scholar, Vol. 4, Issue 6, June 2026, https://academic.oup.com/healthaffairsscholar/article/4/6/qxag108/8672780.
[42] *Commonwealth of Massachusetts, et al. v. Oz, et al.*, Case No. 1:26-cv-12962 (D. Mass), ECF No. 88-2, Exhibit 32 to Declaration of Nita K. Klunder, Declaration of Hannah Katch.

F. The IFR Imposes an Illogical Waiting Period for Short-Term Hardship Exceptions

Regarding short term hardships, the IFR provides that, in order to be "deemed to demonstrate community engagement" under one of these short-term hardship exceptions, a new applicant must demonstrate the exception "for at least one, but not more than 3 consecutive months, as specified in the State plan, immediately preceding the month of application." 91 Fed. Reg. 33473. Thus, even if an applicant can demonstrate qualification for the exception for the same month in which they apply to Medicaid, it will do them no good: under the IFR, only hardships experienced in the month before application count.

For example, an applicant who applies in February 2027 and receives inpatient medical services in February 2027 for serious injuries sustained in an automobile accident on February 1, 2027, will be unable to qualify for the exception because they cannot demonstrate that they received inpatient medical services in January 2027.

This is wholly illogical and contrary to the plain language of H.R. 1. Nothing in H.R. 1 requires States to determine that an individual satisfied a short-term hardship exception, or otherwise complied with work requirements, during a prior month before applying a short-term hardship exception. Instead, H.R. 1 directs states to "deem" certain individuals to have "demonstrated community engagement" "during a month" if "for part or all of such month," the individual meets the specified short-term hardship exceptions. 42 U.S.C § 1396a(xx)(3).

The IFR should be revised to allow States to apply a short-term hardship exception in the month in which an individual experienced the hardship.

G. Declared Emergencies

The IFR provides that a short-term hardship exception based on an emergency declaration "exists when the emergency affects the ability of applicable individuals to demonstrate community engagement in a particular county or other equivalent unit of local government, or multiple counties, or statewide." 91 Fed. Reg. 33473.

The IFR thus imposes an obligation on State Medicaid agencies, which does not exist in H.R. 1, to determine whether a given emergency affects large groups of individuals' ability to comply with the Work Requirements while providing no guidance on how to do so. State Medicaid agencies lack the training and expertise in disaster management to make these determinations.

The IFR should be revised to remove this unlawful limitation on the applicability of the short-term hardship exception for individuals experiencing declared emergencies.

V. CONCLUSION

The States look forward to continuing to work with CMS and HHS in providing Medicaid to Medicaid enrollees. However, many portions of the IFR fail to account for the administrative burdens to the States and the IFR fails to explain its many unlawful departures from the text of H.R. 1. The IFR should be substantially revised before it is promulgated as a Final Rule.

Sincerely,

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EXHIBIT 56

CENTERS FOR MEDICARE & MEDICAID SERVICES

Streamlining Enrollment and Renewal Processes in Medicaid and CHIP (CMS-2421-F2)

May 2024

Streamlining Eligibility for 85 Million Americans

On March 27, 2024, we finalized the 2nd half of our regulation on streamlining enrollment in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP)

Part 2:	Part 1:
Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-F2) Publication Date: March 27, 2024 Effective Date: June 3, 2024 https://www.federalregister.gov/d/2024-06566	Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment (CMS-2421-F) Publication Date: September 21, 2023 Effective Date: November 17, 2023 https://www.federalregister.gov/d/2023-20382

Backdrop: Strengthening Medicaid & CHIP Access

- Presidential Directives
  - Executive Order on Strengthening Medicaid and the Affordable Care Act (January 2021)
  - Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage (April 2022)
- Affordable Care Act (ACA) Accomplishments
  - Streamlined application and renewal processes (e.g., increased reliance on electronic data sources and use of pre-populated forms)
  - Focus on MAGI-based populations

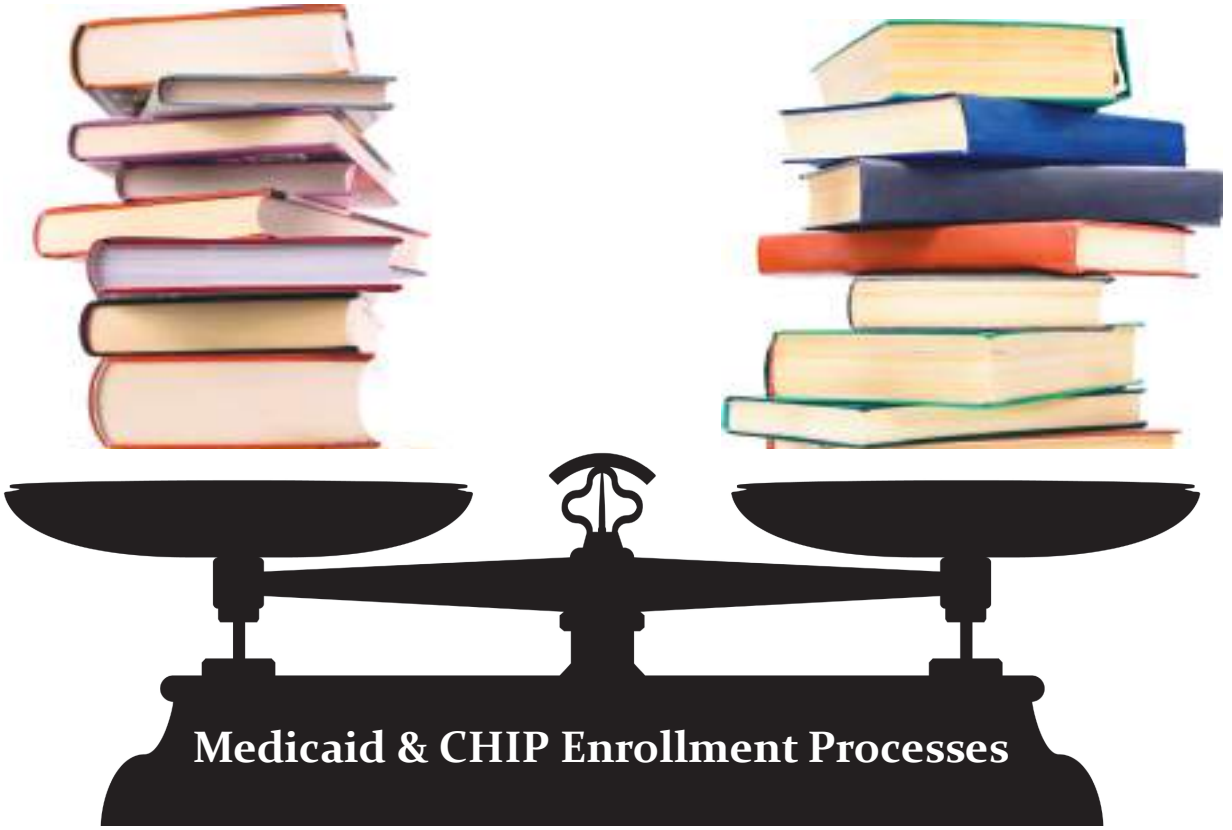
Many important ACA simplifications were not available for eligibility determinations for older adults and individuals with blindness or a disability

Backdrop: Building on Lessons Learned

- Program Integrity Concerns
  - Medicaid and CHIP recordkeeping regulations are both outdated and lacking in specificity
  - Insufficient documentation is a leading cause of eligibility-related improper payments
- Unwinding the Continuous Enrollment Condition
  - Unprecedented number of eligibility renewals as states unwind from the continuous enrollment condition and return to normal operations
  - Active collaboration to ensure that application and renewal protections are available to all individuals during the unwinding period

Finding the Right Balance

Ensuring Enrollment of Eligible Individuals



Preventing Enrollment of Ineligible Individuals

Public Comments = Substantial Support for Proposed Changes

- 7,055 timely comments submitted by state Medicaid and CHIP agencies, advocacy groups, health care providers and associations, health insurers and plans, and individual members of the public
- Most commenters, both individuals and organizations, supported the proposed changes in whole or in part
- A number of individual commenters generally opposed the rule and urged CMS to withdraw it
- 21 state agencies submitted comments, which included significant support, recommendations to increase state flexibility, and some concerns about operational burden related to implementation

Phase-in Compliance over 36 Months

- In response to comments, compliance with new requirements is phased in over 36 months
- Timeframes for compliance vary by provision
- Compliance required upon effective date for some provisions
- For other provisions, compliance date varies from 12 – 36 months
- States encouraged to implement as quickly as possible

Key Objectives

1. Streamline application and enrollment processes
2. Improve retention rates at and between renewals
3. Remove access barriers for children
4. Enhance program integrity

Objective 1: Streamline Application and Enrollment

1 Streamline Application and Enrollment Processes

- Align Non-MAGI with MAGI application requirements (§ 435.907)
- Establish standards when individuals need to provide additional information at application (§§ 435.907 and 457.330)
- Facilitate medically needy enrollment by permitting deduction of prospective medical expenses (§§ 435.831 and 436.831)
- Confirm primacy of electronic verification and applicability of reasonable compatibility standard for resource information (§§ 435.952 and 435.940)
- Streamline verification of citizenship (§§ 435.407 and 457.380)
- Remove requirement to apply for other benefits (§§ 435.608 and 436.608)
- Remove optional limitation on the number of reasonable opportunity periods (§§ 435.956 and 457.380)

Align Non-MAGI with MAGI Application Requirements (§§ 435.907(c)(4) and 435.916(b)(2)(iv))

Make the same streamlined application procedures available to all applicants – both MAGI and non-MAGI applications

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• In-person interviews may not be required for ***MAGI-based applicants*** • States must accept MAGI-based applications online, by phone, through the mail, and in person	• Prohibits in-person interviews for ***all applicants*** • Requires MAGI-excepted applications and supplemental forms to be accepted through all modalities currently provided for MAGI-based applications	None	36 months after effective date

Establish Standards when Individuals Need to Provide Additional Information at Application (§§ 435.907 and 457.330*)

When eligibility cannot be determined based on available information, ensure that applicants have adequate time to provide needed information

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations are ***silent on the timeframes*** for applicants to respond to requests for additional information needed to determine eligibility	• Must provide all applicants with a reasonable period ***(at least 15 calendar days)*** to respond to requests for additional information (RAI) • Establish minimum ***90 calendar day reconsideration period*** for applicants determined ineligible for failure to respond to RAI request • Effective date of coverage for individuals found eligible during reconsideration period the date needed information is received	• Single timeframe ***for all applicants*** to respond to requests for information • Extended reconsideration period at application from ***30 to 90 days*** • Changed effective date of coverage following reconsideration period	36 months after effective date

*This provision applies to CHIP through a cross reference at § 457.330

Facilitate Medically Needy Enrollment: Option to Deduct Prospective Medical Expenses (§§ 435.831(g)(2) and 436.831 (g)(2))

Reduce institutional bias by permitting deduction of constant and predictable non-institutional expenses, along with institutional expenses, when determining medically needy eligibility

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States are permitted to allow medically needy individuals to deduct from income their prospective institutional expenses, but ***not*** non-institutional expenses, to establish medically needy eligibility	States also may allow medically needy individuals to deduct predictable ***non-institutional*** medical or remedial expenses, such as: • Cost of HCBS included in a section 1915(c), (i), (j), or (k) plan of care • Prescription drug expenses included in a patient's pharmacy profile	None	Upon effective date

Option to Deduct Prospective Medical Expenses: Example

Example Scenario:

Individual countable monthly income	$1,200
State's medically needy income level (MNIL)	$700
Difference between countable monthly income and MNIL	$500 ($1,200 - $700 = $500)
State budget period	3 months
Individual's spenddown for budget period	$1,500 ($500 x 3 = $1,500)
Individual's reasonably constant and predictable expenses (*e.g.* drugs prescribed to treat a chronic condition, or services in the individual's 1915(c) plan of care).	$600 per month

Prior Requirements:

- Individual is not eligible at start of budget period
- Medicaid eligibility starts only after $1,500 in expenses is incurred (partway into 3rd month of budget period)
- Individual experiences gap in coverage and cycles on and off Medicaid each budget period

Final Rule Option:

- Individual would be eligible at start of budget period using projected expenses at Medicaid rate ($600 x 3 = $1,800; $1,800 > $1,500)
- Individual does not experience gap in coverage caused by cycling on and off Medicaid each budget period
- The projected expenses used to meet spenddown will be the individual's liability; state will reconcile projected amounts with incurred amounts when budget period ends

Confirm Primacy of Electronic Verification and Applicability of Reasonable Compatibility Standards for Resource Information (§§ 435.952(b) and (c) and 435.940)

Simplifies enrollment by reducing need for applicants and beneficiaries to provide documentation of resources when electronic data is available

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• States are required to verify financial assets (for individuals subject to a resource test) using an Asset Verification System (AVS) • Regulations ***do not explicitly address*** relationship of AVS to other documentation in verifying assets	• Resource information obtained from an electronic data source, such as an AVS, is reasonably compatible with attested information if both are above, at or below applicable resource standard • Individuals cannot be required to provide documentation of resources when asset eligibility can be verified using available electronic data	None	Upon effective date

Streamline Verification of Citizenship (§§ 435.407, 457.380(b)(1)(i), and 435.956(a)(1)(ii)(B)*)

Remove requirement for applicants to provide separate proof of identity when US citizenship is verified with a state's vital statistics records or DHS SAVE, since both sources already provide reliable documentation of identity

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Individuals whose US citizenship is verified with a State's vital statistics agency or DHS' Systematic Alien Verification for Entitlements (SAVE) Program **must also provide separate proof of identity**	Treats verification of US citizenship with a State vital statistics agency or SAVE as stand-alone evidence of U.S. citizenship, ***not*** **requiring separate proof of identity**	None	24 months after effective date

*This provision applies to CHIP through cross references at §§ 457.380(b)(1)(i) and 435.956(a)(1)(ii)(B).

Remove Requirement to Apply for Other Benefits (§§ 435.608 and 436.608)

Remove barrier that required individuals to apply for certain other benefits, as a condition of Medicaid eligibility

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
All Medicaid applicants and beneficiaries ***must apply*** for certain benefits to which they are entitled (e.g., annuities, pensions, retirement, disability, and unemployment benefits) as a condition of eligibility, even in circumstances in which the benefits would not impact eligibility (e.g., the eligibility for which an individual may be eligible does not impose an income test)	• ***Eliminates requirement*** to apply for other benefits as a condition of Medicaid eligibility • States are encouraged to continue educating applicants about other available benefits	None	12 months after effective date

Remove Optional Limitation on Reasonable Opportunity Periods (§§ 435.956(b)(4) and 457.380(b)(1)(ii)*)

Protect access for eligible individuals who may need more than one reasonable opportunity period (ROP), so they can access the benefits to which they are entitled while the state completes verification of citizenship or satisfactory immigration status

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States ***permitted*** to establish limits on the number of ROPs, if needed to ensure program integrity and approved by CMS • No State currently elects this option	***Eliminates*** state option	None	Upon effective date

*This provision applies to CHIP through a cross reference at § 457.380(b)(1)(ii).

Objective 2: Improve Retention Rates

2 Improve Retention Rates at and Between Renewals

- Align MAGI and non-MAGI renewal requirements (§ 435.916)
- Clarify requirements for acting on changes in circumstances (§§ 435.919, 457.344)
- Establish required actions when beneficiaries address changes (§§ 435.919 and 457.344)
- Facilitate transitions between Medicaid and CHIP (§§ 431.10, 435.1200, 457.348, 457.350)

Aligning MAGI and Non-MAGI Renewal Requirements (§§ 435.916(a)(1), 435.916(b)(2)(i) and (iii))

Reduce churning by making the same streamlined renewal procedures available to all beneficiaries – both MAGI and non-MAGI

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Eligibility must be renewed once every 12 months ***and no more frequently for MAGI-based beneficiaries only*** • At renewal, states must provide ***MAGI-based beneficiaries*** with: ❖ Prepopulated renewal form ❖ Minimum of 30 calendar days to return form ❖ Minimum 90 calendar day reconsideration period	Requires same streamlined renewal processes, formerly required only for MAGI beneficiaries, ***for all Medicaid beneficiaries***, except as specifically allowed under statute*	None	36 months after effective date

*Section 1902(e)(8) of the Social Security Act allows States to renew eligibility for QMBs no more frequently than once every 6 months

Acting on Changes in Circumstances (§§ 435.919, 457.344)

Reduce churn between regular renewals by requiring clear action steps and sufficient time for beneficiaries to provide information needed to demonstrate continued eligibility

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations are silent on expectations for processing redeterminations based on changes in circumstances	1. Establishes required steps for states when redetermining Medicaid and CHIP eligibility based on changes in circumstances 2. Requires minimum 30 calendar days to respond to requests for information 3. Provides 90 calendar day reconsideration period 4. Prohibits procedural terminations when verifying eligibility for additional benefits	Streamline requirements for different types of changes into a single set of required actions.	36 months after effective date

Updating Beneficiary Addresses (§§ 435.919(f) and (g) and 457.344 (f) and (g))

Take proactive steps to ensure that eligible individuals don't lose coverage when their address changes

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations do not prescribe proactive steps for obtaining information when a beneficiary's address may have changed, although the Consolidated Appropriations Act, 2023 (CAA, 2023) included new requirements.	***Requires states to take proactive steps*** to update address information • Leverage data from reliable sources for automatic updates • Make a good-faith effort to confirm updated information from other sources • Obtain new information for mail returned without a forwarding address	• Simplify requirements to align with the protections established by the CAA, 2023 • Require states to obtain address changes from USPS and managed care plans and to update in-state contact information	18 months after effective date

Facilitating Transitions Between Medicaid and CHIP (§§ 431.10, 435.1200(b),(e) and (h), 457.340(f), 457.348, 457.350(b) and (e), and 600.330*)

Prevent termination of eligible individuals by seamlessly transitioning them between Medicaid and CHIP when their eligibility changes

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Transfer between Medicaid and separate CHIP based on potential eligibility for the other program • May terminate coverage when data indicates eligibility for separate CHIP (or vice versa) and individual does not respond • Provide combined eligibility notice to the maximum extent feasible	• Seamlessly transition eligibility between Medicaid and separate CHIP when one program determines that the individual is eligible for the other program • Requires combined eligibility notice when eligibility is transferred from one program to the other	None	Upon effective date

* Technical changes only to § 600.330 to maintain current policy for BHP

Objective 3: Remove Access Barriers for Children

3 Remove Access Barriers for Children

- Eliminate premium lock-out periods in CHIP (§ 457.570)
- Prohibit CHIP waiting periods (§§ 457.65, 457.340, 457.350, 457.805, 457.810)
- Remove annual and lifetime benefit limits in CHIP (§ 457.480)
- Establish new optional Medicaid eligibility group for reasonable classifications of individuals under age 21 (§ 435.223)

Eliminate Premium Lock-Out Periods in CHIP and BHP (§§ 457.570 and 600.525(b)(2)*)

Align separate CHIPs with Medicaid and plans available through the Marketplace where lock-out periods are not permitted

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States are permitted to apply a premium lock-out period for up to 90 days to prevent children in a separate CHIP from enrolling in coverage if they have unpaid premiums or enrollment fees	***Eliminates premium lock-out periods*** and encourages separate CHIPs and BHPs to consider other mechanisms for addressing timely payment of premiums including: • Frequent reminders • Multiple payment options • Pursuit of past due premiums	None	Upon effective date for new lock-out periods; for States sunsetting existing lock-out periods, 12 months after effective date

* This requirement applies to BHPs through a cross-reference at § 600.525(b)(2)

Prohibit CHIP Waiting Periods (§§ 457.65(d), 457.340(d)(3), 457.350(i), 457.805(b), 457.810(a))

Align separate CHIPs with Medicaid and plans available through the Marketplace where waiting periods are not permitted

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States may impose up to a ***90-day waiting period*** prior to enrollment in separate CHIP, as a strategy to prevent substitution of group health plan coverage • Most states have eliminated their waiting period and use monitoring strategies to prevent substitution of coverage	***Prohibits waiting periods*** in separate CHIPs • Maintains requirement for states to have reasonable procedures to prevent substitution of coverage • States using a waiting period as the only strategy to prevent substitution of coverage must replace with monitoring strategies	None	Upon effective date for new waiting periods; for States sunsetting existing waiting periods periods, 12 months after effective date

Prohibit Annual and Lifetime Benefit Limits in CHIP (§ 457.480(a))

Remove limits that prevent children from receiving needed health care services and exacerbate unmet treatment needs in separate CHIPs

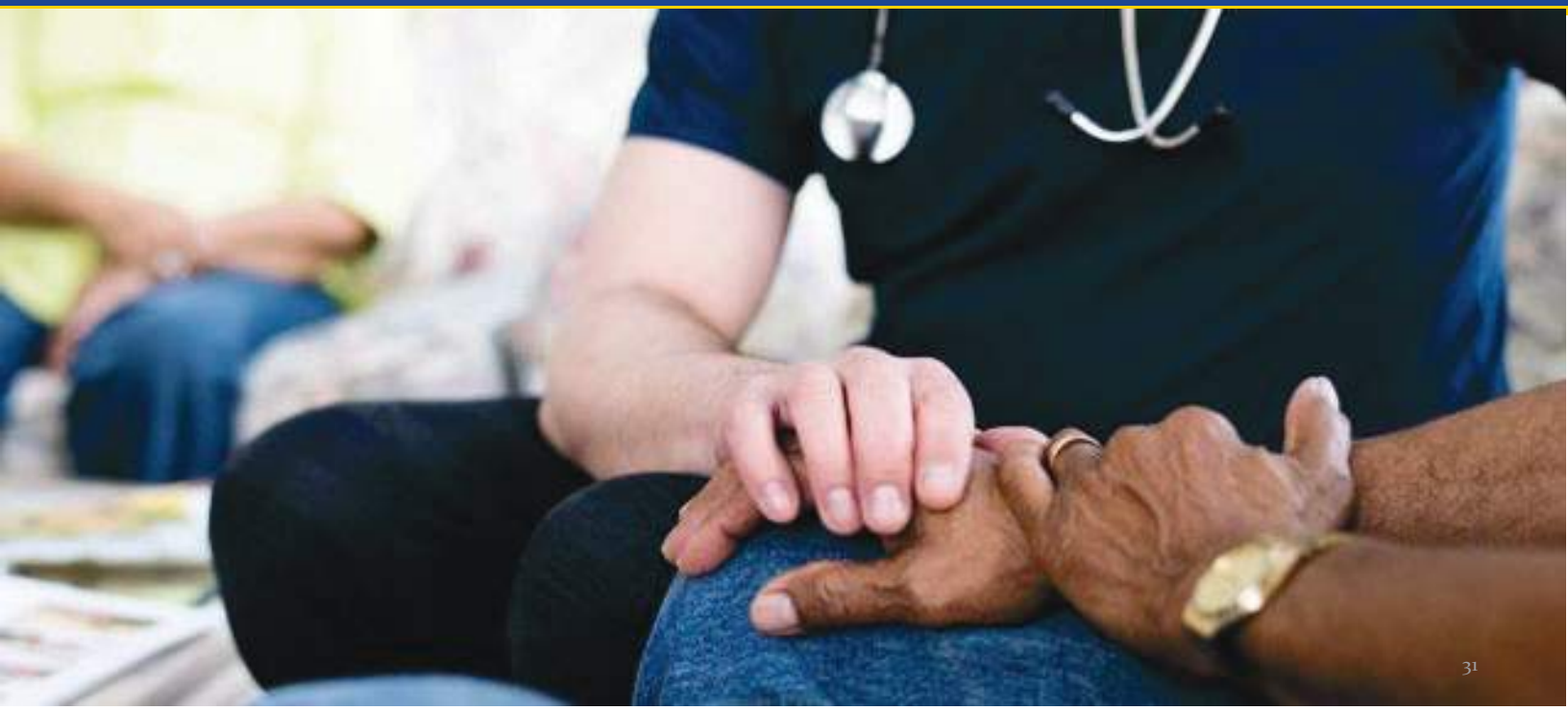
Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Annual and lifetime limits are ***prohibited only for behavioral health benefits*** provided through a separate CHIP due to the Mental Health Parity Act of 1996 • Most States have already taken steps to remove limits on CHIP benefits	Prohibits annual and lifetime limits ***on any CHIP benefits***	None	12 months after effective date

New Optional Medicaid Eligibility Group for Reasonable Classifications of Individuals Under Age 21 (§ 435.223 and § 435.601(f))

Clearly permit states to expand eligibility to reasonable classifications of children who meet eligibility criteria for disability-based or other non-MAGI eligibility groups, and apply disregards to increase effective income and/or resource standard

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulation permitting states to provide optional coverage to reasonable classifications of children (§ 435.222) ***limited to MAGI-based populations***, even though statutory authority is broader	Confirms states' authority to adopt optional eligibility groups serving ***non-MAGI-based*** reasonable classifications of children • States may apply disregards to such groups under the authority of section 1902(r)(2) of the Social Security Act	None	Upon effective date

Objective 4: Enhance Program Integrity



4 Enhance Program Integrity

- Establish maximum timeframes for redetermination of eligibility at renewal and based on changes in circumstances (§§ 435.912 and 457.340)
- Strengthen recordkeeping regulations in Medicaid and CHIP (§§ 431.17, 435.914, and 457.965)

Establish Maximum Timeframes for Redetermination of Eligibility (§§ 435.912(b), (c), and (g), and 457.340(d)(1)*)

Provide states with adequate time to redetermine eligibility while also ensuring timely completion of renewals and changes in circumstances

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Silent on timeframes for processing redeterminations at renewal and changes in circumstances • Renewals must be fully processed prior to terminating coverage, even when information is returned at end of eligibility period • States cannot terminate Medicaid coverage before determining eligibility on all bases	Establishes specific timeframes for completing eligibility redeterminations • Different timeframes for specific scenarios at renewal or change in circumstances (table on next slide) • Timeframes extended when additional information needed, information returned late, and determination on another basis	• Streamline standards and increase state flexibility • Revise thresholds for extending timeframes • Align timeframes when eligibility must be determined on another basis	36 months after effective date

*This provision applies to CHIP through a cross reference at § 457.340(d)(1).

Eligibility Determination-Related Timeframes in the Final Rule

	Application	Change in Circumstances (Reported Change)	Change in Circumstances (Anticipated Change)	Renewal
Maximum Period for State to Complete Timely Determination	• 90 calendar days for applications based on disability • 45 calendar days for all other applications §§ 435.912(c)(3)(i) and (ii); 457.340(d)(1)	• End of month that occurs 30 calendar days following report of change (when no additional information needed), or • End of month that occurs 60 calendar days following report of change, if additional information needed §§ 435.912(c)(5)(i), (ii), and (iii)*; 457.340(d)(1) and (d)(1)(i)	• End of month in which anticipated change occurs, or • End of month following the month in which the anticipated change occurs, if any additional information that may impact the eligibility determination is received less than 30 calendar days before change §§ 435.912(c)(6)(i) and (ii)*; 457.340(d)(1) and (d)(1)(i)	• End of eligibility period, or • End of month following end of eligibility period, if all needed information submitted with less than 30 calendar days in eligibility period §§ 435.912(c)(4)(i) and (ii)*; 457.340(d)(1) and (d)(1)(i)

*If Medicaid eligibility must be newly determined on another basis at renewal or following a change in circumstances, the clock for a timely redetermination of eligibility on another basis begins again on the date the individual is found ineligible on the current basis, and the State must redetermine eligibility within 90 calendar days for determinations based on disability and 45 calendar days for determinations on all other bases

Strengthen Recordkeeping Regulations in Medicaid and CHIP (§§ 431.17(d), 435.914(b), and 457.965)

Modernize outdated recordkeeping requirements to ensure proper documentation of eligibility determinations and electronic verifications

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations on the maintenance of applicant and beneficiary case records are unclear and outdated • Recent audits and reviews highlighted recordkeeping deficiencies	Modernizes states' recordkeeping systems: • Require records to be stored in an electronic format • Define documentation to be retained as part of case records • Establish a minimum 3-year record retention period	• Exception to minimum retention period when an individual's estate is subject to recoveries • Exception to timeframe for making records available due to administrative or other emergencies	24 months after effective date

Questions

EXHIBIT 57

An official website of the United States Government - **Here's how you know**

Administration

Although the Centers for Medicare & Medicaid Services (CMS) is responsible for Medicaid program administration at the federal level, individual state Medicaid agencies establish many policies and manage their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency will often contract with other public or private entities to perform various program functions. For example, most states contract with the private sector to operate their Medicaid Management Information Systems, which are used to process claims for payment to providers, determine eligibility, and perform a variety of other tasks (e.g., monitor service utilization and provide data to meet federal reporting requirements). In addition, state and local agencies, such as child welfare and mental health agencies, may be responsible for various aspects of a state's Medicaid program. Furthermore, during public health emergencies, such as the COVID-19 pandemic, CMS may provide temporary flexibilities to state agencies in how they administer the Medicaid program.

CMS oversees the approval of state plan amendments, waivers, and demonstrations, and provides guidance to states through means that include State Medicaid Director and State Health Official letters. As a condition of receiving federal Medicaid funds, Section 1902 of the Social Security Act requires states to have a state plan on file with CMS that demonstrates an understanding of all federal Medicaid requirements. States are required to submit state plan amendments (SPAs)

to CMS for review and approval prior to making program modifications. In addition to reviewing these SPAs, CMS works with state Medicaid agencies to review and approve applications for waivers of certain federal requirements.

Once states opt to participate in Medicaid, as all currently do, they are obligated to administer their programs within federal guidelines and requirements. The federal share for Medicaid administrative costs is generally 50 percent, but certain administrative functions receive a higher federal share. For example, upgrades to computer and data systems may be eligible for a 75 percent or 90 percent federal match if certain criteria are met. In recent years, state Medicaid program administration costs have grown at about the same rate as service costs and thus have remained a relatively constant share of total Medicaid spending, about 5 percent.[1] Funding for CMS and other federal administrative activities related to Medicaid generally comes from annual appropriations.

As part of their administrative responsibilities, both states and the federal government undertake a variety of program integrity activities to detect and deter fraud, waste, and abuse in Medicaid. Ultimately these activities are intended to ensure that beneficiaries receive quality care and that taxpayer dollars are spent appropriately. Partly in response to concern about Medicaid's vulnerability to significant financial losses and previously low levels of resources devoted to program integrity, Congress has added new requirements and funding for these activities in recent years.

Notes

[1]MACPAC analysis of CMS-64 Financial Management Report net expenditure data. This figure excludes administrative activities that are exclusively federal, such as program oversight by CMS staff.

Learn from the following MACPAC resources:

Background

Federal matching rates for Medicaid administrative activities

State plan

Waivers

Medicaid Administrative Spending by State and Category

Program Administration

Medicaid Administrative Data

Medicaid's Response to COVID-19

Fact sheets

Electronic Visit Verification for Personal Care Services: Status of Implementation

Federal Requirements and State Options: Enrollment and Renewal Procedures

CHIP Health Services Initiatives: What Are They and How States Use Them

Federal Requirements and State Options: Appeals

Federal Requirements and State Options: Premium Assistance

Issue briefs

Federal Requirements and State Options: How States Exercise Flexibility under a Medicaid State Plan

Medicaid's Role in Disasters and Public Health Emergencies

Medicaid in Schools

Process and Oversight for State Claiming of Federal Medicaid Funds

In-depth analysis and policy recommendations

Building Capacity to Administer Medicaid and CHIP

Improving the Effectiveness of Medicaid Program Integrity

Streamlining Medicaid Managed Care Authority

Program Integrity in Medicaid Managed Care

ACA Eligibility Changes: Program Integrity Issues

Update on Medicaid and CHIP Data for Policy Analysis and Program Accountability

State Compliance with Electronic Asset Verification Requirements

Medicaid 101 & Subtopics

Medicaid 101

Putting the program in context

Eligibility

Benefits

Financing

Provider payment and delivery systems

Waivers

Administration

Spending

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The Medicaid and CHIP Payment and Access Commission is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the

State Children's Health Insurance Program (CHIP).

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EXHIBIT 58

KFF The independent source for health policy research, polling, and news.

CMS' New Approach to Federal Medicaid Spending in Cases of Potential Fraud

Authors: Jessica Mathers, Alice Burns, and Robin Rudowitz

Published: May 15, 2026

Note: The map in this brief will be updated regularly to include new federal actions about potential Medicaid fraud and new state responses. The brief was last updated on May 15, 2026.

The current administration is placing a new emphasis on potential fraud in Medicaid with its Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative. The Centers for Medicare and Medicaid Services (CMS') started the new initiative in Medicaid focusing on Minnesota and three other states with Democratic governors (California, Maine, and New York) while the House Committee on Energy and Commerce sent requests for information to 11 states. CMS has historically partnered with states to identify and resolve issues of fraud, waste, and abuse, and denied the federal share of Medicaid spending when fraud has been identified by an audit, investigation, or reported by the state. However, CMS has recently announced a new approach to fraud that will rely more heavily on options to prevent spending federal funds in cases of potential fraud, which could have broad implications for states and enrollees. This issue brief explains the new approach. Key findings include:

CMS' historic practice has relied on disallowing federal Medicaid payments when fraud is identified (typically through an audit), a process that may take several years to implement.

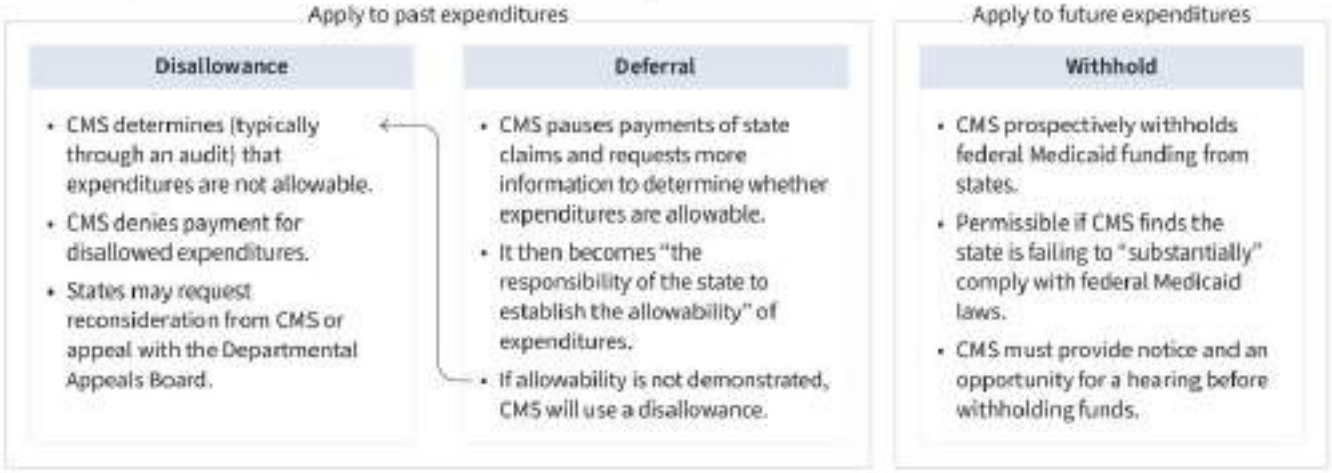
CMS' new approach to potential fraud involves potentially pausing or withholding federal Medicaid payments when fraud is suspected (Figure 1). This approach differs from prior approaches because, if implemented, it could have more immediate consequences, place a much larger share of federal spending at risk (including spending that pays for services uninvolved in fraud), and proactively shift the burden of proof to states to obtain federal funds.

While all approaches aim to limit future fraudulent payments using tools such as corrective action plans, the new approach to federal Medicaid spending when fraud is suspected creates uncertainty for state budgets and could have implications for Medicaid enrollees and providers who are not involved in fraud.

Figure 1

The Federal Government Is Changing How It Provides Access to Medicaid Funds for States in Cases of Potential Fraud

Historically, CMS denied payments for **disallowed or deferred expenditures when fraud was identified.** The new approach **defers and/or withholds federal Medicaid spending *when fraud is suspected*.** That shifts the burden of proof to states and creates uncertainty for state budgets, which could have implications for enrollees and providers who are not involved in fraud.



Note: CMS is the Centers for Medicare & Medicaid Services.

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What is a disallowance?

The federal and state governments share responsibility for financing Medicaid, and states draw on federal funds to pay health care providers and health plans for providing health care to enrollees. The federal government makes quarterly grant awards to states to cover the federal share of Medicaid spending. Awards reflect states' estimated expenditures for the upcoming quarter and adjustments from prior quarters' expenses. Adjustments reflect various considerations such as:

- Instances where states' estimated expenditures are higher or lower than actual expenditures
- Changes to accounting practices or federal matching rates
- Reductions in payment resulting from claims where fraud has been identified

Publicly-available data on Medicaid expenditures show the total amount of adjustments each year, reflecting the net impact of all various factors, and do not specifically identify adjustments due to disallowances and deferrals.

Historically, CMS has used disallowances to deny federal matching funds for state Medicaid expenditures that have already occurred and are later determined to be not allowable. There is limited information available about the frequency and scope of Medicaid disallowances, but an older report by the Government Accountability Office (GAO) suggests that they were not infrequent between 2014 and 2017. Upon receiving a disallowance notice, states may request that CMS reconsider the decision and provide additional information to CMS to demonstrate that the expenditures were allowable or accept the disallowance and resolve it directly with CMS. In all cases, once CMS has issued a disallowance, "the state has the burden of documenting the allowability" of the expenditures to overturn the disallowance. When states request a reconsideration, CMS has 60 days to decide, although this timeline may take longer if CMS requests additional information from the state.

States may appeal the disallowance decisions to a Departmental Appeals Board, but the state still has the burden of proof for documenting the allowability of expenditures and the process may take years to resolve. States are not required to request a reconsideration before appealing the disallowance. More information is

publicly available for cases where states do appeal the decisions than for cases where they settle or request a reconsideration. In such cases, data about the decisions of the Department Appeals Board are available online through the Department's website. Between 2020 and 2025, the Departmental Appeals Board has issued 12 Medicaid disallowance rulings (with 6 rulings being an appeal of a prior case). In all 6 new rulings, there were on average 15 years between the oldest year of disputed expenditures and the final ruling, highlighting how long it takes to resolve these cases (see Figure 2 for an example from Texas). All cases were decided in favor of CMS, but that may reflect the fact that CMS has historically used disallowances only in cases where fraud is well-established.

The amount of disputed disallowances where the Departmental Appeals Board issued a ruling between 2020 and 2025 ranged from less than $500,000 to almost $200 million, but these amounts reflect differences in the number of years and scope of services within the disallowed claims. Some of the largest disallowances to be upheld involve disproportionate share hospital (DSH) payments.

The largest disallowance ruling between 2020 and 2025 was $195.7 million in a case involving Michigan's DSH payments between 2001-2009. In that instance, CMS in 2018 determined that the state had made DSH payments to a small number of hospitals that were ineligible to receive them. The Departmental Appeals Board ruling was in 2024.

The second largest disallowance ruling between 2020 and 2025 was for more than $97 million in a case where Florida made DSH payments between 2006-2013 in excess of the limits established for specific hospitals (CMS first issued this disallowance in 2016 and the Departmental Appeals Board ruling was in 2021).

Figure 2

Disallowance Settlements May Take Years to Resolve

An example from Texas, 2011–2024

Type of Payments Disallowed: Medicaid reimburses health-related services delivered by schools to children who are enrolled in Medicaid and need direct medical services as part of their individualized education plan. Texas, like many other states, pays schools for such services in aggregate instead of requiring schools to submit bills to Medicaid for each service provided to Medicaid enrollees. Instead, states calculate Medicaid's required payments using a federally approved survey method that estimates the percentage of spending attributable to children enrolled in Medicaid. HHS-OIG conducted an audit of Texas's claims for these school-based services as part of series of reviews of these types of payments. HHS-OIG audited other states during this period and found unallowable costs because of similar errors.

2014–2017

Audits Identify Unallowable Payments

In FY 2014, HHS-OIG began a review of Texas's 2010-2011 claims for these school-based services, which took three years to complete. The report found that Texas claimed $18.9 million in unallowable expenses due to errors in how the state calculated payments and missing or incorrect documentation.

June 2021

Disallowance Issued

CMS reviewed HHS-OIG's audit findings and issued a letter of disallowance to Texas of $16.3 million (adjusted downward from $18.9 million after finding that some of HHS-OIG's review included allowable expenses).

August 2021

Texas Requests Reconsideration

Texas requested that CMS reconsider the decision within the required 60-day timeframe.

October 2021

CMS Denies Reconsideration

CMS denied the reconsideration request, and in the notice explained that the State had not justified it with new information.

Late 2021

Texas Appeals Disallowance

Texas appealed CMS' decision to the HHS DAB within the required 60-day timeframe.

June 2022

DAB Issues Ruling

The DAB acknowledged Texas' appeal in January 2022 and issued a ruling about 5 months later that upheld the disallowance in full. The ruling explained that Texas failed to meet its "burden of proof" to show that the disallowed costs were appropriately claimed.

August 2022

Texas Appeals DAB Ruling

Texas appealed the DAB ruling within the required 60-day timeframe.

October 2023

DAB Issues Second Ruling

In October 2023, the DAB upheld the disallowance and declined to revisit the case because the State did not submit sufficient new facts. This second appeal generally represents the final administrative step available to states in the disallowance process.

2024

Disallowance Settlement

Reporting indicates that Texas repaid the disallowed funds to CMS by December 2024 and began working with schools to recover the $16.3 million in disallowed federal financial participation.

Note: FY = fiscal year. HHS-OIG = the Department of Health and Human Services Office of the Inspector General. CMS = the Centers for Medicare and Medicaid Services. DAB = the Departmental Appeals Board.

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What is a deferral?

With deferrals, CMS pauses payment for state Medicaid expenditures that have already ocurred and requires the state to provide additional information demonstrating that expenditures are "allowable." Deferrals are usually initiated by the federal government and may be used to pause federal funding while the state and federal governments work out the details of a disallowance, and in cases where

fraud, waste, or abuse has been identified and the state and federal governments are gauging the extent of the issue. In the past, deferrals were used as temporary measures that pause funding until CMS either reimburses the expenditures or issues a disallowance. Deferral notices must specify the reason for the deferral and include a request for all documents and materials that CMS believes are necessary to determine whether the expenses are allowable. After the notice is sent, the loss of federal funds occurs immediately.

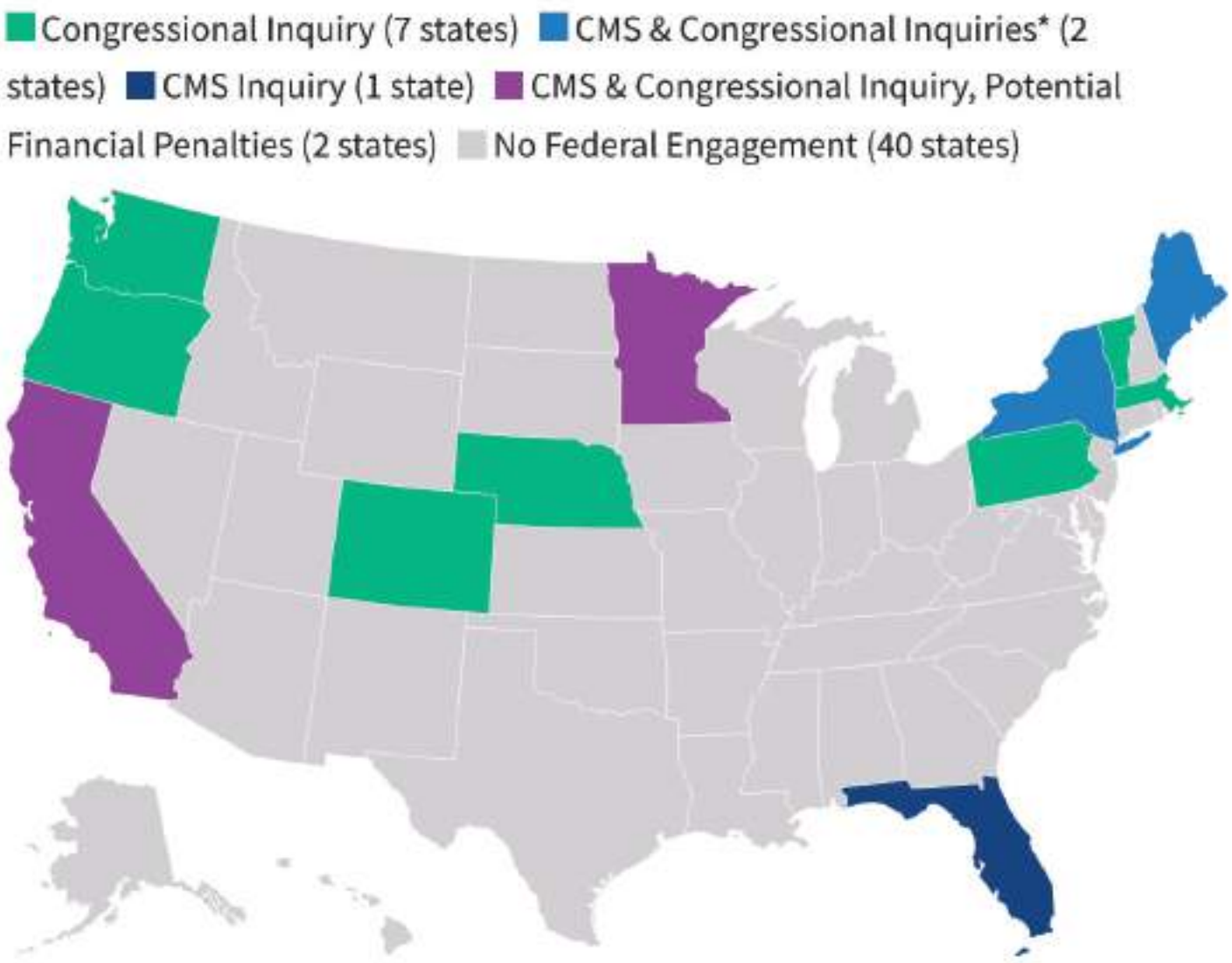
After receiving a deferral notice from CMS, states have 60 days to provide all requested documents and materials unless they request an additional 60-day extension. CMS usually begins document review within 30 days but may request different formats or additional materials from the state. States have 15 days to submit additional materials and if they do not meet that deadline, CMS disallows the expenses. Once all documents are available, CMS has 90 days to review and determine whether expenditures are allowable. If CMS determines expenditures are not allowable, the disallowance process begins, offering the state the opportunity to request a reconsideration and appeal to the Departmental Appeals Board.

Deferrals are receiving new attention after the administration announced that it would temporarily defer $259 million in federal Medicaid payments to Minnesota for expenditures incurred in quarter 4 of in fiscal year (FY) 2025, an unprecedentedly large amount. In the announcement, CMS noted that it may continue to defer federal payments for either additional quarters in 2025 or future quarters in 2026, and that similar announcements for other states would likely be coming soon. As of March 25, 2026, 4 additional states have received formal letters from CMS requesting information about program integrity, and 11 states have received formal letters from the House Committee on Energy and Commerce (Figure 3).

Figure 3

CMS' New Efforts Related to Potential Fraud in Medicaid Focus on 5 States but Congressional Oversight Inquiries Suggest Effects Could Become Broader

Scroll over state for links to federal letters and state responses regarding state Medicaid program integrity, as of May 15, 2026.



Note: CMS is the Centers for Medicare & Medicaid Services. "Congressional Inquiry" refers to requests for information issued by the House Committee on Energy and Commerce. "Financial Penalties" refers to notices of deferral and withholding issued as program integrity-related compliance actions.
*The House Committee on Oversight and Government Reform separately launched an oversight inquiry in alleged fraud in Ohio.

Source: KFF Tracking of Federal Program Integrity Action

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What is a withhold?

In January 2026, CMS notified Minnesota that pending the outcome of a hearing, it would begin withholding $515 million in quarterly federal Medicaid payments moving forward, a process that has seldom been used in prior years. Withholding funds has been referred to as the "compliance process" because it is only permissible in cases where the state is failing to comply with Medicaid law. Prior use of withholding has been limited. When CMS has considered withholding as a compliance tool in the past, it announced withholdings that were at most between 1 and 10 percent of the federal share of Medicaid spending *for specific services* (in most cases, the administrative costs states incurred to implement their Medicaid programs). Prior CMS communication notifying states of possible withholdings appear to have been used when states incorrectly restricted eligibility or benefits, thus failing to comply with minimum requirements regarding access to coverage or eligibility. Minnesota's case is different because of the scope of the proposed withholding and because the proposed withholding would be to address potential future fraud, rather than state policies that restrict Medicaid eligibility or benefits. The announced level of withholding would have represented nearly 20% of the federal share of Minnesota's spending on an annual basis.

To withhold federal Medicaid funds, CMS must first provide states with the opportunity for an administrative hearing, and withholding generally ends when CMS is satisfied with states' resolution of the issue. Withholdings may reflect issues with states' Medicaid approved plans or with states' implementation of the plans. Because CMS has authority to approve states' plans, most issues arise regarding implementation of the plan and are resolved using a corrective action plan. Corrective action plans may also be used to address other types of issues in Medicaid (such as payment error rates or eligibility re-determinations). In general, the plans include a narrative of steps states are planning to take to address issues related to proper implementation of the Medicaid program. On January 13, 2026, Minnesota requested a hearing about the withholding and on January 30, 2026, Minnesota submitted a revised corrective action plan to CMS. On March 20, 2026, CMS accepted

Minnesota's revised corrective action plan. Successful completion of the corrective actions outlined in the plan will resolve the threat of withholding.

What are the implications of new reliance on deferrals and withholds?

The new approach to federal Medicaid spending when fraud is suspected creates uncertainty for state budgets, particularly given the magnitude of federal funding at stake and the time it takes to resolve administrative disputes. Unlike the federal government, states must generally operate balanced budgets, which is one reason states are able to draw down matching funds to finance ongoing expenditures. If withholding is implemented, the loss of federal funds could make it difficult for states to maintain current programs while details of the cases are being sorted out. More extensive use of deferrals could have similar, but more immediate, destabilizing effects on states' budgets because they reduce the amount of federal funds available to states for several months, and the state has no option to request reconsideration or appeal until a disallowance is issued. Increasing the use of deferrals so that it applies to entire categories of services where fraud is suspected but not established would also place a new administrative burden on states to demonstrate the allowability of expenditures. Other approaches to addressing suspected fraud, waste, and abuse remain available to CMS. The National Association of Medicaid Directors (NAMD) has suggested the following actions to help states to address fraud waste, and abuse in Medicaid:

- Help states identify federal materials about best practices such as recommendations and provider enrollment self-assessments;
- Create rapid methods to share information about provider disqualifications between Medicare, the Veterans' Health Administration, and Medicaid;
- Respond more quickly to fraud reports from state attorneys general and the Medicaid Fraud Control Units;

Strengthen procedural pathways for states and CMS to work collaboratively on Corrective Action Plans to enhance adherence to provider requirements while maintaining access to Medicaid benefits;

Conducting additional analysis of Medicaid data through the Center for Program Integrity;

Strengthening federal data sources and their interoperability; and

Providing technical assistance to state officials and staff.

New uncertainty about the availability of federal funding could have implications for Medicaid enrollees and providers who are not involved in fraud. If states have inadequate funding to maintain existing Medicaid services, they may face difficult decisions regarding how to limit Medicaid spending. In general, states can reduce Medicaid spending by decreasing payment rates for providers, covering fewer services, or enrolling fewer people. Such actions could affect enrollees and providers who are not using or providing services in which fraud is suspected. There will also be additional disruptions for providers who lawfully provide Medicaid services where fraud is suspected because of new administrative burdens associated with increased audits, delayed payments, and other administrative practices.

CMS' new approach to addressing cases of suspected fraud may exacerbate administrative and financial challenges states face as they implement the 2025 reconciliation law. The 2025 reconciliation law made historic reductions in federal funding for Medicaid and created new administrative requirements for states, particularly those that must implement work requirements for enrollees eligible for Medicaid through the Affordable Care Act Medicaid expansion. As states work to implement those changes and adjust to changes in federal financing, the new approach to fraud creates additional administrative requirements and potential new reductions in federal funding. Combined, these changes may have more significant implications for states' ability to maintain existing levels of Medicaid payment rates, coverage, and eligibility.

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EXHIBIT 59

Disability Determination Process

Disability Home

Disability Evaluation Under Social Security

Most Social Security disability claims are initially processed through a network of local Social Security Administration (SSA) field offices and State agencies (usually called Disability Determination Services or DDSs). Subsequent appeals of unfavorable determinations may be decided in a DDS or by an administrative law judge in SSA's Office of Hearings Operations.

Social Security representatives in the field offices usually obtain applications for disability benefits in person, by telephone, by mail, or by filing online. The application and related forms ask for a description of the claimant's impairment(s), treatment sources, and other information that relates to the alleged disability. (The "claimant" is the person who is requesting disability benefits.)

The field office is responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status, or Social Security coverage information. The field office then sends the case to a DDS for evaluation of disability.

The DDSs, which are fully funded by the Federal Government, are State agencies responsible for developing medical evidence and making the initial determination on whether or not a claimant is disabled or blind under the law.

Usually, the DDS tries to obtain evidence from the claimant's own medical sources first. If that evidence is unavailable or insufficient to make a determination, the DDS will arrange for a consultative examination (CE) to obtain the additional information needed. The claimant's treating source is the preferred source for the CE, but the DDS may obtain the CE from an independent source. After completing its development of the evidence, trained staff at the DDS makes the initial disability determination.

Then, the DDS returns the case to the field office for appropriate action. If the DDS found that the claimant is disabled, SSA completes any outstanding non-disability development, computes the benefit amount, and begins paying benefits. If the claimant was found not to be disabled, the file is kept in the field office in case the claimant decides to appeal the determination.

EXHIBIT 60

How Does Someone Become Eligible?

To be eligible for Social Security Disability Insurance (SSDI) benefits, you must:

- Have worked in jobs covered by Social Security
- Have a medical condition that meets Social Security's strict definition of disability

In general, we pay monthly benefits to people who are unable to work for a year (12 consecutive months) or more because of a disability. Generally, there is a five-month waiting period and we'll pay your first benefit in the sixth full month after the date we find your disability began.

We may pay Social Security disability benefits for as many as 12 months before the date your application was filed, if we find you had a disability during that time and you meet all other requirements.

Benefits usually continue until you can work again on a regular basis. There are also several special rules, called work incentives, that provide continued benefits and health care coverage to help you make the transition back to work.

If you are receiving SSDI benefits when you reach full retirement age, your disability benefits automatically convert to retirement benefits, but the amount remains the same.

How Much Work Do You Need?

In addition to meeting our definition of disability, you must have worked long enough — and recently enough — under Social Security to qualify for disability benefits.

Social Security work credits are based on your total yearly wages or self-employment income. You can earn up to four credits each year.

The amount needed for a work credit changes from year to year. In 2026, for example, you earn one credit for each $1,890 in wages or self-employment income you work in each quarter of the year. When you've earned $7,560, you've earned your four credits for the year.

The number of work credits you need to be eligible for disability benefits depends on your age when your disability begins. Generally, you need 40 credits, 20 of which were earned in the last 10 years ending with the year your disability begins. This is called the 20/40 Rule. However, younger workers may be eligible with fewer credits.

For more information on whether you are eligible, read our publication *How You Earn Credits* .

> Whatever your age, you must have earned the required number of work credits within a certain period ending with the time your disability begins. If you are eligible now, but you stop working under Social Security today, you may not continue to meet the disability work requirement in the future.

What We Mean by Disability

The definition of disability under Social Security is different than in other programs. We pay only for total disability. **No benefits are payable for partial disability or for short-term disability**.

We consider you to have a qualifying disability under our rules if all the following are true:

- You cannot do work at the substantial gainful activity (SGA) level because of your medical condition
- You cannot do work you did previously or adjust to other work because of your medical condition
- Your condition has lasted or is expected to last for at least one year (12 consecutive months) or to result in death

This is a strict definition of disability. Social Security program rules assume that working families have access to other resources to provide support during periods of short-term disabilities. These include workers' compensation, insurance, savings, and investments.

How We Decide if You Have a Qualifying Disability

If you have worked enough to be eligible for disability benefits, we use a step-by-step process involving five questions to determine if you have a qualifying disability. The five questions are:

1. Are you working?

We generally use earnings guidelines to evaluate whether your work activity is SGA. If you are working in 2026 and your earnings average more than $1,690 ($2,830 if you’re blind) a month, you generally cannot be considered to have a disability.

If you are not working or are working but not performing SGA, we will send your application to the Disability Determination Services (DDS) office. This office will make the decision about your medical condition. The DDS uses Steps 2-5 below to make the decision.

2. Is your condition "severe"?

Your condition must significantly limit your ability to do basic work-related activities, such as lifting, standing, walking, sitting, or remembering – for at least 12 consecutive months. If it does not, we will find that you do not have a qualifying disability.

If your condition does interfere with basic work-related activities, we go to Step 3.

3. Is your condition found in the list of disabling conditions?

For each of the major body systems, we maintain a list of medical conditions we consider severe enough to prevent a person from doing SGA. If your condition is not on the list, we must decide if it is as severe as a medical condition that is on the list. If it is, we will find that you have a qualifying disability. If it is not, we then go to Step 4.

> We have two initiatives designed to expedite our processing of new disability claims:
>
> - Compassionate Allowances: Certain cases that usually qualify for disability can be allowed as soon as the diagnosis is confirmed. Examples include acute leukemia, Lou Gehrig's disease (ALS), and pancreatic cancer.
> - Quick Disability Determinations: We use computer screening to identify cases with a high probability of allowance.
>
> For more information about our disability claims process, visit our Benefits for People with Disabilities website.

4. Can you do the work you did previously?

At this step, we decide if your medical impairment(s) prevents you from performing any of your past work. If it doesn't, we'll decide you don't have a qualifying disability. If it does, we proceed to Step 5.

5. Can you do any other type of work?

If you can't do the work you did in the past, we look to see if there is other work you could do despite your medical impairment(s).

We consider your medical conditions, age, education, past work experience, and any transferable skills you may have. If you can't do other work, we'll decide you are eligible for disability benefits. If you can do other work, we'll decide that you don't have a qualifying disability and your claim will

Special Situations

Most people who receive disability benefits are workers who are eligible on their own records and meet the work and disability requirements we have just described. However, there are some situations you may not know about:

- If You're Blind or Have Low Vision - How We Can Help
- If You Are the Survivor
- Benefits for Children with Disabilities
- Benefits for Wounded Warriors & Veterans

Special Rules for People Who Are Blind or Have Low Vision

We consider you to be legally blind under our rules if your vision cannot be corrected to better than 20/200 in your better eye. We will also consider you legally blind if your visual field is 20 degrees or less, even with a corrective lens. Many people who meet the legal definition of blindness still have some sight and may be able to read large print and get around without a cane or a guide dog.

If you do not meet the legal definition of blindness, you may still be eligible for disability benefits. This may be the case if your vision problems alone or combined with other health problems prevent you from working.

There are several special rules for people who are blind that recognize the severe impact of blindness on a person's ability to work. For example, the monthly earnings limit for people who are blind is generally higher than the limit that applies to non-blind workers with disabilities.

In 2026, the monthly earnings limit is $2,830.

Benefits for Surviving Spouses With Disabilities

When a worker dies, their surviving spouse or surviving divorced spouse may be eligible for benefits if they:

- Are between ages 50 and 60
- Have a medical condition that meets our definition of disability for adults and the disability started before or within seven years of the worker's death

> Surviving spouses or surviving divorced spouses who were receiving benefits for caring for the worker's child(ren) may be eligible for disabled surviving spouse's benefits. They are eligible if they have a disability that begins before those payments end or within seven years after they end.

Surviving spouses and surviving divorced spouses cannot apply online for survivors benefits. If they want to apply for these benefits, they should contact Social Security immediately at **1-800-772-1213** (TTY **1-800-325-0778**) to request an appointment.

To speed up the application process, they should complete an Adult Disability Report and have it available at the time of their appointment.

For these benefits, we use the same definition of disability as we do for workers.

Benefits for Children With Disabilities

A child under age 18 may have a disability, but we don't need to consider the child's disability when deciding if they are eligible for benefits as a dependent. The child's benefits normally stop at age 18 unless they are a full-time elementary or high school student until age 19 or have a qualifying disability.

Children who were receiving benefits as a minor child on a parent's Social Security record may be eligible to continue receiving benefits on that parent's record upon reaching age 18. They must have a qualifying disability.

Adults with a Disability That Began Before Age 22

An adult who has a disability that began before age 22 may be eligible for benefits if their parent is deceased or starts receiving retirement or disability benefits. We consider this a "child's" benefit because it is paid on a parent's Social Security earnings record.

The Disabled Adult Child (DAC) — who may be an adopted child, or, in some cases, a stepchild, grandchild, or step grandchild — must be unmarried and age 18 or older. They must have a qualifying disability that started before age 22 and meet the definition of disability for adults.

> **Example**: A worker starts collecting Social Security retirement benefits at age 62. That worker has an unmarried 38-year-old child who has had cerebral palsy since birth. The child may start collecting a DAC benefit on their parent's Social Security record.

It is not necessary that the DAC ever worked. Benefits are paid based on the parent's earnings record.

- A DAC must not have substantial earnings. The amount of earnings we consider substantial increases each year. In 2026 this means working and earning more than $1,690 (or $2,830 if you're blind) a month.

> Certain expenses the DAC incurs in order to work may be excluded from these earnings. For more information about work and disability, read our publication *Working While Disabled: How We Can Help* .

What if the child is already receiving Supplemental Security Income (SSI) or disability benefits on their own record and turns 18?

A child already receiving SSI benefits or disability benefits on their own record should check to see if DAC benefits may be payable on a parent's earnings record when they reach age 18. Higher benefits might be payable and entitlement to Medicare may be possible.

How do we decide if a child over age 18 is eligible for SSDI benefits?

If a child is age 18 or older, we will evaluate their disability the same way we would evaluate the disability for any adult. We send the application to the DDS in your state that completes the disability decision for us.

What happens if the DAC gets married?

In most cases, DAC benefits end if the child gets married. There are exceptions, such as marriage to another DAC, when the benefits are allowed to continue. The rules vary depending on the situation.

Contact a Social Security representative at **1-800-772-1213** to report changes in marital status and to find out if the benefits can continue. If you are deaf or hard of hearing, call TTY number at **1-800-325-0778**.

> At this time, you cannot apply for DAC benefits online. If you wish to file for benefits, contact us immediately at **1-800-772-1213** (TTY **1-800-325-0778**) to request an appointment. If you delay, some potential benefits could be lost.

To speed up the application process, complete an Adult Disability Report and have it available at the time of your appointment.

Related Information

- Supplemental Security Income (SSI) for Children
- Family Benefits

Publications

- Disability Benefits
- Disability Starter Kits
- If You Are Blind or Have Low Vision—How We Can Help
- SSI Child Disability Starter Kit (for children under age 18)
- Benefits for Children with Disabilities
- Other Disability Publications

For more information about Disability and our services, visit our Publications Catalog.

EXHIBIT 61

Adult Listings (Part A)

Childhood Listings (Part B)

General Information

Evidentiary Requirements

Listing of Impairments (overview)

Revisions to Rules Regarding the Evaluation of Medical Evidence

Disability Evaluation Under Social Security

Part III - Listing Of Impairments

The Listing of Impairments describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity (or in the case of children under age 18 applying for SSI, severe enough to cause marked and severe functional limitations). Most of the listed impairments are permanent or expected to result in death, or the listing includes a specific statement of duration. For all other listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the Listing of Impairments are applicable to evaluation of claims for disability benefits under the Social Security disability insurance program or payments under the SSI program.

Part A of the Listing of Impairments contains medical criteria that apply to the evaluation of impairments in adults age 18 and over. The medical criteria in Part A may also be applied in evaluating impairments in children under age 18 if the disease processes have a similar effect on adults and younger children.

Part B of the Listing of Impairments contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18. Certain criteria in Part A do not give appropriate consideration to the particular effects of the disease processes in childhood; that is, when the disease process is generally found only in children or when the disease process differs in its effect on children and adults. Additional criteria are included in Part B, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in Part A. In evaluating disability for child under age 18, part B will be used first. If the medical criteria in part B do not apply, then the medical criteria in part A will be used.

The criteria in the Listing of Impairments apply only to one step of the multi-step sequential evaluation process. At that step, the presence of an impairment that meets the criteria in the Listing of Impairments (or that is of

equal severity) is usually sufficient to establish that an individual who is not working is disabled. However, the absence of a listing-level impairment does not mean the individual is not disabled. Rather, it merely requires the adjudicator to move on to the next step of the process and apply other rules in order to resolve the issue of disability.

EXHIBIT 62

July 31, 2026

Submitted electronically via regulations.gov

The Honorable Robert F. Kennedy, Jr.
Secretary of the U.S. Department of Health and Human Services
Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20201

RE: American Public Health Association, Grantmakers in Health, Jacobs Institute of Women's Health, National Center for Medical-Legal Partnership, and Public Health Deans and Scholars' Comments on Department of Health and Human Services "Medicaid Program; Community Engagement Requirement for Certain Individuals" (CMS-2454-IFC; RIN 0938-AV98)

Dear Secretary Kennedy:

The American Public Health Association (APHA), Grantmakers in Health, the Jacobs Institute of Women's Health, and the National Center for Medical-Legal Partnership, along with public health and health policy deans, chairs, and scholars (in their individual capacities), file this comment on the Department of Health and Human Services (HHS) June 1, 2026 interim final rule with comment (the Rule),[1] which purports to implement and interpret the Medicaid community engagement requirement under section 1902(xx) of the Social Security Act (the Act) (herein referred to as "community engagement" or "work requirements").

The Rule is inconsistent with the statutory language of section 1902(xx) of the Act, as added by H.R. 1, and with other cornerstone provisions of Title XIX. Specifically, the Rule restricts eligibility for exclusion from the community engagement requirements that Congress explicitly mandated in the text of H.R. 1. Most egregiously, the Rule unlawfully narrows the exclusion for individuals who are medically frail or otherwise have special medical needs, limiting it to only those individuals whose condition "significantly impairs" their ability to comply with the extra-statutory ability to work test that appears nowhere in the statute Congress enacted. The Rule also imposes administrative burdens on states, providers, and beneficiaries that contravene section 1902(xx)'s express terms directing states to rely, wherever possible, on data to make *ex parte* determinations. Finally, the Rule will force states to violate other Medicaid statutory requirements, including the express command to " . . . assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."[2]

The Rule is arbitrary and capricious in violation of the Administrative Procedure Act because it exceeds the authority of Title XIX of the Act. It is also arbitrary and capricious because, in promulgating it, CMS failed to engage in the reasoned decision-making the APA requires: it did not adequately explain or justify its most consequential policy choices, disregarded substantial evidence of the Rule's likely effects, and reversed its own prior guidance without acknowledging

[1] 91 Fed. Reg. at 33348
[2] 42 U.S.C. § 1396a(a)(19)

the change or accounting for the reliance it invited. As just one important example, the Rule fails to consider a longstanding, fundamental policy goal of the Medicaid program, namely, the Rule's impact on the millions of beneficiaries who seek coverage annually because of significant health needs, its effects on access to health care, the stability of the health care system on which Medicaid beneficiaries depend, and ultimately, individual and population health.

The Rule will also cause serious and substantial harms that CMS unreasonably underestimates. States' prior work requirement experiments—each significantly less harsh than the requirements in the Rule—have yielded robust evidence that CMS ignores of the significant harms that will result as states implement this Rule. Contrary to the Rule's suggestions that it will help beneficiaries become more self-sufficient, it will instead cause people who should otherwise remain eligible to lose coverage, reducing access to care and leading to poorer health outcomes and preventable deaths, particularly for individuals with chronic conditions. In turn, this will cause individuals to be unable to work and lead to decreases in labor force participation—the exact opposite of the stated purpose of the Rule. Additionally, CMS significantly underestimates the Rule's impact. It will dramatically increase burdens on providers, including causing increased levels of uncompensated care as patients lose or are denied insurance coverage, an inability to maintain continuous health care for sick or higher need patients, and impossible demands on health care providers. Safety net health care providers are especially threatened, particularly hospitals that furnish a disproportionate percentage of uncompensated care, as well as community health centers, state and local public health clinics, and clinics providing specialized care for people with mental illnesses, substance use disorders, or HIV.

For these reasons, we urge HHS to rescind the Rule and issue a subsequent Rule that is consistent with the law and appropriately accounts for the significant health, public health, and economic harms the Rule will cause.

APHA is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and health-related businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness.

The Jacobs Institute of Women's Health is based at the Milken Institute School of Public Health at George Washington University and publishes the peer-reviewed journal Women's Health

Issues. Its mission is to identify and study aspects of healthcare and public health, including legal and policy issues, that affect women's health at different life stages; to foster awareness of and facilitate dialogue around issues that affect women's health; and to promote interdisciplinary research, coordination, and information dissemination. The Institute supports policies that promote women's access to comprehensive health care and other conditions that enable them to live healthy lives.

The National Center for Medical-Legal Partnership (NCMLP), based at the Milken Institute School of Public Health at the George Washington University, leads education, research, and technical assistance efforts to help health organizations throughout the United States incorporate legal aid services as a standard component of their response to health-related social needs. Medical-legal partnerships integrate the unique expertise of lawyers into health care settings to help health care teams, providers, and systems address the root causes of poor health outcomes and costs. NCMLP aims to shift healthcare practices and policies to proactively consider legal needs and solutions as part of a comprehensive approach to patient care. We achieve this by leading efforts to transform policy and practice, convene stakeholders, build evidence, and attract investment to support medical-legal partnerships.

The individual signatories are distinguished deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals known for their expertise in access to healthcare, including Medicaid as the leading insurer for low-income people and other populations that face systemic barriers to essential healthcare services. The individual signatories join this comment in their individual capacities and not as representatives of their respective institutions. The complete list of individual signatories is included at the end of this letter.

I. The Medicaid Community Engagement Requirement Rule Violates the Law

A. The Rule's Restrictive Definition of Medical Frailty Impermissibly Narrows the Statutory Exclusion and Exceeds the Secretary's Delegated Authority.

1. The "Significantly Impairs" Test Conflicts with the Statute's Own Terms for "Specified Excluded Individual."

The "significantly impairs" standard in the Rule contradicts the statute. The statutory exclusion for individuals who are medically frail or who have special medical needs unambiguously specifies five categories of individuals who must be excluded from the community engagement requirements. Section 1902(xx)(9)(A)(ii)(V) of the Act includes in the definition of "specified excluded individual" an individual who is medically frail or otherwise has special medical needs, "*including* an individual—(aa) who is blind or disabled (as defined in section 1614); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of

daily living; or (ee) with a serious or complex medical condition"[3] (emphasis added). Congress clearly defined these categories by the existence of a medical condition, not by any individual's ability to work, with the sole exception of the Social Security definition of disability in (aa). The Rule, however, redefines the entire medically frail exclusion to reach only those individuals whose "physical, mental, or other behavioral health condition *significantly impairs* the individual's ability to comply with the community engagement requirement"[4] (emphasis added). That extra-statutory test of ability to work exceeds the authority Congress conferred and is contrary to law.

The Secretary's authority to define individuals who are medically frail or who otherwise have special medical needs does not extend as far as CMS contends. Congress delegated authority to define who is medically frail or otherwise has special medical needs,[5] but the statute simultaneously requires that the definition "*includ[e]*" the five enumerated categories of individuals. The word "including" is widely understood as a word of enlargement, expansion, and illustration that is best read to mean "to contain as part of something."[6] The term "including" in 1902(xx)(9)(A)(ii)(V) establishes a floor, not a list of illustrative examples that the Secretary may narrow through added qualifications.[7] The five categories in (aa) through (ee) are mandatory components of the statutory definition, and CMS concedes as much: it acknowledges that its definition must "include[] the five categories specified at section 1902(xx)(9)(A)(ii)(V)."[8] Where CMS is incorrect, however, is that the Secretary's discretion only applies to the umbrella phrase "medically frail or otherwise has special medical needs (as defined by the Secretary)." The parenthetical delegating the Secretary the authority to define "medically frail" or "otherwise hav[ing] special medical needs" does not give him authority to add a work-capacity requirement into each of the categories of individuals Congress mandated be excluded in the subparagraphs that follow. By restricting each enumerated category to require a separate showing that the condition significantly impairs the ability to work, the Rule impermissibly narrows the statutory floor.

Section 1902(xx) of the Act's statutory structure confirms this reading and further demonstrates that it is the only permissible reading of the statute. Congress cross-referenced the Social

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[3] Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act.
[4] 42 C.F.R. § 435.554(c)(5)(i); 91 Fed. Reg. at 33472.
[5] Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act ("who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual— . . . "). The parenthetical "(as defined by the Secretary)" immediately follows and modifies the umbrella phrase "medically frail or otherwise has special medical needs." It precedes the word "including," which introduces the five mandatory subcategories. As a matter of statutory syntax, the delegation attaches to the term being defined, not to the enumerated categories that Congress itself defined by specifying them in the statute.
[6] *Include*, Black's Law Dictionary (11th ed. 2019) ("To contain as part of something. The participle *including* typically indicates a partial list . . . some drafters use phrases such as *including without limitation* and *including but not limited to*—which mean the same thing.").
[7] *See Federal Land Bank of St. Paul v. Bismarck Lumber Co*., 314 U.S. 95, 100 (1941) ("the term 'including' is not one of all-embracing definition but connotes simply an illustrative application of the general principle").
[8] 91 Fed. Reg. at 33373.

Security disability standard, which turns on inability to engage in substantial gainful activity, in only subparagraph (aa). The remaining categories (i.e., substance use disorder, disabling mental disorder, physical, intellectual or developmental disabilities that impact an ADL, and serious or complex medical condition) are stated as conditions alone, joined by "or," with no ability to work qualifier. In fact, the functional limitation test for individuals with disabilities expressly provided for in the statute in (dd) (requiring a "disability that significantly impairs their ability to perform 1 or more activities of daily living") allows individuals to qualify for the exclusion without meeting such a punishing ability to work standard, and in fact, many individuals with ADL limitations are able to work. Congress explicitly excluded this population in (dd) from the work requirement without requiring that their limitations impact their ability to work, recognizing the important services Medicaid provides to people with disabilities and showing how the Rule directly conflicts with the scope of this exclusion.

Under ordinary canons of construction, where Congress includes limiting language in one subsection but omits it from others, the omission is presumed deliberate.[9] The Rule inverts that canon: it extracts the inability to engage in substantial gainful employment construct Congress placed only in subparagraph (aa) and imposes a similar work-impairment test onto every category. Congress knew how to condition an exclusion on impaired ability to work and did so selectively in only subparagraph (aa); CMS may not supply the limitation Congress deliberately withheld for each of the other categories of individuals who are medically frail or have a serious or complex medical condition. Indeed, if every category required a Social Security disability-type showing, the separately enumerated categories, especially the ADL limitation for disabled individuals, would be surplusage.

CMS' unlawful addition of the "significantly impairs" standard is particularly egregious with respect to the category of individuals with "a serious or complex" medical condition. The statutory text leaves no question that such individuals must be excluded from the work requirement without limitation, including showing that their condition makes them unable to work. Congress added language about severity or acuity in other exclusions and intentionally did not do so for this population. Consider that, for example, the statute says that for individuals with mental disorders, the condition must be *disabling*. Similarly, for individuals with physical, intellectual, or developmental disabilities, the disability must impact *at least 1 ADL*. The statute includes no such qualifier before "serious or complex medical condition," demonstrating that the significant impairment test conflicts with the statute.

Moreover, the "significantly impairs" requirement will disproportionately burden and lead to unlawful coverage loss for a key population of individuals with serious or complex medical conditions that the statute explicitly sought to protect: older, poor working-age adults who are health-burdened and nearing the end of their work life (i.e., individuals with serious or complex medical conditions). Among the most vulnerable Medicaid adult group enrollees are individuals living with chronic health conditions such as cancer, HIV, serious heart or pulmonary conditions,

[9] *Russello v. United States*, 464 U.S. 16, 23 (1983).

and other conditions that can be managed with proper care. Paradoxically, Medicaid coverage enables this population to work when they can.[10] The truth—and one that CMS is fully aware of given states' past Medicaid community engagement experiments—is that health-burdened poor working age adults depend on access to stable and continuous health care to be able to work.[11] Yet the Rule not only adds an unlawful condition of eligibility but also demands evidence (proof of inability to work) that state Medicaid programs are not prepared to develop and that health care providers lack the competence and financial support to measure.

Relatedly, the Rule's significant narrowing of the medical frailty exemption is also in tension with other categories excluded from the community engagement requirements, adding to the arbitrariness and capriciousness of the rule discussed in section II of this comment. Specifically, the Rule allows for exemptions from the community engagement for family caregivers who provide care to people with disabilities, as defined under the Americans with Disabilities Act.[12] Yet in many cases, because the disabled person would have to meet the Rule's incredibly high bar of showing that their condition substantially impairs their ability to work, the family caregiver will be exempted but the disabled person to whom they are providing care would not be.

Finally, although courts need to look no further than the plain text of the statute to determine its meaning, the legislative history is instructive here too. In particular, Congressional statements made contemporaneously with the statute's consideration and passage make clear that the Rule's ability to work restrictions are inconsistent with Congressional intent. Members of Congress repeatedly described the medically frail exclusion in purely condition-based terms, with no suggestion that beneficiaries would also need to prove their condition impairs their ability to work. For example, Chairman Guthrie assured the public that individuals are "exempt if you're medically frail, which includes anyone who's blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer," and that "our bill couldn't be clearer" that it "includes a long list of exempted individuals."[13] Senator Grassley likewise explained that Congress provided "reasonable exemptions" for "[i]ndividuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition," tracking the statute's plain terms without reference to

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[10] Compared to other working-age adults, those who work and are low-income are significantly more likely to work at physically demanding jobs; more than half do so; The SCEPA Team. (2017, January 6). Over Half of Low-Wage Older Workers Have Physically Demanding Jobs. Schwartz Center for Economic Policy Analysis The New School. https://www.economicpolicyresearch.org/research/over-half-of-low-wage-older-workers-have-physically-demanding-jobs

[11] Sommers Benjamin D., Goldman Anna L., Blendon Robert J., Orav E. John, & Epstein Arnold M. (2019). Medicaid Work Requirements - Results from the First Year in Arkansas. New England Journal of Medicine, 381(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772

[12] 91 Fed. Reg at 33369–33370.

[13] Center for Health Law and Policy Innovation. (2026, June 17). A Shift Between Congressional Intent and Implementation: Work Requirements. Harvard Law School. https://chlpi.org/wp-content/uploads/2026/06/HCIM_Congressional-Quotes_FINAL_6.17.26-1.pdf

any independent work-capacity threshold.[14] Senator Crapo assured colleagues that the legislation "does not take Medicaid away from . . . the medically frail,"[15] and Senator Sullivan touted exemptions for "individuals who are medically frail or are dealing with a substance use disorder" as unqualified protections.[16] None of these contemporaneous statements suggested that Congress intended medically frail individuals to bear the additional burden of proving that their condition "significantly impairs" their ability to work, confirming that CMS's added requirement is inconsistent with Congress's own understanding of the exclusion it enacted.

In summary, the Rule directly conflicts with the best and only permissible reading of the statute.[17] CMS reasons that the phrase "medically frail or otherwise has special medical needs" in the statute "connotes diminished functional capacity" and therefore requires that a condition impair the ability to meet the community engagement requirement, warning that otherwise individuals capable of 80 hours of monthly activity would qualify.[18] But it is the enumerated categories, not the umbrella phrase, that determine who must be excluded, and Congress defined those categories by condition. CMS's own explanation exposes the overreach: the Rule states that "if a person is able to demonstrate community engagement by performing 80 hours per month of qualifying community engagement activities, notwithstanding their physical, mental, or other behavioral health condition, they would not qualify as medically frail."[19] The Rule additionally states that "it is [not] reasonable to categorically consider conditions as serious or complex without factoring in criteria such as the severity of the condition."[20] That transforms a condition-based, categorical exclusion into an ability-to-work test that appears nowhere in the enumerated categories. The five-year "stable recovery" carve-out CMS engrafts onto the substance use disorder category[21] is a further instance of the same defect: Congress excluded individuals "with a substance use disorder" without qualification, and CMS cannot add a temporal limitation of its own invention. As demonstrated above, these aspects of CMS's Rule cannot be reconciled with the plain text of the governing statute.

2. The Statute Emphasizes E*x Parte* Determinations; the "Significant Impairment" Requirement and Self-Attestation Limitations Render the *Ex Parte* Language Meaningless.

The inability to work ("significant impairment") overlay in the Rule also cannot be squared with the verification framework Congress enacted in H.R. 1's community engagement requirements. Section 1902(xx)(5) of the Act directs States, when determining whether an individual is a specified excluded individual under paragraph (9)(A)(ii), to "establish processes and use reliable

[14] *Id*.
[15] *Id*.
[16] *Id*.
[17] *See* Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024).
[18] 91 Fed. Reg. at 33,373.
[19] *Id.*
[20] 91 Fed. Reg. at 33375.
[21] 91 Fed. Reg. at 33374.

information available to the State (such as payroll data or payments or encounter data [. . .]) without requiring, where possible, the applicable individual to submit additional information."[22] Congress thus contemplated that medical frailty would ordinarily be verified *ex parte*, using administrative data the State already has. The statute's own examples—specifically, payments and encounter data—can show that an individual has a diagnosis or has received services; they cannot show whether a condition "significantly impairs" that individual's capacity to work or volunteer 80 hours per month. In fact, there is no *ex parte* data that can show that an individual has a substantial impairment in their ability to work or volunteer, other than a Social Security disability determination (which is only one of the five categories of medical frailty). By defining the exclusion in terms of a functional judgment that administrative data cannot answer, the Rule renders the *ex parte* pathway Congress prioritized unavailable in precisely the cases it was designed to serve, and forces States to use the very "additional information" Congress told States to avoid "where possible." An interpretation that defeats the statute's chosen verification method is not a permissible statutory interpretation.

Finally, the Rule's restrictions on self-attestation contravene the flexibility Congress expressly preserved for states in H.R. 1 as they implement work requirements. Section 1902(xx)(3)(A) of the Act permits States to "elect to not require an individual to verify information" in order to deem specified excluded individuals—including the medically frail—compliant. The Rule nonetheless bars States, beginning January 1, 2028, from accepting a statement under penalty of perjury to establish medical frailty more than once "during the beneficiary's period of enrollment,"[23] and otherwise requires documentation whenever it is "reasonably available." More specifically, after the one time the state is permitted to verify using self-attestation, the State must verify using reliable information available to the State (e.g., claims or encounter data). When that information is insufficient, which CMS concedes may be the case for determining whether someone's condition "significantly impairs" their ability to work, the state must use documentation submitted by the individual or their provider.[24] Neither the "once-per-enrollment" cap nor the open-ended "period of enrollment" construct appears in the statute. These limits override a discretion the statute affirmatively conferred on the States and are contrary to law for that additional reason.

3. The Rule's Restrictive Eligibility Policies Conflict with Title XIX's Overarching Purpose of Providing Health Coverage and Other Key Title XIX Provisions.

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[22] Section 1902(xx)(5) of the Social Security Act.
[23] 42 C.F.R. § 435.557(f)(1)(ii); 91 Fed. Reg. at 33476.
[24] In the Rule, CMS acknowledges that "States may use an approach that relies on lists of qualifying diagnosis codes combined with utilization data and other factors, such as severity of conditions, to determine medical frailty or otherwise having other special medical needs. However, in some cases, reliable claims information may not be available to the State for individuals who are medically frail or otherwise have other special medical needs, particularly in cases where an individual recently obtained a diagnosis and medical services, but the claims data are lagging." 90 Fed. Reg. at 33406.

The Rule's restrictive eligibility policies are in tension with the purpose of Title XIX as a whole and various individual provisions contained therein. One need look no further than to one of the first sections of Title XIX—its appropriations provision—to understand that the principal objective of Medicaid is providing health care coverage.[25] This provision describes the purpose of Medicaid as:

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.[26]

Looking at the basic definition of "medical assistance" confirms this point. The statute defines "medical assistance" as "payment of part or all of the cost of the following care and services or the care and services themselves."[27]

The Affordable Care Act's expansion of health care coverage[28]—which has withstood consistent attempts to repeal it—remains an eligibility group under Title XIX to which Medicaid's general purpose of furnishing health care coverage continues to apply with equal force. Although this group must now comply with the work requirements mandated by H.R. 1, CMS is not free to implement it in a way that disregards the Medicaid program's purpose or other provisions of Title XIX.

For example, the implementation of the "significantly impairs" test for individuals with serious or complex medical conditions is in tension with the basic structure of Medicaid's eligibility and enrollment requirements, which operate like no other form of health coverage and permit people to enroll whenever they have a need for health care, rather than at fixed open enrollment time periods.[29] The fifth category of specified excluded individuals (i.e., individuals with serious or complex medical conditions) aligns with Medicaid's statutory requirement that embraces those whose serious health needs are the reason for application (i.e., individuals wishing to file an application have an ability to do so and receive a prompt eligibility determination and retroactive eligibility where applicable under sections 1902(a)(8) and (34) of the Act). But, by requiring that a State conduct or await an individualized capacity-to-work assessment before it can resolve eligibility for a person who has just presented with a new cancer diagnosis or cardiac event, for

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[25] Section 1901 of the Social Security Act. See also *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020). Although *Gresham* addressed the Secretary's authority in the context of a demonstration project under section 1115 of the Act, the opinion's underlying principle — that CMS's exercise of any delegated discretion (here, the discretion to *define* 'medically frail) must be exercised consistent with Medicaid's coverage-furnishing purpose — applies with equal force here

[26] Section 1901 of the Social Security Act.

[27] Section 1905(a) of the Social Security Act.

[28] Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

[29] Section 1902(a)(8) of the Social Security Act. See also section 1902(a)(34) of the Social Security Act (providing for retroactive eligibility which permits coverage of health care utilization preceding the date of application).

example, the Rule delays the "reasonably prompt" determination section 1902(a)(8) requires and jeopardizes the retroactive coverage section 1902(a)(34) guarantees for care already received.

As another example, the "significantly impairs" test and its accompanying verification requirements are in tension with the requirements in section 1943 of the Act. Added by the Affordable Care Act, section 1943 imposes a free-standing, preexisting obligation on all Medicaid eligibility and enrollment processes. Separate from section 1902(xx), section 1943 requires such processes to be streamlined and simplified. Such processes must coordinate with state health insurance exchanges and "to the maximum extent practicable . . . determine [] eligibility on the basis of reliable third-party data."[30] Similar to the arguments in section I.A.2 immediately above, the "significantly impairs" overlay also cannot be squared with this verification framework Congress enacted for Medicaid eligibility and enrollment overall. Because the "significantly impairs" test cannot be verified through such data, the Rule's documentation and clinician-attestation requirements are inconsistent with the streamlined, exchange-coordinated processes section 1943 demands.

Finally, a core tenet of the Medicaid statute that states must adhere to—and that CMS cannot disregard—is section 1902(a)(19) of the Act. A longstanding cornerstone of Title XIX, this provision is a mandate to " . . . assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."[31] The "significantly impairs" test and its broad application is antithetical to the requirement to be simple to administer and will significantly harm Medicaid's most vulnerable beneficiaries, as discussed in extensive detail in sections II and III of this comment.

From the first provisions in Title XIX defining the purpose of the Medicaid program to detailed and technical eligibility provisions to broad programmatic safeguards, the requirements of the Medicaid statute are clear that CMS cannot enact roadblocks to eligibility and enrollment where Congress has not explicitly authorized them, particularly where Congress has spoken directly and unambiguously to the precise question. The Rule's "significantly impairs" ability to work test is the most egregious example of such an unauthorized roadblock.

B. The Rule Is Arbitrary and Capricious Because it Ignores the Important Operational Consequences, Disregards Evidence of Predictable Coverage Loss, and Fails to Justify the Agency's Reversal of Position.

In addition to its illegality for exceeding the delegated statutory authority, the Rule—and particularly the medical frailty framework—is arbitrary and capricious for numerous reasons.

1. CMS Failed to Adequately Explain and Justify its Policies in the Rule.

[30] Section 1943 of the Social Security Act; Section 1413(c)(3) of the Affordable Care Act.
[31] Section 1902(a)(19) of the Social Security Act.

The Rule shows that the agency has failed to engage in the reasoned decision-making required by the Administrative Procedure Act. More plainly, CMS's justifications in support of its overly restrictive requirements lack evidence and do not withstand scrutiny. For example, to defend its reverification requirements, including the one-time-only limit on statements under penalty of perjury for medical frailty exemptions, CMS asserts that requiring documentation "will motivate individuals to access care."[32] That rationale is arbitrary for several reasons. First, it has no basis in the statutory text, which excludes the medically frail from the requirement rather than using their exclusion as a motivator for certain behavior. Second, it is unsupported by any study or data showing that conditioning an exclusion for work requirements on documentation causes medically frail people to seek care. Moreover, it is contradicted by the Rule's own recognition that many medically frail individuals "may not identify themselves as having a condition that could qualify them" even after completing a screening tool. If individuals do not recognize their qualifying conditions, documentation requirements cannot rationally be expected to "motivate" care-seeking; the predictable result is instead that eligible people will lose coverage.

The 12-month lookback for claims and encounter data is likewise arbitrary. The Rule directs States to verify medical frailty using "reliable information available to the State," but forbids consideration of any claims or encounter data older than 12 months on the theory that "older information may not reflect the individual's current condition."[33] CMS never grapples with the mismatch between that cutoff and the realities of Medicaid claims processing (e.g., lags among service, billing, and adjudication mean recent care is frequently not yet reflected in the data) nor with permanent conditions, such as quadriplegia, that require no recent treatment yet plainly qualify under the statute.[34] The limitation is especially irrational because CMS's own data systems use far longer reference periods. For example, its Transformed Medicaid Statistical Information System (T-MSIS) and its Chronic Conditions Warehouse rely on windows of roughly 24 months or more.[35] Adopting a 12-month cutoff that CMS's own program experience contradicts, without reasoned consideration of the drawbacks and impacts, is arbitrary agency action.

The once-per-enrollment cap on self-attestation for the medical frailty exemption is also arbitrary for related reasons. Because "period of enrollment" is not time-limited, an individual who attests to one qualifying condition may be barred from ever attesting again, including to a new and unrelated serious condition, for as long as she or he remains continuously enrolled. A beneficiary who attests to a malignant melanoma could not, years later, attest to a newly diagnosed breast cancer, though the statute would plainly exclude her. At the same time, because the Rule imposes no lockout on reapplication, a disenrolled individual may attest anew upon reapplying. In other words, the cap accomplishes little except to generate coverage churn, administrative cost, and

[32] 91 Fed. Reg. at 33406.
[33] 91 Fed. Reg. at 33405; 42 C.F.R. § 435.557(f).
[34] 91 Fed. Reg. at 33409.
[35] Centers for Medicare & Medicaid Services. (2025, June). Time Required for Complete TAF Data. https://www.medicaid.gov/dq-atlas/downloads/supplemental/3051-TAF-Data-Run-Out.pdf

interruptions in care. CMS did not reconcile these consequences with its stated goals, and its assumption that States will "generally . . . be able to reverify on an *ex parte basis*" once a beneficiary accesses care[36] rests on the same flawed premise that claims data can demonstrate functional impairment.

2. CMS Ignored the Rule's Provider Burdens, Predicable Coverage Losses, and Flawed Economic Assumptions.

CMS's inadequate and contradictory justifications demonstrate that CMS failed to consider important aspects of the problem the rule is intended to address. As just one illustrative example, nowhere in the Rule does CMS contend with the burden the Rule's "significantly impairs" test imposes on providers and State agencies. More specifically, because administrative data cannot establish that a condition impairs the ability to work, the test will in practice require clinician documentation and/or individualized State assessments of each beneficiary's capacity to work. These determinations are likely to resemble Social Security's complex disability adjudications, and yet CMS supplies no standard, no definition of "significant impairment," and no consideration of who will perform the assessments or how they will be funded. The Rule threatens States with penalties, including under the enhanced PERM audit program, if they approve medical frailty without sufficient support for a significant-impairment finding,[37] while entirely failing to provide guidance needed to make that finding. Providers are frequently unwilling or unable to complete such attestations—as New Hampshire's experience with a comparable requirement showed[38]—and the documentation workload is enormous: analyses estimate the requirement could cost health care facilities roughly $300 million per year and consume on the order of three million provider hours annually.[39] There is no indication in the Rule that CMS meaningfully considered any of this, and its failure to contend with the operational and provider burden of the *ultra vires* test it created is independently arbitrary and capricious.

Furthermore, as demonstrated by the discussions of substantial research about the impacts of administrative burdens and coverage loss in sections II and III, CMS either did not consider, or without explanation disregarded, extensive evidence that the administrative burdens it is imposing will predictably cause eligible people to lose coverage. Experience with Medicaid work requirements in Arkansas—where roughly 18,000 people lost coverage in seven months, an

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[36] 91 Fed. Reg. at 33407.
[37] 91 Fed. Reg. at 33377.
[38] Hill, I., Burroughs, E., & Adams, G. (2020, February). *New Hampshire's Experience with Medicaid Work Requirements*. Urban Institute. https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf
[39] Ku, L., Orgera, K., Kwon, K. N., Gorak, T., Krips, M., & Cordes J. J. (2026, June 9). *H.R. 1 Funding Cuts Will Overshadow Gains from the New Rural Health Transformation Program*. Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2026/jun/hr-1-funding-cuts-rural-health-transformation

estimated 95% of whom had met the requirement or qualified for an exemption[40]—and in Georgia, where enrollment reached only a small fraction of those eligible amid pervasive procedural denials[41], bears directly on the effects of the Rule's far harsher and more demanding regime. Based on the text of H.R. 1—not the more restrictive language of the Rule—the Congressional Budget Office estimated that at least [42] will lose Medicaid by 2034 due to added administrative steps alone,[OBJ] and CBO and the Urban Institute projected total coverage losses on the order of 5.2 to [43], the great majority of whom are working or exempt.[OBJ][44]Taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[OBJ] The Rule neither confronts this evidence nor explains why its individualized-assessment approach—more restrictive than any prior State's work requirement program—will avoid the same results. An agency that ignores the predictable, well-documented consequences of its action has not engaged in the reasoned decision-making required by law, and therefore its action must be set aside.

Along these same lines, the Rule's economic analysis is deeply flawed and arbitrary and capricious. More precisely, the Rule provides no evidence for its claim that Medicaid work requirements have a positive impact on employment and earnings. Indeed, the two analyses cited in the Rule regarding the impact of the Rule are both deeply inaccurate in their estimates and assumptions.

CMS released its regulatory impact statement quantifying the benefits and costs of Medicaid work requirements, as required by federal rules.[45] The regulatory impact statement is a required element of federal regulations, intended to demonstrate to the public that the government

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[40] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid 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

[41] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker; Thomas, G. (2024, September 5). *Georgia Pathways to Coverage*. Georgia Department of Community Health. https://dch.georgia.gov/document/document/comprehensive-health-coverage-meeting-slide-deckdch-presentation-002/download; Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[42] Congressional Budget Office. (2025, October 28). *Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid*. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[43] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461; Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work

[44] Boozang, P.M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034*. Mannatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034

[45] 91 Fed. Reg. at 33348.

seriously considered potential benefits and costs of its regulation, in order to minimize harm. Analyses conducted by an independent researcher at George Washington University Milken Institute School of Public Health[46] found that CMS overestimates the benefits of Medicaid work requirements, underestimates the harm (or "costs"), and fails to acknowledge that the loss of Medicaid coverage will reduce access to health care and medications, imperil health for needy Americans, harm the nation's health care providers, and damage state economies.[47]

Specifically, the CMS impact statement claims that about five million additional Medicaid beneficiaries will engage in work because of the new rules, and estimates that this will increase incomes and tax revenues. However, as cited in the GW analysis, CMS does not provide any evidence as to where five million additional jobs will come from. In 2025, the US only created 181,000 new jobs. [48] Opportunities for low-income Medicaid beneficiaries are also in less demand, with new job growth favoring those with higher education and specialized job skills.[49] A large body of research has established that Medicaid and SNAP work requirements are unable to significantly increase employment or incomes; instead, the most consistent effects of work requirements are to cause upwards of 50% of targeted recipients to lose health or nutrition benefits.[50] [51] [52] [53] [54]

The CMS impact report also underestimates how many individuals will lose Medicaid coverage. CMS' estimate that 3.1 to 3.3 million individuals will lose coverage is far below expert estimations. Based on the text of HR 1, CBO, RAND, and Urban Institute estimated coverage

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[46] The analysis was led by Leighton Ku, Ph.D., Professor and Director of the Center for Health Policy Research at the George Washington University Milken Institute School of Public Health, who is also an individual signatory to this comment.

[47] Ku, L. (2026, June 29). *Commentary: The Administration's Flawed and Misleading Claims About Medicaid Work Requirements*. The George Washington University Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/commentary-administrations-flawed-and-misleading-claims-about-medicaid-work-requirements

[48] Kopack, S. (2026, February 11). *U.S. had almost no job growth in 2025*. NBC News. https://www.nbcnews.com/business/economy/january-jobs-revisions-trump-rcna258398

[49] Center on Education and the Workforce. (n.d.). *Projections of Jobs, Education, and Training Requirements through 2031*. Georgetown University McCourt School of Public Policy. https://cew.georgetown.edu/cew-reports/projections2031/

[50] Congressional Budget Office. (2022, June 9). *Work Requirements and Work Supports for Recipients of Means-Tested Benefits*. https://www.cbo.gov/publication/57702

[51] Han, J. (2022). The impact of SNAP work requirements on labor supply. *Labour Economics*, *74*, 102089. https://doi.org/10.1016/j.labeco.2021.102089

[52] 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

[53] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid 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

[54] Gangopadhyaya, A., & Karpman, M. (2025). The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data. *Health Services Research*, *60*(5), e14624. https://doi.org/10.1111/1475-6773.14624

loss among five to seven million individuals.[55] [56] [57] The Rule's more restrictive approach to determining "medical frailty"—requiring applicants to demonstrate that their conditions will "significantly impair" their ability to work or volunteer—is likely to increase the number who lose Medicaid coverage, and may exceed the CBO, RAND, or Urban Institute estimates of coverage losses.[58] Indeed, taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[59] Compared to the CBO estimates, CMS also estimates 34% less in federal funding losses due to work requirements.[60] Last, CMS' impact report ignores the enormous economic fallout of Medicaid work requirements. (See Section III, Part E in this comment for more on this.)

Second, the Office of the Assistant Secretary for Planning and Evaluation (APSE) released a report in June 2026—simultaneous with the release of the Rule—that claims that new Medicaid work requirements will improve household earnings and move 1.6 million to 2.9 million people out of poverty.[61] However, these estimates rest upon deeply flawed assumptions and estimates.[62] ASPE's claim that "work requirements can remove 2.9 million out of poverty" is based on the assumption that the nearly six million people who will be subject to work requirements but are not currently meeting these requirements can *immediately* increase work hours to comply with requirements. ASPE's claim that "work requirements can remove 1.6 million people out of poverty" is based on the assumption that half of these individuals (3.3 million) can immediately increase work hours to comply. Both estimates assume that employment will be immediately available to millions of individuals, despite the numerous social and economic barriers that

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[55] Congressional Budget Office. (2025, June 4). *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*. www.cbo.gov/publication/61461

[56] Rao, P., Baker, L., Girosi, F., Li, E., Kerber, R., & Eibner, C. (2026, June 18). S*tate-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*. RAND. https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html

[57] Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work?&utm_source=newsletters&utm_id=health_and_health_care&utm_campaign=HPC

[58] Wagner, J., & Orris, A. (2026, June 3). *Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/administrations-last-minute-restrictions-likely-to-worsen-impact-of-medicaid-work

[59] Boozang, P.M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034*. Mannatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034

[60] Congressional Budget Office. (2025, July 21). *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*. https://www.cbo.gov/publication/61570

[61] Berman, D., Burnszynski, J., Ghertner, R., Macartney, S., Swenson, K., Mulligan, C. B., & Bai, G. (2026, June 1). *Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce Poverty*. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/medicaid-work-requirements-should-incentivize-employment-reduce-poverty

[62] Frank, R. G., & Glied, S. (2026, June 12). *ASPE's Analysis Of Medicaid Work Requirements: Argument By Assumption*. Health Affairs Forefront. https://www.healthaffairs.org/do/10.1377/forefront.20260611.20123

individuals face in finding employment and increasing hours. Many of these barriers are named by ASPE themselves in a 2021 report: lack of employment opportunities, lack of sufficient hours available, lack of transportation, lack of internet access, lack of sufficient education or job training, and more.[63] Moreover, both estimates assume that states will face no implementation challenges—which previous studies have shown is an impossible unsupportable assumption.

The ASPE report cites four studies as evidence that work requirements will have a positive impact on employment and earnings. However, ASPE misuses and misconstrues the findings from the studies. First, none of the cited studies focus on Medicaid work requirement programs; cited studies evaluate work requirements associated with TANF, housing benefits, and welfare-to-work programs.[64] [65] [66] [67] Second, all four studies focus on work requirements accompanied by intensive work supports—such as employment case management, job search support, subsidized employment, childcare, or transportation assistance—which are not included as part of implementation of the Medicaid community engagement requirement in H.R. 1 and the Rule. ASPE also misconstrues findings from the studies they cite; for example, ASPE claims that the Temporary Assistance for Needy Families (TANF) work requirements in Alabama resulted in increases in employment and earnings; however, they fail to mention that these increases resulted from a surge of families exiting the TANF program after the work requirements started.[68]

3. CMS Failed to Consider Significant Reliance Interests.

An agency that changes course must "display awareness that it is changing position" and account for the "serious reliance interests" its prior policy engendered.[69] For nearly a year before the Rule, CMS told the States that it would define medical frailty consistent with its longstanding medical frailty requirements in 42 C.F.R. § 440.315(f), that diagnoses and claims or encounter data could establish the exclusion, and that auditable self-attestations were acceptable when data

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[63] Office of the Assistant Secretary for Planning and Evaluation. (2021, March 11). *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/ecb3c24c41fa4cc18b6ad0243e197c05/medicaid-waiver-evidence-review.pdf

[64] Rohe, W. M., Webb, M. D., & Frescoln, K. P. (2016). Work Requirements in Public Housing: Impacts on Tenant Employment and Evictions. *Housing Policy Debate*, *26*(6), 909–927. https://doi.org/10.1080/10511482.2015.1137967

[65] Congressional Budget Office. (2023, March 9). *The Effects of Work Requirements on the Employment and Income of TANF Participants: Working Paper 2023-03*. https://www.cbo.gov/publication/58867

[66] Research Evidence on the Impact of Work Requirements in Need-Tested Programs. (2026, July 23). https://www.congress.gov/crs-product/R45317

[67] Office of the Assistant Secretary for Planning and Evaluation. (n.d.). *Technical Methodology for Comparing the Impact of Work Promotion Strategies in Health and Welfare Programs*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/appendix-medicaid-work-requirements-study

[68] Congressional Budget Office. (2023, March 9). *The Effects of Work Requirements on the Employment and Income of TANF Participants: Working Paper 2023-03*. https://www.cbo.gov/publication/58867

[69] FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515 (2009); Encino Motorcars, LLC v. Navarro, 579 U.S. 211, 221–22 (2016); Dep't of Homeland Sec. v. Regents of the Univ. of Cal., 591 U.S. 1, 30 (2020).

were unavailable. States designed their eligibility systems in reliance on that guidance.[70] Beneficiary advocates, providers, and other community and public health organizations also relied on this information to plan their beneficiary outreach strategies.[71] Contrary to CMS's preliminary guidance, the Rule abruptly changed direction and imposes a functional-impairment test and self-attestation limits that appear nowhere in the prior guidance. Nothing in the Rule acknowledges the agency's changed position, nor does it explain why the earlier approach was abandoned or address the reliance and implementation costs its reversal imposes on the States and the larger public health community. That failure alone renders the Rule arbitrary and capricious.

II. The Work Requirement Rule Creates Unnecessary Administrative Burdens That Will Cause Millions of People Who Are Otherwise Eligible for Medicaid to Lose Necessary Coverage.

Any work requirement creates administrative and compliance burdens. However, the Rule's particularly restrictive requirements (including imposing an individualized ability to work assessment for the medical-frailty exclusion, limiting self-attestation, and restricting the lookback period to 12 months) compound those burdens far beyond what the statute requires. None of these requirements outlined in the Rule are compelled by the statutory text; in fact, they are inconsistent with the text of the statute and inconsistent with Congress' clear intent to minimize unnecessary administrative burdens. Instead, through the Rule, CMS has chosen to maximize these administrative burdens, which will lead to coverage denials far worse than even the significant losses that have previously occurred in other work requirement experiments.

The Rule's definition of medical frailty—especially the additional requirement to show that a condition "substantially impairs" one's ability to work or volunteer—imposes harsh administrative burdens on potential enrollees and current beneficiaries, which will lead to widespread loss of Medicaid coverage for people who need and are otherwise entitled to access this critical source of health care. The medical frailty determination will require an individualized assessment, making the Rule more restrictive and burdensome than any previous state-imposed work requirement.

Data, studies, and first-hand accounts show that Medicaid work reporting requirements impose burdensome administrative barriers, also known as red tape. This "red tape" leads to denials of or loss of Medicaid coverage for individuals who meet the substantive work requirement or exemption criteria, and therefore should remain enrolled or eligible to enroll. Some of these

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[70] Tolbert, J., Diana, A., Mudumala, A., Brooks, T., Yafimenka, Y., & Lin, A. (2026, April 30). *An early look at policy decisions as states get ready to implement work requirements: Results from the 2026 Medicaid eligibility, enrollment, and renewal policies annual survey.* KFF. https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/

[71] Brykman, K. (2026, April). Data and analytic approaches for medical frailty exemptions to federal Medicaid work requirements. Center for Health Care Strategies. https://www.chcs.org/media/Data-and-Analytic-Approaches-for-Medical-Frailty-Exemptions.pdf; McIntyre, A., Ne'eman, A., & Sommers, B. D. (2026). How to minimize avoidable coverage losses under Medicaid work requirements. JAMA Health Forum, 7(5), e262321. https://doi.org/10.1001/jamahealthforum.2026.2321

barriers are caused by confusing notices and procedures, challenging exemption documentation, limited administrative support for beneficiaries, complex reporting systems, and more. A 2021 report from ASPE found that "large-scale difficulties with meeting reporting requirements have posed risks of coverage loss for many beneficiaries across multiple states implementing work requirements."[72] Further, a report by the Robert Wood Johnson Foundation analyzing experience with work requirements noted that "[m]any studies find that the red tape is often prohibitive and strips people of vital benefits."[73] CMS even recognized the substantial paperwork burdens of the work requirement and estimated that beneficiaries will need to spend *two hours every six months* on paperwork and the value of lost consumer time would be more than $500 million per year.[74]

These burdens fall particularly hard on individuals with chronic illnesses, who are more likely to report experiencing these administrative burdens when applying for Medicaid. A 2025 report found that 29% of people with a chronic illness report a compliance burden with Medicaid, compared to 19% of people without a chronic illness.[75] Reports also highlight how people with disabilities are more likely to experience administrative burdens that result in coverage losses when trying to comply with work reporting requirements.[76] Procedural hurdles and administrative burdens also disproportionately impact Black and Hispanic people trying to receive and maintain coverage under public benefit programs.[77] Additionally, Black and

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[72] Office of the Assistant Secretary for Planning and Evaluation. (2021, March 10). *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence

[73] Robert Wood Johnson Foundation. (2023, May). *Work Requirements: What Are They? Do They Work?* https://stateofchildhoodobesity.org/wp-content/uploads/2023/05/rwjf473381.pdf; Hahn, H. (2018, April). *What Research Tells Us About Work Requirements*. Urban Institute. https://www.urban.org/sites/default/files/publication/98425/what_research_tells_us_about_work_requirements_21.pdf

[74] 91 Fed. Reg. at 33434 (Table 15).

[75] Roll, S., Despard, M., & Chun, Y. (2025). *The experience of administrative burdens in SNAP and Medicaid: New evidence from a nationally representative survey of low-wage workers* (CSD Research Brief No. 25-52). Washington University, Center for Social Development. https://doi.org/10.7936/htq4-vt81

[76] Machledt, D. (2024, December 16). *How Medicaid Work Requirements Hurt People with Disabilities*. National Health Law Program. https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2/; Machledt, D., & Lav, J. (2025, December 3). *Recommendations for Mitigating Harms to People with Disabilities, Older Adults, and Caregivers from Medicaid Work Requirements*. National Health Law Program. https://healthlaw.org/resource/recommendations-for-mitigating-harms-to-people-with-disabilities-older-adults-and-caregivers-from-medicaid-work-requirements/; Sachar, A., Diana, A., Burns, A., & Tolbert, J. (2026, July 29). *What could Medicaid work requirements mean for SSI applicants?* KFF. https://www.kff.org/medicaid/what-could-medicaid-work-requirements-mean-for-ssi-applicants/. Although CMS in the Rule acknowledges that the Americans with Disabilities Act, section 504 of the Rehabilitation Act and section 1557 of the Affordable Care Act provide these individuals with rights to reasonable accommodations related to work requirements, 91 Fed. Reg. 33407, the Rule does nothing more. It entirely fails to contend with what this means or provide states with any guidance about how such accommodations could be ensured in light of the rules overly restrictive requirements (e.g., prohibitions on attestations after 2028).

[77] Haeder, S. F., & Moynihan, D. (2023). Race And Racial Perceptions Shape Burden Tolerance For Medicaid And The Supplemental Nutrition Assistance Program. *Health Affairs*, *42*(10), 1334–1343. https://doi.org/10.1377/hlthaff.2023.00472; *See also* Herd, P., Hoynes, H., Michener, J., & Moynihan, D. (2023).

Indigenous people report significantly higher rates of disability, which further compounds the impacts on people of color with disabilities.[78]

In October 2025, the CBO estimated that at least 2.8 million people will lose Medicaid coverage by 2034 solely due to administrative burdens from HR 1 work requirements; this number is in addition to coverage loss estimates from other provisions in the bill.[79] The CBO report notes that most of these people who lose coverage under the community engagement requirements will remain uninsured because they are unable to get insurance elsewhere.[80] To understand the likelihood of widespread coverage loss due to administrative burdens under the Rule, one can look to examples of how these types of burdens have resulted in coverage loss in similar situations and the impact on individual and population health outcomes. Specifically, data from state-level work requirements in Arkansas and Georgia, early implementation of HR 1 in Nebraska, and post-COVID-19 Medicaid unwinding demonstrate the harms of administrative burdens facing people who will be trying to meet the work requirements under the IFC in order to enroll in or maintain Medicaid coverage.

A. The Process Outlined in the Rule Cultivates the Same—or Even More—Administrative Barriers that Contributed to Widespread Coverage Loss under Arkansas's and Georgia's Medicaid Work Requirement Programs.

From 2018 to 2019, Arkansas implemented work requirements in its Medicaid program,[81] and in 2023, Georgia began implementing its Medicaid work requirement program[82] that is still in effect. In both Arkansas and Georgia, current and potential beneficiaries reported numerous barriers to Medicaid enrollment due to complex work rules and burdensome application processes.[83]

Introduction: Administrative Burden as a Mechanism of Inequality in Policy Implementation. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, *9*(4), 1. https://doi.org/10.7758/RSF.2023.9.4.01; Michener, J. (2020). Race, Politics, and the Affordable Care Act. *Journal of Health Politics, Policy and Law*, *45*(4), 547–566. https://doi.org/10.1215/03616878-8255481

[78] Machledt, D. (2024, December 16). *How Medicaid Work Requirements Hurt People with Disabilities*. National Health Law Program. https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2/

[79] Congressional Budget Office. (2025, October 28). *Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid*. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[80] *Id*.

[81] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid 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

[82] Rayasam, R., & Whitehead, S. (2024, September 13). *The First Year of Georgia's Medicaid Work Requirement Is Mired in Red Tape*. KFF Health News. https://kffhealthnews.org/health-care-costs/georgia-medicaid-work-requirement-red-tape/

[83] Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care*. Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care; Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and

1. Current Enrollees Who Are Eligible to Receive and Are Currently Receiving Medicaid Will Wrongly Lose Coverage and Access to Healthcare Due to Administrative Barriers Under the IFC.

When Medicaid work requirements were in effect in Arkansas, enrollees who were working or should have been exempt lost coverage due to administrative errors and confusion. The processes outlined in the IFC run the same risk of causing individuals who meet Medicaid's eligibility requirements to wrongly lose coverage. Over 18,000 people lost Medicaid coverage in Arkansas during the seven months that its work requirement was in effect.[84] This amounts to one in four individuals who were subject to Arkansas's work requirement losing their health insurance coverage.[85] Of the individuals who lost coverage in 2018, only 11% reapplied for and regained coverage the following year,[86] with many likely remaining uninsured.

Arkansas relied heavily on data-matching to attempt to determine whether enrollees met the work requirements or qualified for an exemption.[87] Arkansas's data matching program was supposed to exempt workers, caregivers, students, or disabled individuals, but failed to identify many of these individuals for exemptions.[88] According to CMS, Arkansas was only able to automatically identify work hours or exemption status for 69% of enrollees, leaving over 30% of enrollees with the burden of having to manually report their activities.[89] Of the nearly 18,000 people who lost coverage over seven months the work requirements were in place, an estimated 95% had met the work requirement or were exempt and therefore should have remained enrolled.[90] A May 2026 study found that when beneficiaries are required to manually report their

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Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

[84] Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[85] Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be; *see also* Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[86] Rudowitz, R., Musumeci, M., & Hall, C. (2019, March 25). *February State Data for Medicaid Work Requirements in Arkansas*. KFF. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[87] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

[88] Harker, L. (2023, August 8). *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

[89] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

[90] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid 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

work status, they are much more likely to be deemed noncompliant.[91] Researchers estimated that if all individuals in Arkansas' program were required to manually report, "noncompliance" would rise to 98%.[92]

Importantly, Arkansas spent months building its data-matching system and still failed to reach almost a third of enrollees.[93] The Rule gives states even less time to build out an even more complex data matching infrastructure. Due to the accelerated implementation of the Rule, many states will not be able to have reliable systems in place for accurate data matching to identify exempted individuals. As a result, with this Rule, states are likely to experience even lower rates of automated data matching, with an even larger share of beneficiaries having to go through the manual reporting process that is shown by various reports to be strongly correlated with an improper finding of "noncompliance" resulting in coverage loss.

Confusion about the work requirement in Arkansas was common, with 44% of the target population reporting that they were unsure whether the requirements applied to them.[94] Awareness of the work requirement among enrollees was also poor, even after the work requirement ended, as more than 70% of Arkansans were unsure whether the policy was in effect at that time.[95]

Similar confusion is currently happening in Nebraska, the first state to roll out the new Medicaid work requirements imposed by HR 1. One month into the May 1st rollout of the program, the media has reported that "state Medicaid staffers are having trouble telling enrollees whether they need to comply with work requirements, as the information is not readily available even to people within the government."[96] Similarly, reports are that some enrollees are also receiving inaccurate or conflicting information about their eligibility and experiencing long call center wait times.[97]

In implementing the statute, the CMS IFC requires redeterminations at least every six months, with an allowance for annual redeterminations of exemptions in some circumstances.[98] These frequent redeterminations for Medicaid coverage are risky and often lead to unnecessary coverage loss, as demonstrated in experiences from post-COVID Medicaid unwinding. In

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[91] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089
[92] *Id*.
[93] *Id*.
[94] 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. *New England Journal of Medicine*, *381*(11), 1073–1082. https://doi.org/10.1056/NEJMsr1901772
[95] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid 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
[96] Johnson, P. (2026, June 1). *Nebraska's Work Requirement Rollout Is a Mess. It's Going to Get Worse*. Health Payer Specialist. https://www.healthpayerspecialist.com/lead/enroll/5170944/734734
[97] *Id*.
[98] 91 Fed. Reg. at 33398.

response to the 2020 COVID-19 outbreak, the Families First Coronavirus Response Act included a provision requiring state Medicaid programs to maintain enrollment in exchange for additional federal funding.[99] In 2023, states went through a process called "Medicaid unwinding," where they were required to redetermine eligibility for all beneficiaries and disenroll those who were no longer eligible or did not complete the renewal process.[100] KFF reports that among people who were disenrolled during Medicaid unwinding, "nearly seven in ten (69%) were disenrolled for paperwork or procedural reasons while three in ten (31%) were determined ineligible."[101] An astonishing 74% of people in Georgia who lost Medicaid during the post-COVID unwinding were disenrolled for procedural reasons and not because they were actually determined to be ineligible.[102] Their inappropriate disenrollment due to administrative barriers has long term consequences. According to a KFF national survey, about a quarter (23%) of people who lost Medicaid during unwinding remain uninsured.[103] In summary, not only do administrative barriers in Medicaid increase the likelihood that eligible beneficiaries lose coverage, they also increase the likelihood that these people will remain uninsured without coverage altogether.

B. Eligible People Applying for Medicaid Will Struggle to Enroll in Coverage Due to Administrative Barriers, Making it Harder to Gain Entry to the Program.

Similar to HR 1, under Georgia's work requirement, applicants must demonstrate compliance before they can enroll in and receive coverage. Unlike Arkansas, Georgia does not use data matching to prove an individual meets the work requirement or qualifies for an exemption and "instead relie[s] entirely on manual reporting."[104] A similar heavy reliance on manual reporting will be required by the IFC's medical frailty definition and the individualized assessment it requires to determine whether a person's condition significantly impairs their ability to work or volunteer. This two-part determination will be extremely hard, if not impossible, to determine from *ex parte* data or medical diagnostic codes alone.

This reliance on manual reporting is important because the medical frailty assessment imposed by the IFR is a harder factual question than the work hour reporting that already proved so burdensome for states to verify. Verifying that someone worked 80 hours in a given month or has a certain medical diagnosis is at least theoretically possible to provide documentation of, whether through providing a pay stub or medical records. By contrast, determining whether a medical condition "significantly impairs" a person's ability to work or volunteer is not the kind of

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[99] Moss, K., Dawson, L., Long, M., Kates, J., Musumeci, M., Cubanski, J., & Pollitz, K. (2020, March 23). *The Families First Coronavirus Response Act: Summary of Key Provisions*. KFF. https://www.kff.org/covid-19/the-families-first-coronavirus-response-act-summary-of-key-provisions/

[100] Lopes, L., Sparks, G., Presiado, M., Tolbert, J., Rudowitz, R., Diana, A., & Kirzinger, A. (2024, April 12). *KFF Survey of Medicaid Unwinding*. KFF. https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/

[101] KFF. (2026, July 1). *Medicaid/CHIP Monthly Enrollment Tracker*. https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8

[102] *Id*.

[103] *Id*.

[104] Henderson, M., Spicer, L., & Middleton, A. (2026). A Tale of Two States: Reconciling Medicaid Work Requirement Enrollment Impacts in Georgia and Arkansas. *AEA Papers and Proceedings*, *116*, 326–330. https://doi.org/10.1257/pandp.20261089

information that easily exists in a database or appears on the face of a diagnosis code. Under the Rule, states will have to push medical frailty determinations into a manual reporting and documentation process similar to (but even harsher than) Georgia's process, which has resulted in low enrollment rates and widespread barriers to coverage.

Georgia's enrollment numbers have consistently been extremely low since its work requirement began. Roughly 20 months into the program, only 7,000 individuals were successfully enrolled, out of the 240,000 uninsured people estimated to be eligible.[105] An interim evaluation of the demonstration found that the "magnitude of difference [between the state's projected enrollment vs. actual enrollment] suggests that many individuals who would be eligible for Pathways are not applying to the program."[106] Application data suggests that in some months, upwards of 40% of people who started applications for Georgia's program gave up.[107] As of April 2026, only roughly 16,700 Georgia residents were enrolled in Georgia's Medicaid demonstration titled "Georgia Pathways to Coverage."[108] After two years of the demonstration project, nearly half of Georgia's counties have 25 or fewer residents ever enrolled in the program, with two counties having zero enrollees.[109] This is likely a major contributor to Georgia's status as the state with the second-highest uninsurance rate.[110]

Focus groups also suggest that many individuals do not feel comfortable applying because they are concerned their application would not be approved, likely due to the complex process and high denial rates in the first year of the program.[111] Georgia Budget and Policy Institute reports

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[105] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker; Thomas, G. (2024, September 5). *Georgia Pathways to Coverage*. Georgia Department of Community Health. https://dch.georgia.gov/document/document/comprehensive-health-coverage-meeting-slide-deckdch-presentation-002/download; Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[106] Public Consulting Group. (2024, December 16) *Pathways Demonstration program interim evaluation report* at A28. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-pa-04282025.pdf (attached as Appendix A to Ga. Dept. of Community Health. Georgia Section 1115 demonstration waiver extension request (April 28, 2025))

[107] Harker, L. (2024, December 19). *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care

[108] Georgia Pathways. (2026, May 31). *Current Enrollment*. https://www.georgiapathways.org/data-tracker

[109] Chan, L. (2025, October 13). *Pathways to Coverage: Looking Back Two Years and Into the Future*. Georgia Budget & Policy Institute. https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/

[110] Fortuna Health. (2026, March 30). *What Medicaid Leaders Think About H.R. 1: Themes Across Three AHIP Panels*. https://www.fortunahealth.com/resources/what-medicaid-leaders-think-about-h-r-1-themes-across-three-ahip-panels

[111] *Id.;* Chan, L. (2024, October). *Georgia's Pathways to Coverage Program: The First Year in Review*. Georgia Budget & Policy Institute. https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf

that 22% of application denials and 30% of disenrollments from Georgia's program were due to procedural barriers, such as missing forms.[112]

Nebraska is already seeing similar instances of declines in enrollment; a health center in the state that usually enrolls around 15 people a month enrolled none in May 2026 after Nebraska implemented the work requirement early.[113] That health center's CEO said this drop in enrollment is unheard of for the organization and believes people are not coming in because they think they are not eligible or believe that "it's going to be too overwhelming or cumbersome to try to keep coverage."[114]

III. The Rule Will Cause Significant Harm to Millions of People Who Should be Eligible For Medicaid Under Title XIX But Will Lose Coverage Due to the Additional Barriers Required by the Rule

A. The Rule Will Harm People With Serious, Complex, and/or Chronic Medical Conditions Who Have Gotten Care That Helps Treat and Manage These Conditions Through the Medicaid Expansion.

Nearly half (44%) of Medicaid expansion enrollees have at least one *chronic condition*, defined as conditions that last at least one year and require ongoing medical care or limit daily activities (e.g, heart disease, diabetes, cancer, mental illness, etc.).[115] [116] Medicaid expansion adults experience high rates of both chronic physical and behavioral health conditions: 33% of expansion adults have a chronic physical condition, and nearly a quarter have a behavioral health condition.[117] The number of expansion adults with at least one chronic condition only increases with age: nearly 60% of expansion adults ages 50-64 have a chronic condition.[118]

Medicaid was specifically designed to allow people to enroll at the point of illness, ensuring immediate access to care when health needs are most urgent. H.R. 1 maintained a critical pathway for individuals with serious, complex, or chronic conditions to rapidly access care—consistent with extensive evidence that timely Medicaid access improves coverage, care utilization, and health outcomes for people requiring specialty services. Indeed, numerous studies

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[112] Fortuna Health. (2026, March 30). *What Medicaid Leaders Think About H.R. 1: Themes Across Three AHIP Panels*. https://www.fortunahealth.com/resources/what-medicaid-leaders-think-about-h-r-1-themes-across-three-ahip-panels; Chan, L. (2025, October 13). *Pathways to Coverage: Looking Back Two Years and Into the Future*. Georgia Budget & Policy Institute. https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/

[113] Grabenstein, H. (2026, June 5). *As states face stricter Medicaid work requirements, Nebraska is an early test*. PBS News. https://www.pbs.org/newshour/nation/as-states-face-stricter-medicaid-work-requirements-nebraska-is-an-early-test

[114] *Id.*

[115] Mathers, J., Tolbert, J., Chidambaram, P., & Cervantes, S. (2025, April 25). *5 key facts about Medicaid expansion*. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/

[116] Centers for Disease Control and Prevention. (2026, May 14). *About Chronic Diseases*. https://www.cdc.gov/chronic-disease/about/index.html

[117] Mathers, J., Tolbert, J., Chidambaram, P., & Cervantes, S. (2025, April 25). 5 key facts about Medicaid expansion. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/

[118] *Id*.

have demonstrated that Medicaid expansion *has significantly increased access to specialty care among those with chronic conditions*, including but not limited to: cancer care, heart health care, diabetes care, mental health and substance use disorder (SUD) care, and specialty care for those with disabilities. As discussed above in section I, members of Congress explicitly stated at the time of passage that people with chronic health conditions, like cancer, mental health conditions, and substance use disorders, would unequivocally be excluded from the community engagement requirements.

In contradiction to the language in section 1902(xx) of the Act and Congress' intent, the Rule effectively shuts down access to care for people who need it most. It is also inconsistent with the structure of Medicaid, which allows people to enroll at the moment of illness to ensure access to care at the moment of greatest need. Closing the door on Medicaid coverage for people with serious or complex health conditions is irrational, especially given the overwhelming evidence of expansion's positive impact on coverage, access, and health for this population. Appendix A describes the vast evidence base demonstrating large improvements in access to needed care for people with chronic health conditions like cancer and mental health disorders and people with disabilities following Medicaid expansion, as compared to similarly situated adults in non-expansion states, and the resulting improvements in their health and reduced healthcare costs.

B. The Rule Jeopardizes the Health Care Coverage and Access of Millions of People Who Gained Coverage Under Medicaid Expansions, Particularly Those With Chronic Health Conditions Who Will Experience Increased Health Problems and Unnecessary Deaths.

Since the passage of the ACA, the number of uninsured low-income adults in expansion states has dramatically fallen, from 35% to 15%.[119] In contrast, non-expansion states' uninsured rates remain *double* that of expansion states (30% vs 15%).[120] Decreases in uninsurance in expansion states are largely driven by new Medicaid coverage of low-income adults who previously had not been eligible for coverage.[121] [122]

Medicaid expansion has been profound in its ability to improve health coverage for low-income workers in expansion states—including those with chronic conditions—and thereby protect individuals' health so that they can remain in the workforce or seek employment. From 2013-2022, rates of uninsured low-income workers decreased from 38% to 17% in expansion states.[123]

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[119] Harker, L., & Sharer, B. (2024). *Medicaid expansion: Frequently asked questions.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0
[120] *Id*.
[121] Olfson, M., et al. (2019). *A national survey of trends in health insurance coverage of low-income adults following Medicaid expansion*. Journal of General Internal Medicine. Advance online publication. https://doi.org/10.1007/s11606-019-05409-5
[122] Miller, S., & Wherry, L. R. (2019). Four years later: Insurance coverage and access to care continue to diverge between ACA Medicaid expansion and non-expansion states. *American Economic Association Papers and Proceedings, 109*, 327–333. https://doi.org/10.1257/pandp.20191046
[123] Harker, L., & Sharer, B. (2024). *Medicaid expansion: Frequently asked questions.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0

(In comparison, the uninsured rate among low-income workers in non-expansion states remains at 31%.[124])

The Rule's harsh interpretation of H.R. 1's community engagement requirements will dramatically reverse this trend. Based on the statutory language of H.R. 1, the Congressional Budget Office (CBO) estimated that by 2034, approximately 5.2 million working-age adults will lose Medicaid expansion coverage as a result of H.R. 1's community engagement requirements,[125] with the majority being individuals who should remain eligible because they work but lose access because of administrative barriers. Estimates from other entities such as the Urban Institute place the coverage loss estimates under H.R. 1's statutory language even higher. Urban projected that as many as 7 million people could lose coverage without strong state mitigation measures—the majority of whom should be eligible because they are working or should be exempt.[126] Both CBO and Urban estimates were generated prior to the release of the June 2026 IFR, which substantially narrows statutory exclusion of "medically frail individuals," limits the ability of states to make *ex parte* determination, and limits the ability of individuals to self-attest. Taking into account the more restrictive exclusions in the IFR, estimated Medicaid coverage losses are likely to be even higher than those originally calculated by the CBO and Urban. Indeed, taking into account the more restrictive language of the Rule, Manatt estimates that IFR implementation would result in 8.2 million Medicaid coverage losses by 2034.[127]

The CBO projects that among the 5.2 million adults who will lose coverage, the vast majority (4.8 million) will become uninsured.[128] [129] This is consistent with research that has found that those who lose Medicaid coverage have no other health coverage options, including among those who are employed. A study evaluating the impact of Arkansas's previous work requirement found that as Medicaid coverage was lost and uninsurance increased significantly, rates of

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[124] *Id*.
[125] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461
[126] Buettgens, M., Karpman, M., Haley, J. M., Carter, J., & Kenney, G. M. (2026, March 25). *Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations*. Urban Institute. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work
[127] Boozang, P. M., Herring, A., Striar, A. D., & Scott, E. A. (2026, July 16). *CMS' Medicaid work requirements rule: A 50-state analysis of additional coverage losses, FFY 2027–2034*. Manatt. https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034
[128] Congressional Budget Office. (2025, June 24). *Estimated effects of Medicaid policies in H.R. 1, the One Big Beautiful Bill Act, on health insurance coverage: Letter for Representatives Arrington and Guthrie* [PDF]. https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf
[129] Congressional Budget Office. (2025, June 3). *Estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act*. https://www.cbo.gov/publication/61461

employer coverage did not substantially change.[130] According to the authors, "Arkansas's experience suggests nearly all adults losing Medicaid would become uninsured."[131]

Low-income working individuals often depend on Medicaid coverage because of the characteristics of their employers. In 2023, 46% of working adults with Medicaid were employed by firms with fewer than 25 employees.[132] These employers "are not subject to ACA penalties for not offering affordable health coverage and are less likely to offer health insurance to their workers than larger firms."[133] For example, in 2022, just over half of employers with fewer than 50 employees offered health insurance to their workers, compared to 99% of employers with 100 or more employees.[134] Additionally, nearly half of working adults with Medicaid are employed in the agriculture and service industries (including construction, leisure and hospitality services, wholesale and retail trade), which have historically low employer-sponsored insurance offer rates.[135] Despite being employed, these workers are likely to rely on Medicaid because their employer does not offer health insurance at all or does not offer insurance that is affordable.

Losing health coverage deeply compromises a person's ability to afford care for chronic conditions. Individuals with chronic conditions are already more likely to have inadequate financial resources, medical debt, a low credit score, and recent bankruptcy—with financial difficulty increasing as the number of chronic conditions increases.[136] [137]

As those with chronic conditions become uninsured, the ongoing cost of managing chronic diseases will become financially catastrophic, and will force many to forgo needed care and treatment. Indeed, studies consistently demonstrate that uninsured individuals forgo necessary healthcare due to cost: three-quarters of uninsured adults have reported skipping or postponing necessary healthcare due to cost, uninsured adults are nearly three times more likely than insured adults to skip or delay prescription medications due to cost, and less than half of uninsured

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[130] Gangopadhyaya, A., & Karpman, M. (2025, April 9). The impact of Arkansas Medicaid work requirements on coverage and employment: Estimating effects using national survey data. *Health Services Research*, e14624. https://doi.org/10.1111/1475-6773.14624

[131] Karpman, M., & Gangopadhyaya, A. (2025, April 23). New evidence confirms Arkansas's Medicaid work requirement did not boost employment. *Urban Institute*. https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment

[132] Tolbert, J., Cervantes, S., Rudowitz, R., & Burns, A. (2025, February 4). Understanding the intersection of Medicaid and work: An update. *KFF*. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/

[133] *Id*.

[134] *Id*.

[135] *Id*.

[136] Davis, V. H., Zhang, G., & Patel, M. R. (2025). Chronic disease and future perceptions of financial control: Results from the Midlife in the United States cohort study. *Medical Care, 63*(5), 353–357. https://doi.org/10.1097/MLR.0000000000002126

[137] Becker, N. V., Scott, J. W., Moniz, M. H., Carlton, E. F., & Ayanian, J. Z. (2022). Association of Chronic Disease With Patient Financial Outcomes Among Commercially Insured Adults. *JAMA internal medicine*, *182*(10), 1044–1051. https://doi.org/10.1001/jamainternmed.2022.3687

individuals had a doctor's visit in the past year.[138] [139] [140] One analysis estimates that upwards of 20 million medical visits and 40 million prescription refills could be disrupted annually, as a result of millions of individuals losing coverage under new work requirements.[141]

As people are forced to skip medically necessary care, several consequences will emerge: not only will individuals experience worsening health conditions and lose their ability to work, but losing access to chronic care treatment can be deadly. Researchers estimate that Medicaid work requirements under H.R. 1 could cause 7,000 to 9,200 preventable deaths per year, as well as hundreds of thousands of cases of uncontrolled diabetes or cardiovascular disease.[142]

C. The Rule Will Cause Millions of People to Lose Access to Treatment That Will Severely Limit Their Ability to Work in Contradiction to H.R. 1 and the Rule's Stated Goal of Increasing Employment for Medicaid Beneficiaries.

Ongoing and uninterrupted healthcare services are necessary to maintain work and seek employment, especially among those with chronic health conditions.[143] Many chronic conditions require routine access to care—including prescription medications, ongoing disease management, and acute care when issues arise. [144] As Medicaid enrollees with chronic conditions lose insurance, they will be forced to choose between catastrophic out-of-pocket costs or delaying/forgoing care. As noted above, the research is well-established that adults who become uninsured are significantly more likely to forgo care, including both preventive and chronic care services. [145]

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[138] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[139] Sparks, G., Lopes, L., Montero, A., Presiado, M., & Hamel, L. (2026, April 30). *Americans' challenges with health care costs*. KFF. https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/

[140] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[141] Ku, L. (2026, June 29). *The administration's flawed and misleading claims about Medicaid work requirements*. Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/commentary-administrations-flawed-and-misleading-claims-about-medicaid-work-requirements

[142] Pandey, A., Ye, Y., Bawden, C., Singer, B. H., & Galvani, A. P. (2025). Quantifying the mortality and morbidity impact of Medicaid work requirements: A modeling study. *The Lancet Regional Health - Americas, 51*, 101232. https://doi.org/10.1016/j.lana.2025.101232

[143] Wen, H., Saloner, B., & Cummings, J. R. (2019, April 1). Behavioral and other chronic conditions among adult Medicaid enrollees: Implications for work requirements. *Health Affairs, 38*(4), 660-667. https://doi.org/10.1377/hlthaff.2018.05059

[144] Musumeci, M., & Zur, J. (2017, August 18). *Medicaid enrollees and work requirements: Lessons from the TANF experience*. KFF. https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/

[145] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key facts about the uninsured population*. KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

Delayed and inadequate healthcare can exacerbate chronic conditions, increase risks of complications, and limit persons' ability to live independently and work. [146] [147] This is especially true for Medicaid enrollees, as "[m]any of the jobs held by people with low incomes involve walking, standing, lifting and carrying objects, repetitive motions, and other physical labor."[148] Indeed, uninsured individuals are more likely to be hospitalized and experience declines in their overall health.[149] Among individuals with chronic conditions, worsening health can significantly erode their capacity to work, leading to lost wages and reduced labor force participation.

Indeed, multiple studies show that expansion supports the ability of enrollees, including those with chronic conditions, to work, seek work, or volunteer . Studies have found that large percentages of expansion beneficiaries report that Medicaid enrollment made it easier to seek employment (among those who were unemployed but looking for work) or continue working (among those who were employed).[150] [151] In Michigan, one study found that nearly 70% of enrollees who were working said they performed better at work once they got expansion coverage. [152] Another study found that nearly half of primary care physicians who were surveyed reported that Medicaid expansion had a positive impact on their patients' ability to work.[153]

National research has found that Medicaid expansion is associated with significant increases in the number of individuals with disabilities reporting employment after expansion, and decreases in the number reporting not working due to a disability.[154] [155] The data showed that from 2013-2017, the percentage of individuals with disabilities in expansion states who reported being employed or self-employed rose from 41% to 47%, and in the same timeframe, the percentage of

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[146] Glied, S., & Ding, D. (2025, June 5). *Any way you look at it you lose: Medicaid work requirements will either fall short of anticipating savings or harm vulnerable beneficiaries*. Brookings Institution. https://www.brookings.edu/articles/any-way-you-look-at-it-you-lose-medicaid-work-requirements-will-either-fall-short-of-anticipating-savings-or-harm-vulnerable-beneficiaries/

[147] Saunders, H., Burns, A., & Rudowitz, R. (2025, April 10). *5 key facts about Medicaid coverage for adults with chronic conditions*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/

[148] Musumeci, M., & Zur, J. (2017, August 18). *Medicaid enrollees and work requirements: Lessons from the TANF experience*. KFF. https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/

[149] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key facts about the uninsured population*. KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[150] Ohio Department of Medicaid. (2018). *The Ohio Medicaid Group VIII assessment* [PDF]. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[151] Tipirneni, R., et al. (2019). Changes in health and ability to work among Medicaid expansion enrollees: A mixed methods study. *Journal of General Internal Medicine, 34*(2), 272–280. https://link.springer.com/article/10.1007/s11606-018-4736-8

[152] *Id*.

[153] Goold, S. D., et al. (2018). Primary care clinicians' views about the impact of Medicaid expansion in Michigan: A mixed methods study. *Journal of General Internal Medicine, 33*(8), 1307–1316. https://link.springer.com/article/10.1007/s11606-018-4487-6

[154] Hall, J. P., Shartzer, A., Kurth, N. K., & Thomas, K. C. (2018). Medicaid expansion as an employment incentive program for people with disabilities. *American Journal of Public Health, 108*(9), 1235–1237. https://doi.org/10.2105/AJPH.2018.304536

[155] *Id*.

the same population that reported not working because of disability dropped from 32% to 27%.[156] These post-expansion changes were likely due, in large part, to increased access to *supported employment services* funded by Medicaid. However, the IFC explicitly states that "these Medicaid-covered employment services are different from work programs as defined at § 435.552(b) and do not independently satisfy the work program community engagement requirement." [157]

Last, several studies have shown that Medicaid expansion is *not* associated with reduced labor force participation nor reduced efforts to search for employment. [158] [159]

D. CMS's Rule Will Lead to the Loss of Numerous Additional Gains From Expansion, Including Improved Coverage and Health Outcomes Among Other Special Populations like Rural Populations and Communities of Color.

As discussed earlier in this comment, Medicaid expansion has substantially improved coverage, health care utilization, and health outcomes among those with chronic conditions. However, these outcomes have also been realized for the larger Medicaid expansion population, including other special populations that have experienced chronic disparities in health outcomes, such as rural populations and communities of color. The Kaiser Family Foundation (KFF) and the George Washington University have collectively identified over 700 studies from 2014-2026 that demonstrate the enormous positive impacts that Medicaid expansion has had on healthcare access, utilization, health outcomes, and financial well-being among low-income persons. The IFC will lead to the loss of many of these life-saving gains. [160] Examples of the significant gains for two additional special populations—rural populations and communities of color—are summarized below.

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[156] *Id*.
[157] 91 Fed. Reg. at 33356.
[158] Buchmueller, T. C., Levy, H., & Valletta, R. G. (2021). Medicaid expansion and the unemployed. *Journal of Labor Economics, 39*(S1), S575–S617. https://doi.org/10.1086/712478
[159] Lavender, M., & Johnston, E. (2024). Labor force effects of Medicaid and Marketplace expansions: Variation by gender, parental status, and household structure. *Southern Economic Journal, 90*(4), 949–1001. https://doi.org/10.1002/soej.12678
[160] Murphy, C., Laferriere, E., Krips, M., & Rosenbaum, S. (2026, May). *How the Affordable Care Act's Medicaid expansion improved coverage, health care access, and health: An update*. Geiger Gibson Program in Community Health. https://geigergibson.publichealth.gwu.edu/sites/g/files/zaxdzs4421/files/2026-05/Medicaid%20Expansion%20Policy%20Brief_GG%20-%205.27.pdf

First, rural areas have seen profound health coverage gains because of Medicaid expansion.[161] [162] [163] [164] Prior to expansion, rural areas in both expansion and non-expansion states had similar coverage rates, but by 2015, rural adults in expansion states had *double* the coverage rate of rural adults in non-expansion states.[165] Indeed, Medicaid expansion is a large contributor to rural insurance coverage overall: over 20% of adults are now covered by Medicaid in expansion states.[166]

Expansion coverage has also been associated with increased usage of life-saving care in rural areas: rural community health centers in expansion states report significantly increased volume for eighteen of twenty-one types of visits—particularly those for mammograms, abnormal breast findings, alcohol-related disorder, and other substance abuse disorders.[167] The significant loss of Medicaid coverage due to the Rule will reverse these gains.

Second, communities of color have also experienced substantial gains in health coverage, access to care, and health outcomes because of Medicaid expansion. Among persons of color, expansion

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[161] Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., Zapata, D., & Fazlul, I. (2018). The three-year impact of the Affordable Care Act on disparities in insurance coverage. *Health Services Research*. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13077

[162] Soni, A., Hendryx, M., & Simon, K. (2017). Medicaid expansion under the Affordable Care Act and insurance coverage in rural and urban areas. *The Journal of Rural Health*. http://onlinelibrary.wiley.com/doi/10.1111/jrh.12234/full

[163] Agarwal, A., Katz, A., & Chen, R. (2019). The impact of the Affordable Care Act on disparities in private and Medicaid insurance coverage among patients under 65 with newly diagnosed cancer. *International Journal of Radiation Oncology, Biology, Physics*. https://www.redjournal.org/article/S0360-3016(19)30783-7/pdf

[164] Han, X., Yabroff, K. R., Ward, E., Brawley, O. W., & Jemal, A. (2018). Comparison of insurance status and diagnosis stage among patients with newly diagnosed cancer before vs after implementation of the Patient Protection and Affordable Care Act. *JAMA Oncology, 4*(12), 1713–1720. https://jamanetwork.com/journals/jamaoncology/article-abstract/2697226

[165] Foutz, J., Artiga, S., & Garfield, R. (2017, April 25). *The role of Medicaid in rural America*. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

[166] Osorio, A., Alker, J., & Park, E. (2023, August 17). Medicaid's coverage role in small towns and rural areas. *Georgetown Center for Children and Families*. https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/

[167] Cole, M. B., Wright, B., Wilson, I. B., Galárraga, O., & Trivedi, A. N. (2018). Medicaid expansion and community health centers: Care quality and service use increased for rural patients. *Health Affairs, 37*(6), 900–907. https://doi.org/10.1377/hlthaff.2017.1542

is associated with reduced disparity in uninsurance rates, improvements in having a usual source of care, and fewer persons of color forgoing care due to cost. [168] [169] [170] [171]

These coverage and access gains have translated into life-saving health outcomes: among persons of color, expansion is associated significant reductions in hospitalizations, improved timely cancer treatment, greater access to life-saving surgeries and inpatient trauma rehabilitation, and lessening racial disparities in infant mortality and preterm birth.[172] [173] [174] [175]

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[168] Baumgartner, J. C., Collins, S. R., Radley, D. C., & Hayes, S. L. (2020, January 16). *How the Affordable Care Act has narrowed racial and ethnic disparities in access to health care*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access

[169] Hayes, S., Riley, P., Radley, D., & McCarthy, D. (2017, August 24). *Reducing racial and ethnic disparities in access to care: Has the Affordable Care Act made a difference?* The Commonwealth Fund. http://www.commonwealthfund.org/publications/issuebriefs/2017/aug/racial-ethnic-disparities-care

[170] Lee, H., Hodgkin, D., Johnson, M. P., & Porell, F. W. (2021). Medicaid expansion and racial and ethnic disparities in access to health care: Applying the National Academy of Medicine definition of health care disparities. *Inquiry: A Journal of Medical Care Organization, Provision and Financing, 58*, 0046958021991293. https://doi.org/10.1177/0046958021991293

[171] Lipton, B. J., Decker, S. L., & Sommers, B. D. (2019, April 27). The Affordable Care Act appears to have narrowed racial and ethnic disparities in insurance coverage and access to care among young adults. *Medical Care Research and Review, 76*(1), 32–55. https://doi.org/10.1177/1077558717706575

[172] Metzger, G. A., Asti, L., Quinn, J. P., Chisolm, D. J., Xiang, H., Deans, K. J., & Cooper, J. N. (2021, December). Association of the Affordable Care Act Medicaid expansion with trauma outcomes and access to rehabilitation among young adults: Findings overall, by race and ethnicity, and community income level. *Journal of the American College of Surgeons, 233*(6), 776–793.e16. https://doi.org/10.1016/j.jamcollsurg.2021.08.694

[173] Adamson, B. J. S., Cohen, A. B., Gross, C. P., Estévez, M., Magee, K., Williams, E., Meropol, N. J., & Davidoff, A. J. (2021, July 19). ACA Medicaid expansion association with racial disparity reductions in timely cancer treatment. *The American Journal of Managed Care, 27*(7), 274–281. https://doi.org/10.37765/ajmc.2021.88700

[174] Eguia, E., et al. (2018, October). Impact of the Affordable Care Act (ACA) Medicaid expansion on cancer admissions and surgeries. *Annals of Surgery, 268*(4), 584–590. https://journals.lww.com/annalsofsurgery/Abstract/2018/10000/Impact_of_the_Affordable_Care_Act__ACA__Medicaid.6.aspx

[175] Bhatt, C., & Beck-Sague, C. (2018, March 7). Medicaid expansion and infant mortality in the United States. *American Journal of Public Health, 108*(4), 565–567. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218

[176] [177] [178] [179] [180] Similarly, the Rule will cause significant harm to these communities of color as they lose access to Medicaid coverage.

E. The Rule Drastically Underestimates Its Negative Economic Impacts; The Rule Will Cause Uncompensated Care to Dramatically Increase Among Hospitals and Community Health Centers (CHCs), Forcing Many to Close and Lay Off Employees.

The Rule's Regulatory Impact Analysis (RIA) does not analyze the Rule's impact on hospitals, community health centers, or other providers at all; it states that its cost-benefit analysis "examines the anticipated benefits for three principal parties implicated by the new requirement: Medicaid applicants and beneficiaries subject to the community engagement requirement, States, and the Federal government."[181] The RIA's only acknowledgment that coverage losses will affect providers appears in a single footnote to its accounting statement, which references transfers to "State or local jurisdictions that reimburse providers for otherwise-uncompensated care"—without any attempt to quantify the scale of that uncompensated care or its effect on provider operations.

Medicaid expansion has played an essential role in protecting hospitals' and community health centers' financial health by reducing uncompensated care (UCC) and improving operating margins. These improvements have been especially profound among safety net hospitals, community health centers, and rural facilities.[182]

Following expansion, hospitals in expansion states report less than half the UCC that non-expansion states experience (2.7% vs 7.3%), with safety-net hospitals experiencing the greatest reductions in UCC (e.g., a $9.5 million UCC reduction at safety net hospitals, versus a $5.8

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[176] Brown, C. C., et al. (2019, April). *Association of state Medicaid expansion status with low birth weight and preterm birth*. *JAMA, 321*(16), 1598–1609. https://jamanetwork.com/journals/jama/fullarticle/2731179

[177] Breathett, K., Allen, L. A., Helmkamp, L., Colborn, K., Daugherty, S. L., Khazanie, P., Lindrooth, R., & Peterson, P. N. (2017). The Affordable Care Act Medicaid Expansion Correlated With Increased Heart Transplant Listings in African-Americans But Not Hispanics or Caucasians. *JACC. Heart failure*, *5*(2), 136–147. https://doi.org/10.1016/j.jchf.2016.10.013

[178] Hanchate, A. D., Abdelfattah, L., Lin, M.-Y., Lasser, K. E., & Paasche-Orlow, M. K. (2023). Affordable Care Act Medicaid expansion was associated with reductions in the proportion of hospitalizations that are potentially preventable among Hispanic and White adults. *Medical Care, 61*(10), 627–635. https://doi.org/10.1097/MLR.0000000000001902

[179] Eguia, E., et al. (2018). Impact of the Affordable Care Act (ACA) Medicaid expansion on cancer admissions and surgeries. *Annals of Surgery, 268*(4), 584–590. https://journals.lww.com/annalsofsurgery/Abstract/2018/10000/Impact_of_the_Affordable_Care_Act__ACA__Medicaid.6.aspx

[180] Mahal, A. R., et al. (2020). Early impact of the Affordable Care Act and Medicaid expansion on racial and socioeconomic disparities in cancer care. *American Journal of Clinical Oncology*. https://doi.org/10.1097/coc.0000000000000588

[181] 91 Fed. Reg. at 33450.

[182] Ku, L., Krips, M., Kwon, K. N., & Jacobs, F. (2025). *Widening holes in the safety net: Community health centers at risk*: Geiger Gibson Policy Issue Brief No. 73). Milken Institute School of Public Health, The George Washington University. https://geigergibson.publichealth.gwu.edu/73-widening-holes-safety-net-community-health-centers-risk

million UCC reduction among non-safety net hospitals). [183] [184] Community health centers—which serve the most underserved and low-income populations and routinely run on razor-thin margins—rely on Medicaid expansion to keeping their centers staffed and margins out of the red. One study estimated that Medicaid expansion increases community health center staffing capacity by 25%, and health center capacity to schedule patient visits by 24%.[185] Expansion is also associated with centers' capacity to open additional sites in chronically underserved areas (27% increase in CHC sites), with a larger effect in rural counties.[186] Similarly, rural hospitals in expansion states have experienced significantly improved operating margins since Medicaid expansion, as compared to their counterparts in non-expansion states.[187]

As millions of patients become uninsured, the Rule will directly harm hospitals' and safety-net providers' financial standing. H.R. 1's community engagement requirements are estimated to decrease expansion state hospitals' operating margins by 12-13%, and safety-net and rural hospitals will bear the brunt of the impact, with operating margins anticipated to fall by 26-30%.[188] Community health centers are especially at risk—with upwards of 72% of Medicaid patients at the centers at risk of losing Medicaid coverage (despite most of these individuals working or qualifying for an exemption). [189] These coverage losses could translate into community health centers experiencing $16-32 billion in reimbursement losses over the next five years—a devastating financial loss that many centers in expansion states may not recover from.[190] The Rule—with its harsh, extra-statutory limitations on medical frailty exemptions and increased administrative burdens—means that these are likely underestimates of the financial impacts on safety net providers.

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[183] Blavin, F., & Ramos, C. (2021). Medicaid expansion: Effects on hospital finances and implications for hospitals facing COVID-19 challenges. *Health Affairs, 40*(1), 82–90. https://doi.org/10.1377/hlthaff.2020.00502
[184] Medicaid and CHIP Payment and Access Commission (MACPAC). (2023). *Annual analysis of Medicaid disproportionate share hospital allotments to states* (Chapter 4). https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf
[185] Jiao, S., Konetzka, R. T., Pollack, H. A., & Huang, E. S. (2022). Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. *The Milbank Quarterly*, *100*(2), 504–524. https://doi.org/10.1111/1468-0009.12560
[186] Paintsil, E. & Linde, S. (2026). State-Level Medicaid Expansion and Hospital, Federally Qualified Health Center, and Rural Health Clinic Availability. *The Journal of Rural Health, 42(2)*. E70159. https://doi.org/10.1111/jrh.70159
[187] Levinson, Z., Godwin, J., & Hulver, S. (2023, February 23). *Rural hospitals face renewed financial challenges, especially in states that have not expanded Medicaid*. KFF. https://www.kff.org/health-costs/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/
[188] Haught, R., Coleman, A., Dobson, A., Richards, C., & McGuire, C. (2025, September 18). *The impact of proposed federal Medicaid work requirements on hospital revenues and financial margins*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/sep/impact-medicaid-work-requirements-hospital-revenues-margins
[189] Rosenbaum, S., Jacobs, F., & Johnson, K. (2025, May 30). *Nearly 5.6 million community health center patients could lose Medicaid coverage under new work requirements, with revenue losses up to $32 billion*. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2025/community-health-center-patients-medicaid-coverage-work-requirements
[190] *Id*.

Additionally, medical documentation required by the Rule's provisions could cost health facilities $300 million each year.[191] One analysis estimates that it may take three million provider hours annually to document medical frailty exemptions consistent with the Rule (assuming three million Medicaid expansion enrollees seek medical frailty exemptions, and that documentation takes 30 minutes every six months). With primary care providers averaging $100/hour, three million provider hours could total $300 million in additional costs for healthcare facilities.

Financial pressures on health facilities caused by the Rule will result in closures and job loss, leading to substantial adverse impacts to state economies. One study used economic modeling to estimate the impact of H.R. 1's community engagement requirements on state economies and found that the requirements will lead to large-scale job loss (including among health care workers), reductions in state economic activity, and reductions in state and local tax revenue.[192] Again, these likely are an underestimate given the additional coverage loss and burdens imposed by the Rule. Another analysis, completed before the legislation was finalized, found that H.R. 1's community engagement requirements alone could induce the loss of 322,000 to 449,000 jobs.[193] Most of the recent job growth in the U.S. has been in healthcare, but the Rule jeopardizes this critical sector of the economy.[194] Large-scale layoffs and negative economic impacts run counter to the stated intent of Medicaid work requirements to increase employment and reduce poverty.

Conclusion

For all the foregoing reasons, the Rule cannot stand. CMS's addition of a "significantly impairs" ability-to-work test exceeds the plain terms of section 1902(xx) of the Act, disregards Congress's deliberate statutory structure, and is inconsistent with the contemporaneous statements of the Rule's own legislative sponsors. The Rule is independently arbitrary and capricious: CMS failed to adequately justify its most consequential policy choices, ignored substantial and readily available evidence of the coverage losses and provider burdens its restrictive medical frailty framework will cause, and reversed course from its own prior guidance without acknowledging the change or accounting for the reliance it invited. Finally, by imposing burdens that go well beyond anything the statute requires or Congress intended, the Rule will strip health coverage from millions of people who remain eligible under the law, disproportionately harming individuals with chronic, serious, or complex medical conditions, straining the hospitals and

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[191] Ku, L., Orgera, K., Kwon, K. N., Gorak, T., Krips, M., & Cordes, J. J. (2026, June 9). *H.R. 1 funding cuts will overshadow gains from the new rural health transformation program*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2026/jun/hr-1-funding-cuts-rural-health-transformatio

[192] Ku, L., et al. (2025, May). *How national Medicaid work requirements would lead to large-scale job losses, harm state economies, and strain budgets*. The Commonwealth Fund. https://doi.org/10.26099/6tcv-fh75

[193] Ku, L., Kwon, K. N., Nketiah, L., Gorak, T., Krips, M., & Cordes, J. J. (2025, March 25). *How potential federal cuts to Medicaid and SNAP could trigger the loss of a million-plus jobs, reduced economic activity, and less state revenue*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/how-cuts-medicaid-snap-could-trigger-job-loss-state-revenue

[194] Kopack, S. (2026, February 11). *U.S. had almost no job growth in 2025*. NBC News. https://www.nbcnews.com/business/economy/january-jobs-revisions-trump-rcna258398

community health centers that serve them, and imposing significant and unnecessary costs on states, providers, and beneficiaries alike.

APHA, Grantmakers in Health, the Jacobs Institute of Women's Health, the National Center for Medical-Legal Partnership, and the individual public health deans and scholars listed below urge HHS to withdraw the Rule in its entirety and, at a minimum, to rescind the medical frailty "significantly impairs" standard, the restrictions on self-attestation and *ex parte* verification, and the 12-month lookback limitation discussed above. Any replacement rule should conform to the plain text of section 1902(xx) of the Act, honor Congress's stated intent to protect individuals who are medically frail or have special medical needs, and reflect the significant health, public health, and economic harms documented in this comment.

We further request that the full text of this comment, together with each of the individual studies, reports, and other supporting materials cited and made available through active links herein, be included in the formal administrative record for this rulemaking for purposes of the Administrative Procedure Act. If HHS is unable for any reason to access or preserve any of the linked materials, we would welcome the opportunity to submit copies of those materials directly for the administrative record.

We appreciate the opportunity to comment on this Rule and welcome the opportunity to discuss these concerns further. If you have questions or need any additional information, please contact Alison Barkoff at Alison.Barkoff@gwu.edu.

A. Public Health Organizations

1. American Public Health Association (APHA)
2. Grantmakers in Health
3. Jacobs Institute of Women's Health
4. National Center for Medical-Legal Partnership

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3. Ettner, Susan L., PhD, Dean Emerita of Graduate Education, Distinguished Professor, David Geffen School of Medicine, Division of General Internal Medicine and Health Services Research, Distinguished Professor, Fielding School of Public Health, University of California, Los Angeles

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10. Rimer, Barbara K., DrPH, Professor Emerita, Department of Health Behavior, Dean Emerita, UNC Gillings School of Global Public Health

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16. Ahmed, Aziza, JD, MS, Professor of Law, Boston University School of Law

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Appendix A

Cancer care: Medicaid expansion has had an enormous impact on expanding access to cancer care and preventing cancer-related mortality and morbidity. Indeed, dozens of studies have found that Medicaid expansion is associated with earlier and increased likelihood of cancer diagnosis, as well as fewer late-stage diagnoses, improved time to treatment initiation, improved access to treatment, and improved likelihood of cancer survival rates among those with breast cancer, cervical cancer, lung cancer, colorectal cancer, endometrial, ovarian, advanced-stage skin cancer, and more.[195] [196] [197] [198] [199] [200] [201] [202] [203] [204] [205] [206]

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[207] [208] [209] [210] [211] [212] [213] [214] [215] [216] [217] Expansion is also associated with lessening racial disparities in coverage and access to cancer treatment.[218] [219] [220]

Cardiovascular care: Medicaid expansion is also associated with increased cardiovascular care among nonelderly adults, including a 38% greater increase in rates of outpatient disease management visits, a 43% greater increase in rates of prescription for cardiovascular disease management, increased vascular-related surgeries, and improved access to regular care for

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individuals with heart disease.[221] [222] [223] Expansion also increased access to heart transplantation, and especially for Black populations.[224] [225]

Care for mental health and substance use disorders: In expansion states, adults with mental illnesses have experienced substantial improvements in access to care, including increased access to prescriptions to treat mental illness and mental health facilities.[226] [227] [228] A significant number of studies demonstrate that Medicaid expansion is associated with increased healthcare access among individuals with SUD, including disorders related to use of alcohol, opioids, methamphetamines, amphetamines. Expansion is associated with an increased likelihood of individuals with SUD having covered care, [229] [230] as well as increased access to critical SUD treatments such as psychosocial services, SUD specialty facilities, therapies, and pharmaceutical treatments, including overall and/or Medicaid-covered medication-assisted treatment (MAT),

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naloxone, and medication to address psychiatric comorbidities.[231] [232] [233] [234] [235] [236] [237] [238] [239] [240] [241] [242] [243] [244] [245] [246] While mental health and SUD services are in high demand across the general

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population, Medicaid's services can be particularly life-saving for low-resourced individuals with complex mental health needs, which disproportionately includes those involved in the justice system, those experiencing homelessness, and veterans.[247]

Kidney and diabetes care: Medicaid expansion is associated with improved coverage and healthcare access for individuals with diabetes, including earlier pre-dialysis care.[248] [249] [250] [251] [252] Indeed, following Medicaid expansion, community health centers in expansion states reported greater utilizations of care among adults with abnormal blood glucose, as compared to health centers in non-expansion states.[253]

Care for individuals with disabilities: Medicaid expansion plays an essential role in advancing health access for individuals with disabilities. For example, it fills a critical gap in coverage for individuals undergoing the lengthy (i.e., six or more months to years) and burdensome Supplemental Security Income (SSI) determination process when applicants are frequently unable to work and would otherwise be at great risk of uninsurance. In a recent analysis, KFF found that 42% of new SSI enrollees in expansions states had previously received Medicaid coverage through expansion. KFF also found that previous Medicaid coverage for new SSI enrollees was *twice* as high for individuals in expansion states compared with non-expansion states.[254] These data underline the role expansion plays in helping individuals with disabilities

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maintain health coverage during their SSI process, although new H.R. 1 administrative burdens around "medical frailty" severely threaten these gains.

Medicaid expansion is also associated with improved receipt of primary and preventive care.[255] [256] For individuals with intellectual disabilities, expansion is associated with decreased likelihood of forgoing medical care, specialist visits, or mental health care due to cost.[257] And, among adults who report experiencing limitations caused by a chronic condition, expansion is associated with increased likelihood of having an office visit in the past two weeks.[258]

These increases in care access and utilization have translated into significant health improvements in expansion states, including among people with chronic conditions. For example, Medicaid expansion is associated with reductions in hospital readmissions and complications, improvements in self-reported health, and significant decreases in mortality.

Reductions in hospital readmissions and complications. In Medicaid expansion states, hospitals have reported significant reductions in readmission rates and complications for numerous conditions, including pneumonia, heart attack, heart failure, and cirrhosis, as compared to non-expansion states.[259] [260]

Improvements in self-reported health, including among those with chronic conditions. Following expansion, individuals in expansion states report significant improvements in self-reported health.[261] [262] In fact, studies have found that those with chronic conditions are significantly more likely to report physical and mental health improvements following enrollment in Medicaid

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expansion, as compared to enrollees without chronic conditions.[263] In comparison, individuals residing in non-expansion areas are more likely to self-report poor or fair health.[264]

Significant decreases in mortality. Medicaid expansion is associated with an overall 4% decrease in mortality, which is equivalent to 11 fewer deaths per 100,000 people.[265] Indeed, between 2010-2022, expansion was estimated to be associated with approximately 27,400 saved lives.[266] Expansion has been found to decrease mortality among those with serious physical and behavioral health conditions; for example, Medicaid expansion is associated with decreased in-hospital mortality following surgeries, higher rates of survival among adults with traumatic injuries, and reduced mortality from suicide and overdose.[267] [268] [269] [270] [271] [272] [273] Specifically, expansion has led to a significant reduction in mortality among families of color.[274] [275]

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EXHIBIT 63

An official website of the United States government

Executive Order Review Search Results

EO Review Search Criteria: Agencies=All; Review Status=Pending Review,Concluded; Terms= 0938-av98;

Number Of Records Found: 1 **New Search**

Received Date	RIN	Agency	Rule Title	Status	Concluded Date	Conclusion Action
03/31/2026	0938-AV98	0938-HHS/CMS	Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social Security Act (CMS-2454)	Concluded	05/29/2026	Consistent with Change

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EXHIBIT 64

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Nebraska Medicaid Work Requirements

Medically Frail and SUD Treatment Program Exemptions

May 1, 2026

Starting May 1, 2026, Nebraska Medicaid will use a streamlined process to determine whether individuals qualify for an exemption from Medicaid work requirements due to being medically frail or participating in a substance use disorder (SUD) treatment program.

How Nebraska Medicaid Determines Exemptions

For Existing Enrollees

Nebraska Medicaid will review available medical claims data approximately 90 days before the end of a member's eligibility period. If qualifying medical conditions or treatment indicators are identified based on diagnosis and procedure codes, the individual will be treated as exempt without needing to take additional action.

If Nebraska Medicaid does not have medical claims for existing enrollees with qualifying medical conditions, the individual will need to submit a self-declaration and provide basic information about their medically frail condition or SUD treatment provider.

For New Applicants

Individuals may self-declare that they are medically frail or enrolled in an SUD treatment program. Individuals will be asked to provide basic information about their medically frail condition or SUD treatment provider. No additional documentation is required at this time.

Individual Declaration Form

Medically Frail

For existing enrollees and new applicants that need to use the individual declaration form to claim the medically frail exemption, the following information must be submitted:

- Description of health condition
- Name, address, and telephone number of the doctor or healthcare provider
- If services for the identified health condition were provided while the individual was enrolled in Medicaid

SUD Treatment

For existing enrollees and new applicants that need to use the individual declaration form to claim the SUD treatment exemption, the following information must be submitted:

- Name of treatment facility
- Contact name and phone number at the treatment facility
- The dates services were provided at the treatment facility
- If services for the identified health condition were provided while the individual was enrolled in Medicaid

No additional documentation is required to be submitted with the individual declaration form. The individual declaration form may be submitted using one of the following methods:

- Online: at https://iserve.nebraska.gov/
- By mail: P.O. Box 2992
  Omaha, NE 68103-2992
- By phone:
  - Phone Number: (855) 632-7633 (select option 3)
  - Lincoln Phone Number: (402) 473-7000 (select option 3)
  - Omaha Phone Number: (402) 595-1178 (select option 3)

All declarations are made under penalty of perjury. This means individuals must provide truthful and accurate information when reporting a medical condition or participation in an SUD treatment program.

How Conditions Are Identified

Medically Frail
DHHS staff have reviewed thousands of medical diagnosis and procedure codes, including ICD-10, CPT, and HCPCS codes, to identify conditions that may qualify an individual as medically frail or participating in an SUD treatment program. This review includes physical health conditions, mental health conditions, and substance use disorders, and considers the severity and impact of each condition.

DHHS staff will continue to review and update these codes over time as clinical guidance evolves, additional data becomes available, and federal direction is clarified. Updates will be reflected on the Medicaid work requirements website. Please reference Nebraska Medicaid Work Requirements - Medically Frail and SUD Conditions.

SUD Treatment
DHHS review of claims data and declaration forms will include identifying individuals who have participated in a qualified drug or alcohol treatment program. Nebraska will identify qualified drug or alcohol treatment programs using the same criteria used in the Nebraska 1115(a) demonstration waiver for substance use treatment programs. This criteria includes inpatient and outpatient treatment options across the continuum of care.

Federal and Statutory Basis
This approach aligns with federal requirements under Section 71119 of the Social Security Act, which defines individuals who are medically frail or have special medical needs. These include individuals with substance use disorders, disabling mental disorders, serious or complex medical conditions, or conditions that significantly limit daily activities including physical, intellectual, or developmental disabilities. Individuals participating in a drug or alcohol treatment program are also included under federal law.

Nebraska Medicaid's use of claims data and medical coding is designed to operationalize these federal definitions in a consistent, objective, and administratively efficient manner while minimizing burden on applicants and enrollees.

Future Updates

Nebraska Medicaid will continue to fine-tune its verification processes as additional data sources become available. Over time, the State will move from self-declaration to more automated verification methods consistent with federal guidance.

EXHIBIT 65

RESEARCH REPORT

New Hampshire's Experience with Medicaid Work Requirements

New Strategies, Similar Results

Ian Hill *Emily Burroughs* *Gina Adams*

February 2020

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Executive Summary

In June 2019, New Hampshire required Medicaid beneficiaries to report compliance with work requirements in its Medicaid expansion program, Granite Advantage Health Care Program (hereafter called Granite Advantage), becoming just the second state to do so after Arkansas. Specifically, these rules required adults between ages 19 and 64 earning incomes up to 138 percent of the federal poverty level to work 100 hours per month and report those hours monthly to the New Hampshire Department of Health and Human Services (DHHS) or risk losing their health coverage. Exemptions were available for people who are disabled, deemed medically frail by a provider, or pregnant or fewer than 60 days postpartum and for one parent or caretaker (per household) of a dependent child under age 6, among others. Several of these rules were considerably more stringent than those in other state Medicaid work requirement waivers, notably requiring 100 hours of work or community engagement per month and subjecting people up to age 64 and parents of school-age children (ages 6 and above) to the requirements.

Leading up to program implementation, New Hampshire officials repeatedly made statements like, "We are doing things differently in New Hampshire," and "We are not Arkansas, we can do better," expressing confidence that their program would avoid the problems of Arkansas's first-in-the-nation Medicaid work requirement waiver that disenrolled over 18,000 adults during only its first six months of implementation.[1] These officials pointed to strategies that would make New Hampshire's requirements kinder and more flexible and accommodating than those of Arkansas, including broader, more multifaceted outreach efforts; a "no wrong door" policy that allowed enrollees to report their activities online, by phone, in writing, or in person at a local DHHS office; a "curing" process that allowed enrollees who fell short of 100 hours to make up the missing hours the following month; and reestablishment of eligibility at any time once a person meets the 100-hour threshold after their coverage was suspended. Indeed, even consumer and legal advocates with whom we spoke expressed sincere belief that "no one in New Hampshire pursued this policy because they wanted to disenroll people from Medicaid."

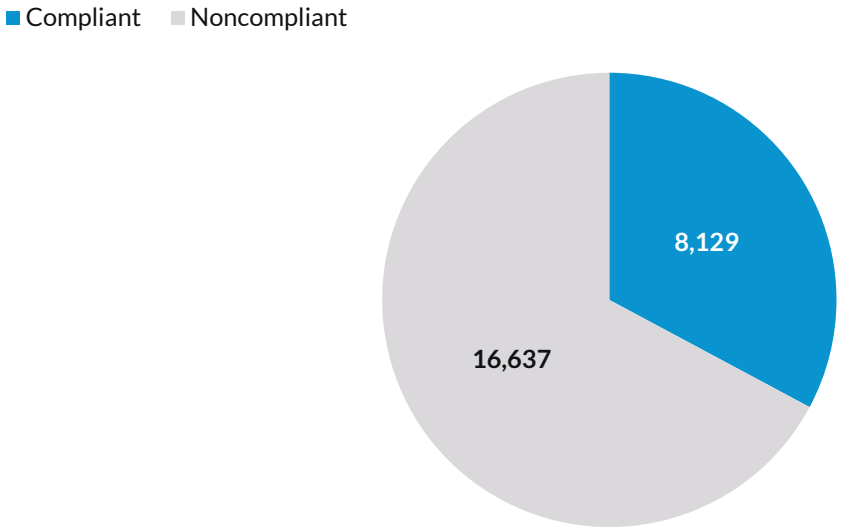
Yet by late June, less than one month after Granite Advantage beneficiaries had to start reporting work and community engagement hours, state officials worried that they had not succeeded in reaching the target population. News reports described confused beneficiaries who could not understand the state's letters and were puzzled by the new rules and unsure about how to comply. More importantly, data showed extremely low compliance rates; of the nearly 25,000 Granite Advantage enrollees without an exemption and subject to work requirements, only about 8,000 (or 32 percent) were in

compliance with the 100-hour target. Thus, in early July, an estimated 17,000 Granite Advantage enrollees (about one-third of the program's total enrollment) were scheduled to start receiving letters saying they were out of compliance with Medicaid work rules and could lose Medicaid in August (figure ES.1).

FIGURE ES.1

Granite Advantage Beneficiaries Subject to the Medicaid Work Requirement, by Compliant or Noncompliant Status, June 2019

Of 24,776 beneficiaries subject to the requirement



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Source: *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services, accessed January 27, 2020, https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf.
Note: Noncompliant beneficiaries include those who may have complied with the 100-hour work requirement but failed or were unable to report their hours to DHHS.

On July 7, DHHS Commissioner Jeffrey Meyers suspended implementation of Granite Advantage's work requirement for three months, citing the agency's difficulty reaching program beneficiaries. An array of stakeholders applauded the move, saying the state government demonstrated both good faith and a desire to avoid unfairly causing beneficiaries to lose coverage. A few weeks later, on July 29, and to the relief of many, New Hampshire's Medicaid work requirements were halted by a federal district court presided over by the same judge who had halted such programs in Arkansas and Kentucky. Shortly thereafter, Governor Chris Sununu and the Centers for Medicare & Medicaid Services appealed the decision.

This case study, which builds on our prior Arkansas-focused study, provides additional evidence, based on a series of key informant interviews and focus groups with Medicaid beneficiaries, of the numerous problems associated with implementing Medicaid work requirements:

- **Outreach.** Though New Hampshire was eager to avoid repeating Arkansas's implementation mistakes, it succumbed to many of the same outreach errors. The state did not allow enough time to publicize and educate beneficiaries about new work rules before implementation, and outreach efforts were not sufficiently funded. The state relied too heavily on mail- and telephone-based communication that failed to reach a population who is transient, moves frequently, possesses limited-minute phone plans, and faces numerous social challenges related to mental health, substance use, and homelessness. Information conveyed was overly complex and left beneficiaries confused and bewildered about how the rules affected them. As one focus group participant explained, "I got 10 letters right in a row...I didn't know how to read them. I don't know how to read. [My husband] don't know how to read either. He doesn't understand." Though the state conducted a door-to-door outreach campaign in late June to address these shortcomings, the effort was largely unsuccessful. Community-based service providers interviewed for this study told us a more effective strategy would have been to fully fund comprehensive outreach and education, including paying for health and social service providers, who regularly assist these populations, to provide hands-on help. However, one interviewee felt that even if these strategies were adopted, they would not have fully informed and educated this hard-to-reach population.
- **Promoting work.** New Hampshire launched a pilot work support program, Granite Workforce, in tandem with its Medicaid work requirements to help the Medicaid expansion population gain important skills and to incentivize employers to hire beneficiaries. But the program was crippled by eligibility restrictions because of the Temporary Assistance for Needy Families funding used to support it—it could only help people between ages 19 and 24 or parents of dependent children under age 18—and the pilot period lasted just six months. Stakeholders, including state officials, agreed that an effective work support effort would need more time to become established and would need to be available to people of all ages. Further, such an effort would have to more rigorously address common barriers to employment, such as lack of transportation, affordable child care, and housing.
- **Reporting work and community engagement.** Here, too, New Hampshire officials tried to avoid mistakes made in Arkansas by designing a no-wrong-door approach to reporting work and community engagement hours, allowing beneficiaries to report online, by mail, over the

phone, or in person. But beneficiaries and key informants reported that paper forms were poorly designed, the state's web portal was "glitchy," there were long waits when trying to get help over the phone, and staff members of the state's contracted call center were sometimes rude. The state's curing system—which allowed beneficiaries who fell short of the 100-hour threshold an extra month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause—was confusing to stakeholders and consumers alike. One beneficiary with whom we spoke described his confusion, saying, "I didn't make the hour requirement, so I figured, 'Why report it?' So I don't know how the system worked to report the hours…I got very close. I had upper 90s, so just a few hours short." Focus group participants and many key informants, including those at community agencies, believed reporting might have been less onerous for beneficiaries if providers and community-based organizations had received funding to support assisters or navigators to provide hands-on help to affected enrollees. However, some voiced concern that reporting challenges would still cause people who were in compliance to lose coverage even with this additional support.

- **Obtaining exemptions.** Like Arkansas, New Hampshire attempted to proactively exempt as many Granite Advantage members as possible from Medicaid work requirements, doing so for those deemed compliant with or exempt from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program work requirements or who were disabled, pregnant or fewer than 60 days postpartum, or parents of children under age 6. But also like Arkansas, New Hampshire did not use claims data from health plans or other sources to automatically exempt people with medical frailty, and because the state legislature required beneficiaries to get providers to certify their inability to work, this proved to be the most problematic aspect of the state's exemption system. Beneficiaries with physical and behavioral health problems reportedly struggled when applying for exemptions, often because primary care providers resisted signing forms declaring that their patients were unable to work. A woman in our focus groups described the difficulties she faced, saying, "I had six brain aneurysms…but [the doctor] said, 'If you can walk, you can work.' Then they got me another doctor and…she signed the form." Meanwhile, parents with school-age children subject to work requirements likely would have faced challenges finding child care, struggled to afford child care, and confronted barriers to getting assistance to defray some of the costs of such care. State-based policy researchers, legal advocates, and beneficiaries with whom we spoke agreed that New Hampshire should have made exemptions simpler and more data driven, exempting broader groups from work requirements, including all parents of children younger than 18, homeless people, people with opioid and/or substance use disorders, and people over age 49.

- **Implications of disenrollment.** Medicaid beneficiaries told us their health coverage was critical, that it kept them healthy and able to work, and that loss of Medicaid would have been devastating. As one focus group participant said, "When you are looking at not getting your medicine or not being able to go to the doctor, that is a really scary thing." Providers and health plans, too, said that Medicaid expansion had helped increase people's financial access to care and decreased uncompensated care. They also expressed concern over how coverage losses would affect patient health and increase use of expensive emergency room care.

Though New Hampshire officials implemented numerous strategies to differentiate their program from that of Arkansas, they found themselves at nearly the same end point: on the brink of disenrolling a large share of the state's Medicaid expansion population. Moreover, New Hampshire reached this point in a fraction of the time; Arkansas disenrolled 18,000 people over six months of implementation, but New Hampshire might have disenrolled up to 17,000 after just two months, a startling 67 percent of those subject to the requirements. The unique feature of New Hampshire's program not present in Arkansas's—state authority to suspend the program if undue harm to beneficiaries was expected—was added by the state legislature just in time to save 17,000 people from potentially losing health coverage.

At the time of this writing, no date has been set to hear oral arguments on the federal government's appeal of the lower court ruling that halted the state's Medicaid work requirements, so the program's ultimate resolution is uncertain. Still, setting aside the fundamental question about the legality of work requirements in Medicaid, which the courts are currently considering,[2] and based on the experiences of the first two states to implement Medicaid work requirements (using different approaches and under different circumstances), evidence suggests such programs cause significant harm to Medicaid beneficiaries while not appreciably supporting their ability to work.

New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results

Introduction

In June 2019, New Hampshire required Medicaid beneficiaries to report compliance with work requirements in its Medicaid expansion program, Granite Advantage Health Care Program (hereafter called Granite Advantage), becoming just the second state to do so after Arkansas.[3] In the fall of 2018, the state's Department of Health and Human Services (DHHS) had started sending letters to Granite Advantage enrollees informing them of new reporting and eligibility rules, as specified in New Hampshire's Section 1115 waiver approved by the Centers for Medicare & Medicaid Services (CMS) in November 2018.[4] Specifically, these rules required adults between ages 19 and 64 earning incomes up to 138 percent of the federal poverty level to work 100 hours per month and report those hours monthly to DHHS or risk losing their health coverage. Besides work, enrollees could meet the 100-hour threshold through various "community engagement" activities, including job training, attending a secondary school or college, searching for work, and volunteering community or public service. Exemptions were available for people who were disabled, deemed medically frail by a provider, pregnant or fewer than 60 days postpartum, a parent or caretaker of a dependent child under age 6 (one per household), or compliant with or exempt from work requirements under either Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program.

Several of these rules were more stringent than those in other approved state Medicaid work requirement waivers; requiring 100 hours per month and subjecting people up to age 64 to the rules are the strictest work requirements of any state in the nation.[5] New Hampshire's exemption of one parent per household with dependent children only up to age 6, which leaves most parents with school-age children exposed to the work requirements, was also stricter than many states' parental exemptions (Adams et al. 2019).

Leading up to program implementation, New Hampshire officials in both the state legislature and government repeatedly made statements like, "We are doing things differently in New Hampshire," and "We are not Arkansas, we can do better,"[6] expressing confidence that their program would avoid the problems of Arkansas's first-in-the-nation Medicaid work requirement waiver that disenrolled over

18,000 adults during only its first six months of implementation (Hill and Burroughs 2019). These officials pointed to strategies that would make New Hampshire's requirements kinder and more flexible and accommodating than those of Arkansas, including broader, more multifaceted outreach efforts; a "no wrong door" policy that allowed enrollees to report their activities online, by phone, in writing, or in person at a local DHHS office; a "curing" process that allowed enrollees who fell short of 100 hours to make up the missing hours the following month; and reestablishment of eligibility at any time once a person meets the 100-hour threshold after their coverage was suspended. Indeed, consumer and legal advocates and progressive Democratic legislators interviewed for this study expressed sincere belief that "no one in New Hampshire pursued this policy because they wanted to disenroll people from Medicaid." A Republican legislator was quoted as saying, "None of us wants…inadvertent denial of benefits."[7]

Yet by late June, less than one month after Granite Advantage beneficiaries had to start reporting work and community engagement, state officials worried that they had not successfully reached the target population. News reports described confused beneficiaries who could not understand the state's letters and were baffled by the new rules and unsure about how to comply.[8] More importantly, data showed extremely low compliance rates; of the nearly 25,000 Granite Advantage enrollees without an exemption and subject to work requirements (about one-half of the program's total enrollment), only about 8,000 (or 32 percent) were counted as having met the 100-hour target, and three-quarters of those did not actually *report* their own activity but were proactively deemed compliant by DHHS based on its analysis of state labor data.[9] Thus, in early July, an estimated 17,000 Granite Advantage enrollees were scheduled to start receiving letters saying they were out of compliance with Medicaid work rules and could lose Medicaid in August if they did not cure their missing hours (figure ES.1).

A month earlier, the Democratically controlled state Senate had been putting the finishing touches on S.B. 290,[10] a bill that would loosen some of Granite Advantage's strictest rules. Early versions of the bill proposed lowering the upper age limit to 49, lowering the hour requirement to 80, exempting parents and caretakers of children under 16 (instead of 6), and creating a trigger that would automatically suspend the work requirements if 500 people (i.e., roughly 1 percent of Granite Advantage's total enrollment) were disenrolled.[11] Bill sponsors, however, were told that Republican Governor Chris Sununu would not sign a bill with such drastic changes. But Republican legislators already saw the growing risk of substantial Medicaid disenrollment and signaled a willingness to compromise. In the end, S.B. 290 did not include many of the proposed changes but contained more flexible language that gave authority to the DHHS commissioner to suspend the work requirements if "a substantial number" of enrollees were "more likely than not" to be suspended from the program

because of circumstances like DHHS's inability to communicate with and counsel all beneficiaries on the rules.[12] On July 7, DHHS Commissioner Jeffrey Meyers suspended implementation of Granite Advantage's work requirements for three months, citing the agency's difficulty reaching program beneficiaries. An array of stakeholders applauded the move, saying the state government demonstrated both good faith and a desire to avoid unfairly causing beneficiaries to lose coverage. A few weeks later, on July 29, New Hampshire's Medicaid work requirements were halted by a federal district court presided over by the same judge who halted such programs in Arkansas and Kentucky. Governor Sununu and CMS appealed the decision shortly thereafter.[13] As of this writing, no date has been set for oral arguments on the appeal.

In the end, despite intentionally adopting policies designed to avoid negative consequences, New Hampshire, like Arkansas, faced the prospect of disenrolling a large share of its Medicaid expansion population for not meeting new work requirements. This paper analyzes the structure and implementation of the state's work requirements and identifies the challenges that surrounded its roll-out, based on interviews with key stakeholders and focus groups with Granite Advantage beneficiaries. Building on our earlier report that examined Arkansas's experience with work requirements in Medicaid, this analysis explores New Hampshire's experiences with outreach, work supports, reporting work and community engagement, and exemptions (including an in-depth exploration of issues surrounding access to child care), and the implications of work requirements for consumers, health care providers, and health plans. We finish with concluding observations comparing and contrasting the experiences of the first two states to implement Medicaid work requirements.

Methods

We began by reviewing articles and reports on New Hampshire's Medicaid work requirements from news and policy research sources and by conducting phone interviews with researchers and analysts who had been studying the program to understand what they had learned. We also studied materials that New Hampshire DHHS had produced before and during implementation of the Medicaid work requirements, including summary-level data on beneficiary engagement with the requirements.

In July 2019, we conducted eight telephone interviews with 11 key informants. Then, over three consecutive days in October 2019, we conducted a site visit to New Hampshire, where we completed seven more interviews with 13 key informants and two focus groups with 11 Medicaid enrollees. Also in October 2019, we spoke with 11 additional key informants by phone, many of whom focused more deeply on issues surrounding child care and how Medicaid work requirements affect parents with

dependent children. Our interviewees represented a range of stakeholders, including state DHHS and Department of Employment Security (NHES) officials, health care providers, health plan representatives, consumer and legal advocates, policy researchers, and child care experts. Our focus groups consisted of adults enrolled in Granite Advantage. Semistructured interviews and focus groups captured reflections on experiences with New Hampshire's work requirements and perspectives on their strengths and weaknesses.

Our core interview protocol and focus group moderator's guide included questions that explored stakeholders' and enrollees' experiences and opinions across eight domains:

- outreach and education efforts
- training and employment resources
- work reporting systems
- exemptions from work requirements
- enrollee understanding of work requirements
- implications of Medicaid coverage loss for health care providers and health plans
- opinions of the Medicaid work requirements

We also developed a targeted interview protocol for child care stakeholders to explore the child care implications of the requirement for parents with school-age children. This protocol included sections on the respondent's knowledge of the Medicaid work requirements and the supply and affordability of child care, and it solicited respondents' suggestions regarding what policies could help avoid loss of Medicaid eligibility.

We recruited focus group participants with the assistance of a federally qualified health center (FQHC), a family health center, and consumer and legal advocates. The health center staff and advocates engaged participants in person and with fliers and phone calls, using protocols and scripts provided by Urban to ensure neutral and systematic recruitment. The clients they recruited met the criteria to participate, which included

- being between ages 19 and 64,
- having received Medicaid coverage any time in the past year and having been subject to the Medicaid work requirements as a condition of eligibility, and

- speaking English as a primary language and/or being comfortable participating in a group discussion conducted in English.

We conducted two focus groups with 11 participants total. Before the start of each focus group and interview, we followed informed consent procedures approved by the Urban Institute Institutional Review Board. All interview and focus group participants spoke to us voluntarily and were assured that their identities would be protected. We digitally recorded and transcribed interview and focus group proceedings and destroyed notes when we finished transcribing and cleaning them. Each focus group lasted 90 minutes and included a light meal. All participants received $60 for their participation.

Focus group participants also voluntarily completed a questionnaire that gathered basic demographic characteristics and information on program participation and food and housing insecurity (table 1). The questionnaires were anonymous and not linked to focus group participant responses. All 11 participants completed the questionnaire.

To analyze the interview and focus group results, we used commonly accepted qualitative research methods. We systematically reviewed interview and focus group notes and unabridged transcripts, and we categorized the responses using a thematic analytical framework that mirrored the content of the interview protocol and focus group moderator's guide. We noted and summarized dominant themes, divergent opinions, and participant experiences. Finally, we selected relevant quotations based on frequency and richness to illustrate key points. Though focus groups provided valuable and nuanced insight into people's experiences with Granite Advantage, by their nature they obtain information from relatively few people and thus do not represent the entire population of interest.

TABLE 1

Focus Group Participants' Questionnaire Responses

Characteristics	Number of participants
Gender	
Male	5
Female	6
Age	
18–24	1
25–29	0
30–39	3
40–49	2
50 and above	5
Race/ethnicity (all that apply)	
American Indian/Alaska Native	1
Asian	0
Black or African American	0
Hawaiian Native/Pacific Islander	0
White	10
Educational attainment	
Less than high school	2
High school/GED	3
Some college	5
College degree	1
Employment status	
Not employed	5
Working < 20 hours a week	4
Working 20+ hours a week	1

Source: Urban Institute focus groups, October 2019.

Notes: GED = general education diploma. Though all 11 focus group participants filled out the questionnaire, they may not have completed all parts.

Background on New Hampshire's Passage of Medicaid Work Requirements

After garnering bipartisan support in the state legislature, New Hampshire expanded Medicaid in April 2014. The expansion added more than 50,000 beneficiaries, pushing the state's total Medicaid population over 180,000 by 2016 (NH DHHS 2019). Key informants interviewed for this study noted two possible reasons why Republicans supported the expansion: First, like Arkansas, New Hampshire designed its program, the New Hampshire Health Protection Program, as a private option, meaning the state would use Medicaid funds to purchase private insurance for beneficiaries in the federal health insurance marketplace. All expansion beneficiaries were enrolled in the marketplace, except those who were American Indian or Alaska Native or had self-attested as being medically frail. Stakeholders in New Hampshire, just as in Arkansas, told us the private option was viewed as a way to appeal to

conservative lawmakers who otherwise might have voted against expansion. Second, the legislation included language requiring DHHS to pursue work requirements in its 2014 Section 1115 waiver application. Democratic lawmakers indicated that they went along with this provision because they believed the Obama administration would not approve work requirements and, indeed, it did not authorize this portion of the waiver.

Initially, New Hampshire lawmakers authorized Medicaid expansion for two years and thus had to continue brokering political compromises to keep the program in place. Upon reapproving the program for two additional years in 2016, lawmakers again sought a waiver to add work requirements. Once again, CMS rejected it. However, by 2018, the Trump administration had publicly encouraged states to pursue Medicaid work requirements. The New Hampshire legislature passed S.B. 313 in July 2018,[14] which called for adopting work requirements and eliminating the 90-day retroactive eligibility. Additionally, the bill included provisions to switch expansion beneficiaries out of private insurance and into Medicaid managed care, under the newly named Granite Advantage Health Care Program. According to state officials, the shift to managed care was both a cost-saving measure, because it was projected to save $200 million, and a response to rapidly rising premiums on the exchange. CMS approved the waivers effective January 1, 2019.

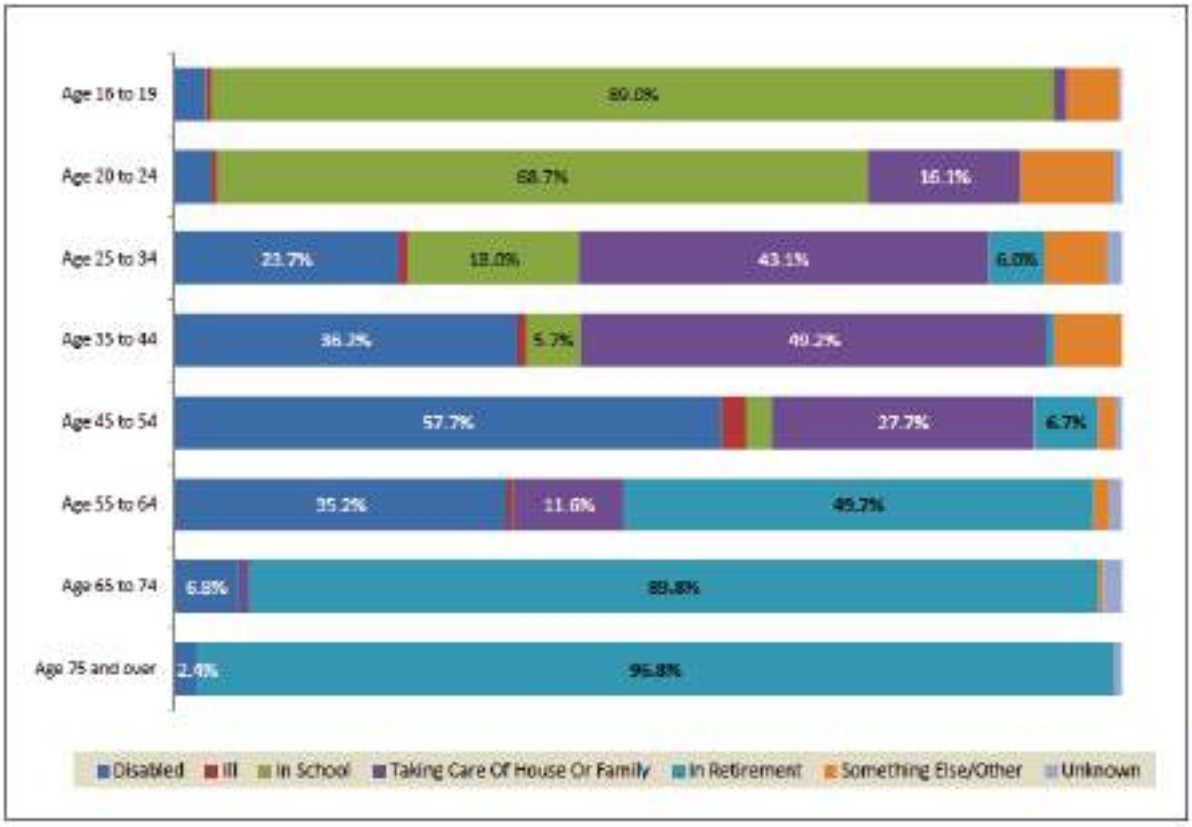
Among New Hampshire Medicaid beneficiaries, an estimated 65 percent were working part- or full-time in 2017 (Garfield et al. 2019). Generally, the stakeholders we interviewed agreed that the vast majority of Medicaid beneficiaries who could work were working. Those who were un- or underemployed, according to key informants, were either participating in other community engagement activities (e.g., attending school), would qualify for an exemption (e.g., for being medically frail or having serious mental health or substance use challenges), or faced insurmountable barriers to employment (such as lack of transportation or affordable child care). Statewide data from NHES appear to corroborate these beliefs; reasons reported for not being in the labor force almost entirely fall within the categories identified by stakeholders (figure 1). In addition, Urban Institute analysis of national data shows that the population subject to Medicaid work requirements faces particular barriers to securing and maintaining stable employment. These obstacles include low educational attainment, health problems, limited transportation and internet access, criminal records, and residence in high-unemployment or high-poverty neighborhoods (Karpman 2019).

Stakeholders told us the instability of seasonal work or self-employment and the lack of child care and transportation were especially common obstacles to finding and maintaining stable employment for New Hampshirites. These problems are amplified for residents in rural areas and the North Country, the northern tip of the state. Finding affordable housing poses a challenge to maintaining employment

as well; according to a 2019 New Hampshire Housing Finance Authority report, the state's vacancy rate was less than 1 percent, compared with 7 percent nationally. The report also found that in the past five years, the statewide median gross rent increased over 20 percent (NHHFA 2019). As stated, low educational attainment is another significant barrier to employment for Medicaid beneficiaries. Data presented in early 2019 suggest the job market for people possessing less than a college degree in New Hampshire is unfavorable; though 13,380 people with less education than a college degree were seeking jobs in the state, there were just 6,132 job openings for people with that education level (NHFPI 2019). Urban Institute findings show that many of the jobs attainable for Medicaid enrollees are unsteady, pay low wages, and either do not offer employer-sponsored insurance or only offer unaffordable insurance.[15] Consequently, many workers in these positions may continue to rely on Medicaid for health insurance. They also may struggle to be deemed compliant with work requirements because of nonstandard work schedules, lack of control over their own hours, or difficulties reporting their hours because, for example, they lacked access to transportation.

FIGURE 1

New Hampshirites' Reasons for Not Being in the Labor Force, by Age Cohort, 2017



Source: State of New Hampshire, *New Hampshire 2018 Workforce Analysis in Review* (Concord, NH: State of New Hampshire, 2018).
Note: Data are for the entire state and not specific to the Medicaid population.

Reaching Out to and Educating Medicaid Beneficiaries

Though New Hampshire state officials were eager to avoid repeating Arkansas's implementation mistakes, the two states experienced similar outreach challenges. For example, both states allowed themselves inadequate time to ramp up and publicize their Medicaid work requirements before implementation. One DHHS official explained that after receiving CMS's approval to implement the work requirements on November 30, 2018, "the program [start date] was announced for March 1 [yet] the first set of rules were not passed until late February." Thus, the state began planning outreach and education activities before the program design was finalized.

This insufficient ramp-up period was particularly problematic because of the obstacles associated with reaching this population. Stakeholders in New Hampshire, like those in Arkansas, feared that

because beneficiaries are often transient, traditional outreach methods, such as letters and phone calls, would not be effective. They mentioned that beneficiaries' phone numbers and home addresses may change, and their phones may have limited minutes. One interviewee commented, "It is a transient population…Identifying and locating them is part of the challenge." Further, stakeholders believed that beneficiaries may distrust the government.

Even when the state could reach beneficiaries, the information they tried to convey was overly complex. A policy and advocacy organization attempted to create a brochure for beneficiaries but struggled to distill the information down to a clear, concise message; as one staff member said, "The department wanted us to use certain language…but that language would have taken its own brochure [to explain]. We tried to simplify it as much as possible, but [the language] was still very confusing." Focus group participants said the communications they received were unclear and occasionally contradictory (box 1). One participant reported that she received letters stating that she was exempt and letters that said she was subject to the requirement. Several changes to the Medicaid expansion program happening simultaneously further complicated this already complex information; not only was DHHS implementing work requirements, but they were switching the same beneficiaries out of private insurance plans and into managed care, and they renamed the Medicaid expansion program.

From the outset, DHHS also faced legislatively limited funding for outreach and enrollment. DHHS was prohibited from using general funds to support outreach efforts and thus had to find alternative funding streams. Given the difficulties associated with reaching this population, stakeholders felt the state did not have adequate resources to be successful.

Despite these hindrances, the state developed an outreach and education strategy they believed would be more robust and successful than Arkansas's.[16] DHHS communications included letters, phone calls, public forums and targeted information sessions, radio advertisements, text messages, and emails, each of which we discuss in more detail below.

BOX 1

What Focus Groups Said about Outreach and Education Efforts

Though 8 of the 11 focus group participants reported having heard about the Medicaid work requirements, confusion was widespread. Six participants confirmed that they received a letter in the mail, but several reported difficulty understanding the letter's content. Other participants said they never received any letters. Participants reported seeking further explanation from DHHS by phone or in person but complained of long hold times and judgmental staff. Two participants reported receiving conflicting letters: some saying they were subject to the requirement and others saying they were exempt. Only one participant said they had been contacted by phone. A handful of others did not think phone calls were an effective way to reach this population. Participants were generally aware that the work requirements had been halted.

> "I got 10 letters right in a row...I didn't know how to read them. I don't know how to read. [My husband] don't know how to read either. He doesn't understand."
>
> "I got a letter and then…I called the state office. I said 'What is going on here? What is this?'"
>
> "You'll get one [letter] that says you are required to do it and then get one that [says] you are exempt. It was very confusing."
>
> "I never heard of it [and never got a letter]…I was couch surfing, completely homeless."
>
> "Half the time [the mail I receive] doesn't apply to me, or I can't understand what they are trying to say, so why open it? You can't understand what they are saying so you have to go there and listen to them try to explain it."
>
> "You go to the welfare office and you are sitting there talking to a person and…it feels judgmental. Like you are supposed to understand these big words…Sometimes they put things way over your head."
>
> "They did call me a couple times. They explained that I needed to do 100 hours of work or community service. Around June 1st, they alerted me that it was starting and gave me a number to call at the end of the month to let them know how many hours I accumulated. That was all the contact they had with me."
>
> "I don't like people calling me. I get scam calls. My phone blows up enough as is. I don't need more people adding to it."
>
> "Not everyone answers their phone; I don't."

Source: Urban Institute focus groups, October 2019.

Letters. From April through June 2019, the state mailed 48,280 letters to Granite Advantage enrollees subject to work requirements.[17] Four versions of a letter were sent: one for beneficiaries subject to the requirements, one for beneficiaries who were subject to the requirements but already

complying with the 100-hour requirement (according to state calculations), one for exempt beneficiaries, and one for beneficiaries the state believed were medically frail. Of these letters, 10,798 went to medically frail people and included an exemption request form (discussed in the Obtaining Exemptions section). Several stakeholders thought the volume of mail may have been too high; one interviewee commented, "People came in to see me with collapsible file folders that were thick from DHHS and Social Security and other assistance programs they are on. It is absolutely overwhelming [and] staggering for these people that I work with."

Phone calls. The state contracted with MAXIMUS, an out-of-state call center, to place over 50,000 phone calls to beneficiaries. However, the phone campaign was seriously flawed. DHHS reported that less than 10 percent of people called by the center answered their phones.[18] At first, the calls showed up on beneficiaries' caller IDs as an out-of-state number, thus beneficiaries reportedly ignored them as spam. Then DHHS instructed MAXIMUS to change the number so it would appear as coming from "State of New Hampshire." This didn't help much, because beneficiaries were just as wary of calls from the government. One stakeholder sympathized, saying, "I don't pick up my phone if it is not someone I know. And these clients have prepaid or limited minutes." When people answered, call center staff could only proceed if beneficiaries verified their identities by providing their Medicaid ID or Social Security numbers, because they needed to discuss personal information. Only 10 percent of those who answered the phone provided this information; very few beneficiaries knew their Medicaid numbers, and the rest refused to give out their Social Security numbers over the phone. In total, the state reported spending $108,723 on outbound calling.[19]

Public forums and targeted information sessions. DHHS reported holding 11 public forums across the state between November 2018 and March 2019, as well as close to 50 targeted information sessions for "providers, agencies, managed care organizations, and other stakeholder organizations" through June 2019.[20] The forums were hosted in public locations such as a city hall, a community college, and a public library. Officials from both DHHS and NHES presented information on the transition from premium assistance to managed care, the new Medicaid work requirements, and a new work-supports pilot program called Granite Workforce (discussed further in the Promoting Work through the Granite Workforce Pilot Program section). However, stakeholders said these forums were not well attended; one stakeholder said she attended a session with just six beneficiaries. The state also led a handful of additional community outreach sessions at hospitals in late July but reported assisting just 14 people.

Radio advertisements. According to state officials, DHHS ran radio advertisements on 98 radio stations for eight weeks in spring 2019. DHHS said these advertisements intended to prompt beneficiaries to seek out counseling and answers to their questions about work requirements at DHHS

district offices. State officials told us that at these offices, DHHS staff members were available for two to three hours three days per week to provide one-on-one assistance.

Text messages and emails. Though DHHS sent text messages and emails, it reportedly only had cell phone numbers and email addresses for some of the Granite Advantage population; state officials said they had cell phone numbers for 10,000 nonexempt enrollees and email addresses for 12,000.

As described above, by June 2019 DHHS officials realized their outreach activities had been insufficient and unsuccessful. With the deadline for the first month of reporting looming, they decided to scale up outreach efforts over the summer and concentrated most of their resources (approximately $43,000) on a door-to-door campaign beginning in late June.[21] But it, too, was largely unsuccessful: DHHS and NHES staff members went to 2,011 beneficiaries' homes in communities with high concentrations of Granite Advantage enrollees (like Manchester and Nashua) and went to the homes of beneficiaries from whom they had not received any information (e.g., reported hours or exemption requests), but just 13 percent of these visits resulted in in-person contact.[22] Multiple stakeholders pointed out that this strategy was poorly designed, because state officials only knocked on doors between 10:00 a.m. and 3:00 p.m., when people would mostly likely be at work or school. The strategy was also undermined by many beneficiaries' frequent address changes, because significant numbers of Granite Advantage beneficiaries are unstably housed or homeless. Lastly, when officials increased outbound calling to medically frail beneficiaries, they only reached 528 participants.

Because funding for outreach was legislatively limited, the state relied on other entities, such as professional organizations, health plans, providers, and nonprofits, to bolster outreach efforts with their own resources. Stakeholders said the New Hampshire Hospital Association pushed out information on the work requirements to their members and tried to ensure that providers at hospitals were informed. We were also told that a health plan gave a script to their community outreach team, so that they could inform Granite Advantage clients about the requirements at their own outreach events. In addition, under new contracts developed in 2019, managed care organizations were required to assist with implementation of the work requirements. However, these contract provisions were not supposed to take effect until after the program was halted, so stakeholders said this assistance never came into play. In addition, we were told that state Medicaid officials never reached out to the child care community to inform them of the work requirements and seek their support of parents affected by the requirements.

Perceptions of whether providers were informed and engaged varied widely. On one hand, we heard that on either organizational or individual levels, some health centers and employees took it upon

themselves to champion work requirement outreach; stakeholders mentioned that some organizations (primarily FQHCs) created their own outreach materials, described as more user friendly than DHHS's, and translated them into more languages than DHHS did. We also spoke with several health center employees serving as navigators or application assisters who felt it was their job to educate clients and help them report hours or apply for exemptions. On the other hand, stakeholders and focus group participants also spoke of many instances where providers did not have sufficient knowledge of the work requirements and could not help their patients.

Stakeholders reasoned that this variation might have owed to the state not providing financial support to these providers or organizations; these organizations took on outreach efforts at their own expense, and these efforts fell onto their employees' already full plates. One health plan representative emphasized that they would have worked to help their clients maintain coverage as their capacity allowed, but he "did not feel like it was going to be all that realistic for care managers, at their current level of caseload and understanding," to help much. Finally, federal funding cuts had greatly reduced the number of navigators and application assistors, who may have been best positioned to help beneficiaries navigate work requirements.

Despite these financial investments and staff time, stakeholders agreed that, like Arkansas, New Hampshire conducted ineffective outreach efforts. This sentiment is underscored by (1) the state not having any information for 17,000 beneficiaries who, by the end of June, were facing loss of Medicaid coverage, and (2) some of our focus group participants saying they had never even heard of the requirements. Several interviewees commented on the problematic nature of placing phone calls to people with limited phone minutes, mailing letters to people who were homeless or moved around frequently, and visiting homes during work hours.

However, many also agreed that DHHS made a good-faith effort and "did the best they could, given very limited resources." One interviewee felt that even if these issues were somehow addressed, a successful outreach campaign for Medicaid work requirements was impossible, "because this population is busy, overstretched, skeptical of government, moves around a lot, is difficult to reach, and might have limited literacy for how to navigate the system."

Promoting Work through the Granite Workforce Pilot Program

To accompany their adoption of Medicaid work requirements, New Hampshire policymakers created a companion Granite Workforce pilot program to encourage and facilitate work by addressing known barriers to employment and incentivizing employers to hire Granite Advantage beneficiaries. However, the program's scope was quite narrow because of restrictions on its funding stream, and it fell far short of expectations.

Granite Workforce diverted $3 million from TANF reserves to NHES to support impressive benefits, including up to $5,000 per enrollee in tuition assistance, mileage reimbursement up to $160 a month for four months, emergency housing support up to $650, adult basic education assistance up to $450, and $4,000 in incentives to employers for hiring Granite Workforce enrollees (half paid after three months of employment, the second half paid after nine months).[23] Each Granite Workforce enrollee also received case management support from staff at NHES's 12 NH Works/American Job Centers across the state. The pilot program lasted just six months, from January through June 2019.

However, because of federal restrictions on how TANF funding could be spent, Granite Workforce was limited only to Granite Advantage beneficiaries between ages 19 and 24 and who were parents of children under age 18, therefore excluding most people subject to work requirements. DHHS and NHES officials jointly promoted the pilot during 11 public forums and 50 targeted information sessions held at such places as FQHCs, hospitals, refugee assistance centers, homeless shelters, and Job Corps events.[24] During these sessions, attendees over age 24 reportedly expressed surprise and frustration that the program could not help them. Still, state officials estimated that they would assist between 1,200 and 1,500 Medicaid expansion beneficiaries. However, they ended up only serving 120, or just 10 percent of the target population. By extension, Granite Workforce spent only a fraction of its $3 million budget, roughly $390,000 (table 2). Stakeholders attributed low uptake to the program's eligibility restrictions and limited outreach.

TABLE 2

Granite Workforce Expenditures, by Activity Type

Activity	Expense
NHES memorandum of understanding for staff provided to DHHS	$226,770.41
Barrier-reduction costs	$8,400.00
Transportation reimbursement	$2,476.62
Employer subsidy	$0.00
Fees and supplies	$296.41
Child care registration fees	$100.00
Emergency housing support	$3,336.75
Tuition	$147,739.69
Basic education	$100.00
Outreach calling	$0.00
Total	**$391,219.88**

Source: New Hampshire Department of Health and Human Services, letter to Senators Feltes and Rosenwald and Representative Wallner, RE: Costs to implement the community engagement requirement for Granite Advantage, October 24, 2019.
Notes: NHES = Department of Employment Security. DHHS = Department of Health and Human Services.

Beyond Granite Workforce, NHES has long operated its work support program, NH Works, across New Hampshire. Supported primarily by federal Workforce Innovation and Opportunity Act funds, NH Works accepts referrals from several state and local agency partners and provides services ranging from job search assistance to help with developing a résumé, as well as more intensive job-specific training for people meeting stricter eligibility criteria (including evidence documenting the need, utility, and appropriateness of providing training). Box 2 summarizes what focus group participants said about help they have received from NHES.

NHES leadership had long viewed the Medicaid expansion as a golden opportunity to extend NHES services to people who could benefit from the assistance. When Granite Workforce was authorized, it allowed NHES to promote to Granite Advantage enrollees not only the benefits of the pilot program but NH Works services more broadly. Though NHES and DHHS officials jointly publicized the work requirements and Granite Workforce, and all work requirement–related letters and materials mailed to beneficiaries included information about NHES assistance, the state did not successfully raise awareness about these work supports, according to key informants and focus group participants.

BOX 2

What Focus Groups Said about Training and Employment Resources

Of the 11 focus group participants, only 2 had received services through NHES. Both reported very positive experiences with those services. However, none of the participants knew about or had received services from the Granite Workforce pilot program.

> "They do job search, they help you with your résumé. If you want to go back to school, they help you do that. It has been very helpful. [The staff members] are great. Not at all [judgmental]. They help pay for a lot; if your car breaks down, they will help to pay to fix that. It is a really good program. They are awesome. They help you learn how to interview properly and be prepared."
>
> "I went there and made a résumé, and they paid for my nursing training a while ago…They will help you find a job."
>
> "I don't recall [seeing information about employment services] on the website. But that could be because I was already working two jobs, so they didn't send it to me."

Source: Urban Institute focus groups, October 2019.

Stakeholders agreed that the Granite Workforce pilot program failed to extend meaningful job support to the entire Medicaid expansion population. Pivoting off this experience, and independent from the state's Medicaid work requirements, the state legislature authorized an expanded NHES job training program and tripled NHES's budget from $2 million to $6 million by diverting a portion of unemployment compensation tax revenues from administrative contributions to the new program. Starting January 2020, this program provides expanded services to Granite Advantage enrollees, including job training and transportation assistance, and provides subsidies to employers who hire enrollees. The program also helps people transitioning out of prison find meaningful employment along with their Medicaid coverage. Whether this expanded program will fully meet the needs of un- and underemployed New Hampshirites is unclear, but NHES officials expressed excitement over the increased funding.

Reporting Work and Community Engagement

Based on the experiences of Arkansas (Hill and Burroughs 2019), New Hampshire officials intentionally set out to design a reporting system for its Medicaid work requirements that was more flexible and not primarily dependent on online submission. Instead, the state's no-wrong-door approach intended to allow Granite Advantage enrollees to report their hours online, by mail, over the phone, or in person at

any of New Hampshire's 11 DHHS district offices. Further, reporting required limited documentation or verification; in some situations, only self-attestation of hours worked or spent in community engagement was necessary.

Still, just one month of experience during June 2019 indicates that the reporting system did not work as planned. Most notably, the paper form beneficiaries received in the mail did not have a field where they could enter their work hours. Rather, it only allowed entry of hours spent on other community engagement activities.[25] This surprising omission was the result of state officials trying to save beneficiaries a step, because most Granite Advantage enrollees had been sent letters by DHHS telling them how many hours they had worked—having accessed those data from a state labor department database—and whether they had met the state's 100-hour threshold. But this inability to report work hours was understandably confusing for beneficiaries, and DHHS officials admitted, "We tried to make things easier, but we inadvertently made them harder and more confusing." This was especially problematic for self-employed workers, whose work hours were not known or available to the state and thus not shared in advance with enrollees, and for people who had worked some hours but less than the 100 required. Though such people were at first stymied from accurately filling out the form, DHHS ultimately added spaces at the bottom of the form for people to report self-employment and additional work hours.

Other challenges with the reporting system, according to key informants, included the web portal being "glitchy" at times, long wait times for beneficiaries reporting hours by phone, and staff at the state's contracted call center reportedly being rude to clients (including one anecdote of a consumer being told, "Maybe you should just get another job"). On the bright side, enrollment specialists at FQHCs and other agencies could access DHHS's NH EASY online eligibility system and help beneficiaries report their hours. According to one staff person we interviewed, this was an easy process, once she had been trained to use the system. On the other hand, interviewees repeatedly said resources in the community for providing hands-on help to consumers were limited. Hospital and health plan representatives told us they were not set up to provide such assistance, and health care providers, including FQHCs, noted that they had many fewer staff members to provide help because navigator and application assister funding, originally provided by the Affordable Care Act, had been dramatically cut in recent years. One key informant summed up DHHS's no-wrong-door approach as follows:

> "If you have to go to the library or pick up the phone and wait on hold for 10 minutes to verbally report your hours or fill out a form and get it to a mailbox...the doors are there, but to get through them is not easy."

Another component of New Hampshire's reporting system, its curing feature, was also confounding. People who fell short of reaching the 100-hour threshold were given one month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause. But this process, though well intentioned, confused both stakeholders and consumers, partly because it was unclear whether beneficiaries only needed to make up the shortfall from the previous month, or whether they were required to work a full 100 hours *plus* the hours needed to meet the prior month's shortfall.

Box 3 summarizes what focus group participants told us about their experiences with reporting.

BOX 3

What Focus Groups Said about Work Reporting Systems

The 11 focus group participants had limited experience with reporting work or community engagement hours. Only 1 participant completed the process; he opted to bring a letter stating his hours to a district office. Another participant reported using NH EASY, which she found to be user friendly, but ultimately received an exemption and did not need to report hours. Notably, a third participant said he did not report his hours because he knew he would be a few hours short of the 100-hour requirement, not understanding that he could have made up the hours shortage the following month through the curing process. None of the participants had attempted to report hours by phone, though several participants reported general difficulties reaching the state office by phone. They cited issues such as long hold times and having their calls transferred many times.

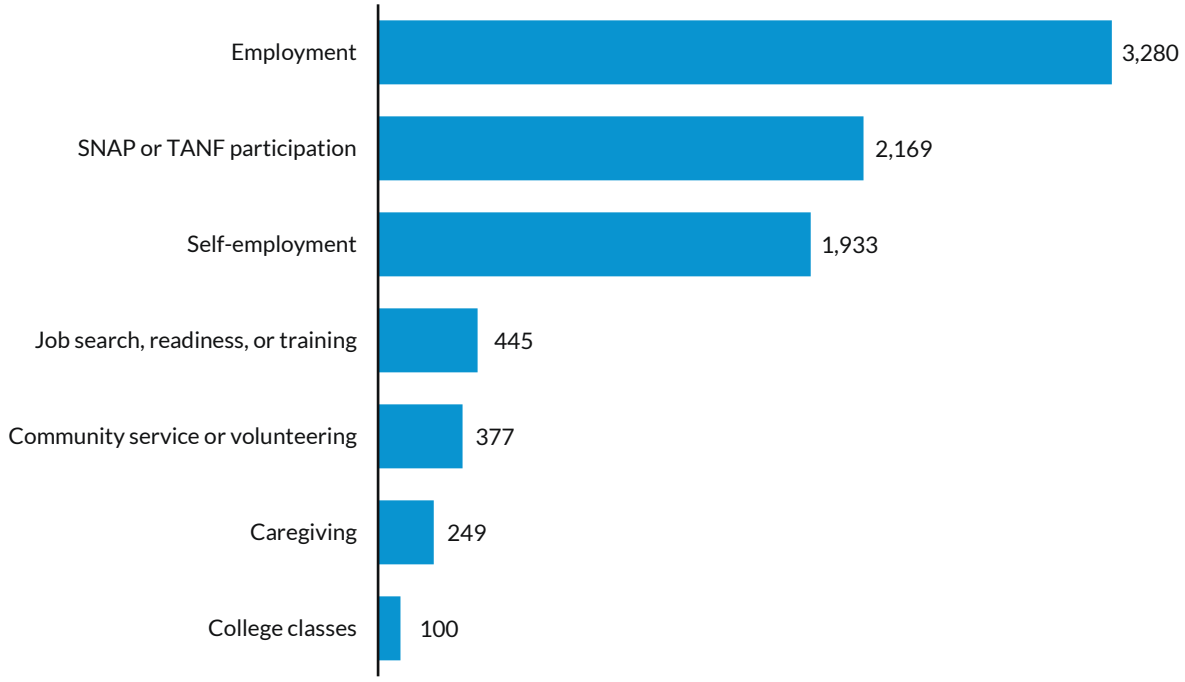
> "I already had my hours done, and I had a letter prewritten, brought in, stating how many hours I had done of volunteering, and they took it."
>
> "I started to fill out the paperwork and then I got a gut feeling, and I was like, 'I am going to wait on this because I don't need to stress myself out until I find out what is going on.'"
>
> "I have NH EASY. It is easier for me to download my information into the computer instead of running into the offices…The website is pretty user friendly."
>
> "I didn't make the hour requirement, so I figured, 'Why report it?' So I don't know how the system worked to report the hours…I got very close. I had upper 90s, so just a few hours short."
>
> "If you have time to wait on hold for 20 minutes, then [calling] is the way to do it."
>
> "You call one number and have to transfer to 84 different departments until you get to the one you need."

Source: Urban Institute focus groups, October 2019.

In the end, 8,129 people, 33 percent of the 24,766 people subject to mandatory reporting, complied with the requirement during June 2019, the first month reporting was required.[26] However, of these, only a small fraction, just 663 people, actually reported their hours either online, by phone or mail, or in person. The state automatically deemed the remaining 7,466 beneficiaries compliant. Figure 2 presents DHHS data on beneficiaries classified as having met the program's 100-hour requirement—either because they reported hours or the state deemed them compliant—and the work and community engagement activities through which they complied. The state determined that the largest subset of these beneficiaries were working sufficient hours by matching their information with NHES earnings data and then estimating how many hours they worked by dividing beneficiaries' wages by the federal minimum wage.

FIGURE 2

Number of Granite Advantage Beneficiaries Complying with Work Requirements, by Activity Type, June 2019



URBAN INSTITUTE

Source: New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.
Notes: SNAP = Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. Numbers do not total to 8,129 because beneficiaries could report activity in more than one category.

Obtaining Exemptions

In June 2019, DHHS exempted 15,941 beneficiaries from the work requirements,[27] 33 percent of the total 47,619 Granite Advantage enrollees.[28] DHHS automatically granted 81 percent of these exemptions by identifying beneficiaries in state databases for people who were disabled, enrolled in the Health Insurance Premium Payment program, compliant with or exempt from TANF or Supplemental Nutrition Assistance Program work requirements, the parent or caretaker of a child under 6, the parent or caretaker of a child with a developmental disability, or pregnant or fewer than 60 days postpartum.[29] As shown in table 3, several hundred more beneficiaries applied for exemptions for these same reasons. Others applied for exemptions because they were

- a caretaker residing with a family member with a disability;
- a caretaker of a family member who had a serious illness or had been hospitalized;
- ill, incapacitated, or receiving outpatient treatment;
- in inpatient hospitalization;
- medically frail; or
- participating in a state-certified drug court program.

TABLE 3

Number of Granite Advantage Beneficiaries Qualified for Reporting Exemptions, June 2019

	Number of Beneficiaries		
Reason for exemption	With automatic exemptions	Who requested exemptions	Total
Parent or caretaker of child under 6	4,515	307	4,822
Disability	4,401	176	4,577
Exempt in SNAP/TANF	3,698	—	3,698
Medically frail	—	1,951	1,951
Pregnant or 60 or fewer days postpartum	217	—	217
Parent or caretaker of family member needing care	—	201	201
Illness, incapacitation, or outpatient treatment	—	186	186
Parent or caretaker of child with developmental disability	110	36	146
Caretaker of family member with disability	—	54	54
Caretaker of family member with serious illness or hospitalization	—	32	32
State-certified drug court program	—	23	23
Enrolled in HIPP	21	—	21
Inpatient hospitalization	—	13	13
Total automatic and requested exemptions	**12,962**	**2,979**	**15,941**

Source: New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.
Notes: SNAP = Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. HIPP = Health Insurance Premium Payment program. Cells are marked with a dash when the row does not apply to the column head.

Far more beneficiaries applied for medical frailty exemptions than any other category, accounting for 1,951 (65 percent) of the requests. However, this number did not come close to the amount stakeholders expected. Years earlier, thousands more beneficiaries had self-attested to being medically frail under the initial private-option Medicaid expansion program, and as stated in the outreach section, DHHS mailed 10,798 letters to people they believed to be medically frail based on these past self-attestations.

Additionally, beneficiaries could submit a request for a good cause exemption if they could not fulfill the hour requirement because of unforeseen circumstances in a given month. DHHS developed a separate form specifically for these requests, which includes the following categories: birth or death of a family member, severe inclement weather, family emergency or life-changing event, parent or caretaker of a child 6 to 12 years old unable to secure child care, and other. Beneficiaries checked the appropriate box and, for some categories, were asked to provide additional information; for example, for a birth or death of a family member, DHHS asked the name of the family member, the date of the event, and the beneficiary's relationship to that person. Other reasons, such as hospitalization or serious illness, required copies of medical records. Parents could self-attest good cause requests for inability to find child care without providing proof or documentation. DHHS only granted 89 good cause exemptions for the June reporting period.[30]

To try to automatically exempt more beneficiaries, state officials included in S.B. 290 (passed June 27, 2019) alterations to several exemption policies: For the month of June, parents and caretakers of children up to age 6 were exempted, but the new bill raised the age to 13. People experiencing homelessness were also automatically exempted or could apply for a long-term exemption, as opposed to a one-month good cause exemption.[31] However, because the work requirements were suspended immediately after the bill passed, and then the court halted the program at the end of July, these exemption policies never took effect.

Though stakeholders praised the breadth of exemptions, obtaining them proved challenging. Because beneficiaries needed a medical professional to complete the medical frailty exemption request, as required by the state law enacting Medicaid work requirements, it was critical that providers be informed of and willing to engage in the process. However, stakeholders said many providers were confused or did not want to participate at all. One interviewee said, "We heard that some doctors would

say, 'I don't know what to do,' and others would say, 'I don't agree with this [work requirement] program, so I won't sign the certification.'" Stakeholders said that in some cases, doctors were unsure whether their patients could work and were uncomfortable certifying that they could not, and others did not want to participate because they did not want to enforce a policy they disagreed with. Other providers reportedly did not understand that they needed to determine whether their patient could work 100 hours every month, not whether they could work *at all*. If they felt their patients could work 10 hours per week—not enough to meet the requirement—some hesitated to certify medical frailty. Another interviewee sympathized, saying, "I don't think [DHHS] understood the pressure this put on physicians."

Though focus group participants and stakeholders both mentioned pushback from primary care doctors, they said behavioral health providers were more consistently willing to abet exemptions (box 4). This may be because the medical frailty form specifies that physical health conditions must "significantly impair the ability to perform one or more activities of daily living," whereas behavioral health providers only had to confirm diagnoses of mental health conditions. Further, one stakeholder speculated that the recent shift to Medicaid managed care may have inadvertently autoassigned enrollees to new primary care providers with whom they did not have established relationships. As one key informant explained:

> "If beneficiaries don't have a relationship with their doctors, that might have been a disconnect. If I just walk into my doctor's office and they don't know me, and I say, 'Sign this medical frailty form,' how is the doctor going to do that?"

Consequently, primary care doctors may not have felt they knew their patients well enough to confirm the impact patients' health had on activities of daily living, whereas behavioral health providers did not have to make that determination.

BOX 4

What Focus Groups Said about Exemptions from Work Requirements

Six of the 11 focus group participants received exemptions from the work requirements. Five of those participants requested the exemption, and the other received the exemption request form while seeking behavioral health care. This participant filed for an exemption but felt he could work and was offended when the provider assumed he needed the exemption. Three participants reported that their primary care provider would not sign their exemption form, two of whom ultimately got signatures from behavioral health providers. The third had a particularly difficult time receiving an exemption; after experiencing six brain aneurysms and consequently undergoing multiple brain surgeries in another state, her surgeon could not sign the form because the hospital prohibited it. Back in New Hampshire, a different primary care physician refused to sign the form. She sought out a third provider who finally signed and approved her exemption. Several participants reported that it took between one and three months to get their exemption request signed and approved. Though a handful of participants successfully obtained exemptions, there was general confusion surrounding exemption policies and processes.

> "I called the state office to find out what was going on, and I explained all my disabilities and that I was on Social Security. And she said that because of my disabilities and I am on [Supplemental Security Income], that I am exempt. So I could work if I wanted to, but it wouldn't affect me if I didn't want to."
>
> "I explained to my therapist that as I have worked, things have bubbled up and become worse. Going to work was giving me a lot of anxiety, I was losing weight, and it was a huge struggle for me to get up in the morning…I was awarded the letter and I sent it in."
>
> "I had six brain aneurysms…but [the doctor] said, 'If you can walk, you can work.' Then they got me another doctor and…she signed the form."
>
> "I had to go to my neurologist to get my paperwork signed. My doctor wouldn't sign it, so my neurologist did it."
>
> "I brought my [exemption] paper to my doctor…and she knows me personally and knows that I try to do as much as I can, but she said, 'Technically you don't qualify for any exemptions on this, but I know you are taxed.' My therapist ended up signing it because I have major depression. It took a few months [to get the exemption], after…all the back and forth."

Source: Urban Institute focus groups, October 2019.

Stakeholders and focus group participants also agreed that filling out and submitting exemption forms was excessively complex, as were the forms. Beneficiaries had to determine which exemption they might qualify for, obtain the associated form—from among three forms for medical frailty, good cause, and all other exemptions—and for most exemptions, find a provider willing to fill out the form.

Beneficiaries were also often asked to submit documentation with the request (e.g., an exemption for hospitalization or serious illness required copies of discharge summaries or billing information). Only a select few good cause exemptions, such as inability to find child care and homelessness, could be self-attested. In addition, different exemptions had varying durations, so forms had to be submitted at different intervals. Good cause exemptions lasted up to one month, whereas medical frailty exemptions lasted up to one year. State officials admitted that though they worked with physicians to design the forms, they were ultimately still too complex.

Child Care Implications of Exempting Only Parents with Children Younger Than 6

One noteworthy policy in New Hampshire's initial Medicaid work requirement legislation was only exempting one parent per household with children younger than age 6. With this policy, New Hampshire joined eight other states who similarly proposed to require parents with school-age children at home to comply with work requirements (Adams et al. 2019). This raises questions of whether New Hampshire parents could have found child care, how many parents would have been able to comply, and to what extent work requirements would have adversely affected child and family well-being.

Our interviews suggest that though some child care stakeholders raised questions about the child care implications of work requirements as the law took shape, many others were unaware of the potential effects that the policy would have had on the well-being of children and the child care system. This section examines two critical questions about child care challenges that might have faced New Hampshire families subject to the work requirement with children over age 6: Would parents have been able to find child care? And would parents be able to afford care if they could have found it?

WOULD PARENTS HAVE BEEN ABLE TO FIND CHILD CARE?

Respondents described the child care landscape for school-age children as a mix of school-based programs, programs in community organizations, local child care centers, family child care homes, and arrangements with family, friends, and neighbors. The settings families use vary within and across different communities and parts of the state and vary based on needs. When asked about the options available to parents subject to work requirements, one respondent suggested that finding care would depend on "the luck of the draw." Specifically, respondents suggested that though some parents might have been able to find care, others would have confronted barriers related to the following:

- **Statewide staffing crisis.** Child care programs are struggling to staff their classrooms and therefore cannot serve to their capacity. One respondent suggested that this problem is resulting in a loss of overall supply, particularly in rural areas.
- **Rural areas**. Rural regions across the country face child care supply constraints (Henly and Adams 2018), and more than a third of New Hampshire's population lives in rural areas.[32] As one respondent noted, "North of Concord, you have these tiny towns that only have a few people, and you might only have one or two children that need child care. You aren't going to have a child care center [in these places]."
- **Lack of transportation.** Transportation challenges confront families in areas lacking afterschool programs in their schools. As one interviewee said, "Students live in one area, parents work in another area, and then [the kids] are bused to yet a different area for afterschool...There is no transportation to get the kids home or back to their school."
- **Care for nontraditional schedules**. It is likely that some families subject to the work requirements would be engaged in activities that do not fit a 9–5 schedule, and respondents highlighted the challenges of finding care for parents who work nontraditional, irregular, or part-time schedules; one interviewee noted, "There is almost no child care in New Hampshire available in those times."
- **Care on short notice or for specific times of the year.** Respondents discussed the challenges of finding care quickly, because programs can have waiting lists and available spaces tend to fill up quickly. One respondent noted that it "requires significant advanced planning by families to reserve a slot in any quality program." Interviewees also discussed challenges finding care during summer months, when many programs are closed.
- **Care for young school-age children.** Respondents suggested that elementary school programs fill up quickest, meaning supply challenges are more acute for families with younger school-age children.
- **Care for middle- and high-school students.** The child care subsidy system cuts off at age 12, and our respondents worried about older students' needs. They noted the gap in programming and safe places for adolescents after school and were concerned that the work requirements would push parents to leave their older kids alone. One respondent noted, "It would be nice to not have an end date to childhood. You should be around other people and cared for and in a good pace to do homework or learn or do activities."

- **Variation in quality.** Families can also face challenges finding quality care. This is concerning because research has shown that participation in high-quality afterschool programs is linked to higher test scores, improved work habits, and reduced behavior problems (Durlak and Weissberg 2007; Vandell, Reisner, and Pierce 2007), and differences in program quality can shape outcomes (Pierce 2010; Vandell, Shumow, and Posner 2005).

COULD PARENTS AFFORD CARE IF THEY COULD FIND IT?

Respondents indicated that the cost of child care varies widely in New Hampshire, from free—if parents can find family members or friends willing to help for a sustained period or an opening in a highly subsidized program—to between $50 and $125 per child a week during the school year. These costs would be significantly higher during the summer, when children would need care for more hours.

Clearly, families with low incomes will likely find it challenging to afford higher-cost care if they cannot access free or low-cost care. Therefore, parents may seek public child care assistance (known as scholarships in New Hampshire) to help them defray some or all of the costs of such care. These scholarships are funded by the Child Care and Development Fund, the primary child care source for families with low incomes, and they are difficult to obtain.

Consequently, a key question is whether parents would likely have been able to get a scholarship, which respondents said depends on two issues. First, would they be eligible? The activities parents must engage in to comply with the Medicaid work requirements and the activities that make parents eligible for child care subsidies/scholarships only partially align. Though parents are eligible for scholarships if they are working or looking for work (though job search is limited to 92 days), the kinds of education and training that meet the eligibility criteria for child care assistance are limited, and volunteering is not an approved activity.

Second, even if eligible, can families get a scholarship? Nationally, limited Child Care and Development Fund funding means the program only serves a fraction of those eligible for services (Chien 2019). Though New Hampshire did not have a waitlist for subsidized child care at the time of our interviews, respondents worried that under work requirements, the lack of surplus funding for new applicants would result in a waitlist, further delaying assistance to families.

Finally, some respondents suggested the scholarship may not sufficiently reduce the cost of care for low-income families. Depending on parents' income, the sliding-scale scholarship copayment may equal the cost of care. A recent study found that in 2019, New Hampshire parents in the scholarship program

with incomes at the poverty level would pay $133 per month, or about $30 per week (Schulman 2019), for subsidized care—exceeding the costs of some unsubsidized school-age child care programs.

Respondents also noted that some child care providers seemed less interested in accepting scholarship clients given the state's new scholarship-related licensing and health and safety requirements. They suggested that the high demand for child care, due to the tight labor market, may be making providers less willing to take the steps necessary to meet the new, stricter requirements for serving scholarship clients, because they can easily fill slots with private-paying parents.

Implications of Disenrollment for Providers, Hospitals, and the Beneficiaries They Serve

New Hampshire expanded Medicaid under the Affordable Care Act in 2014, successfully extending coverage to tens of thousands of previously uninsured residents. By 2016, new Medicaid enrollees numbered more than 52,000, representing 28 percent of total program enrollment at the end of that year (NH DHHS 2019). By 2017, New Hampshire's uninsurance rate had decreased by 45 percent (Berchick, Hood, and Barnett 2018). To date, the state's Affordable Care Act/Medicaid expansion has brought in approximately $2.1 billion in federal funds.[33]

Medicaid work requirements, however, were poised to reverse some of these gains. As discussed above, nearly 17,000 Granite Advantage beneficiaries were due to receive letters from DHHS in July 2019 notifying them that they had not met the state's 100-hour work/community engagement threshold and would lose coverage if they did not cure their shortfall and come into compliance by August. But this potential crisis was averted when, on July 7, the DHHS commissioner announced a three-month suspension of the requirement, and the federal courts followed suit later that month by halting the state's work requirement indefinitely. Interestingly, DHHS officials pointed out that Granite Advantage enrollment had slipped below 50,000 (to 49,783) for the first time in years in May 2019 (NH DHHS 2019). Key informants interviewed for this study speculated that work requirements might have contributed to this decline, even though the program was stopped before any formal disenrollment occurred. As we learned in our focus groups, confusion and concern surrounding work requirements caused some people to think they might have already lost coverage and discouraged others from renewing their coverage, because they did not think they would meet the 100-hour requirement in the future. However, publicity for the Medicaid work requirements and the federal proposal to make

receipt of Medicaid benefits a "public charge" coincided, and some stakeholders believed the latter reduced enrollment more than the work requirements.

Beneficiaries participating in our focus groups told us how they depended on Medicaid for maintaining their health and how work requirements might affect, or had already affected, them (box 6).

BOX 6

What Focus Groups Said about Implications of Disenrollment for Beneficiaries

Though the work requirements were only implemented for a brief period and no one was disenrolled, focus group participants still felt their impact. Of the participants that had heard of the work requirements, most reported feeling stressed upon learning about them. One participant even decided to forgo needed care because he knew he was not going to meet the hour requirement for June and thought he no longer had coverage (even though he did). Several participants felt they were doing as much as they could and expressed that the imposition of a 100-hour work requirement affected their feelings of self-worth. Other participants spoke about the ramifications of losing insurance, and many voiced that they would have to go without needed care and medications.

> "I was like, 'What am I going to do?' This [health coverage] is how I survive."
>
> "I went for a physical, and we concluded I was depressed and should be seeing a therapist. I wasn't sure if I would still have insurance, [so] I have been putting it off…because I was going to be a couple hours short of the 100-hour requirement."
>
> "I often feel like I can't really do enough. Even at less than 100 hours, the limited hours I had, it still felt like a lot of work for me and left me in a bad state of mind."
>
> "How did it make me feel [when they said I needed more hours]? I felt like I was not good enough…like what I had going on wasn't enough."
>
> "When you are looking at not getting your medicine or not being able to go to the doctor, that is a really scary thing."
>
> "I had one medication that, without insurance, costs 150 bucks a month. And would probably cost my life if I couldn't get it."
>
> "Here is the kicker: I work three days per week at the office I work at. I was working two days on the weekend as a waitress until [the state] said I was making too much money to get medical assistance. So one extra day of work made my income too high, and one less day made me ineligible because I didn't work enough [to meet the 100-hour requirement]. It is a trap. If I had the ability to work full time and get insurance, I would."

Source: Urban Institute focus groups, October 2019.

Hospital representatives said New Hampshire's Medicaid expansion had been important to the state's 26 hospitals: uncompensated care dropped significantly, no hospitals had closed for many years, and emergency department utilization had dropped dramatically. Though no formal analysis of potential impacts of work requirements in Medicaid had been conducted, these stakeholders expressed concern about the implications of coverage losses, citing potential deterioration in patient health and increased use of expensive emergency room care.

FQHC officials said one of their greatest concerns was insufficient funding to cover the cost of caring for people who lost coverage because of the Medicaid work requirements. New Hampshire officials adopted a less punitive policy for its program than Arkansas and other states; technically, rather than formally disenrolling people who did not report enough hours, they would have suspended enrollees' coverage until they could make up hour shortfalls, and then the state would reactivate enrollees' Medicaid coverage if they complied. But this approach left FQHCs vulnerable; they could not bill Medicaid for services rendered to people with suspended coverage, nor could they use federal Section 330 grant funds to cover the cost of such care, because those with suspended coverage would still be officially "enrolled" in Medicaid. FQHC representatives estimated that if 10 percent of their patients had suspended coverage, they would lose approximately $350,000 in revenue annually.

Three qualified health plans currently participate in Granite Advantage: Well Sense Health Plan, NH Healthy Families/Centene, and Amerihealth Caritas New Hampshire. For them, Medicaid expansion meant expanded membership given the more than 50,000 newly covered lives. Like hospitals, health plans had yet to conduct formal analyses of how high disenrollment rates might have affected their bottom lines. But before the requirements were stopped, plan administrators had become increasingly concerned about losing up to 10 percent of their members and how those losses would affect their risk pools.

Diverging Opinions of Medicaid Work Requirements

Opinions about Medicaid work requirements remain mixed in New Hampshire. Legal advocates and many state-based policy researchers strongly believe they are wrong headed and illegal under the Medicaid statute, and that they will ultimately be stopped by the courts. Republican lawmakers maintain that work requirements represent a legitimate experiment worth conducting and point to the popularity of the policy among the voting public. Though Granite Advantage participants in our focus groups believed in the merits of work, they also felt strongly that if someone cannot work, or cannot work 100 hours each month, they should not be punished with loss of health coverage (box 7).

BOX 7

What Focus Group Said about Work and the Work Requirements

Focus group participants generally agreed that beneficiaries capable of working should do so; most of our participants were either working or unable to work because of physical or mental health limitations. Participants not working enough to meet the 100-hour requirement generally felt they were incapable of doing more, though they wished they could. Generally, participants thought the work requirement was not a fair policy and that it was excessively harsh. Consequently, they expressed frustration and defeat.

> "People that could work, should work…But yanking health insurance for not complying is harsh because people need their medications and doctors' appointments."
>
> "I like to work. I wish I had the stamina to work more...I would work more if I could."
>
> "I just remember thinking, 'I am doing all I can do. How can I do more? How can I squeeze in where they want me to do it?' I already had two jobs and was working as much as I could work, physically and mentally."
>
> "I see what they are going for, but there are people like me who just…in the state I am in, it would be very difficult for me mentally. I see that they don't want people sitting around and getting [health coverage] for free, but I am currently one of those people...That is difficult to think about."
>
> "Fundamentally, I understand why it needs to be implemented. [But] on the fairness issue, one shoe doesn't fit all."
>
> "You can't [kick people off Medicaid]. That is traumatic. For people who qualify for the help, they have already gone through the process of qualifying…and now you are adding more stipulations on them. They changed the rules of the game while the game is in play."
>
> "The state likes to keep us in the dark and up the creek without a paddle."
>
> "[The state] just throws everyone to the wolves and says, 'Let's get some popcorn.'"

Source: Urban Institute focus groups, October 2019.

Some stakeholders we interviewed occupy middle ground; they may object to the requirements' punitive nature but feel politically compelled to accept the requirements in return for the benefits of Medicaid's coverage expansion. One stakeholder suggested an alternative to work requirements could be a voluntary work support program for adults newly covered by Medicaid expansion, like that originally adopted in Montana, saying, "People need to be healthy to work. Taking away their health insurance is not going to make that easier."

Conclusions

A federal court halted New Hampshire's Medicaid work requirement program on July 29, 2019, just a few weeks after state officials had temporarily suspended it and roughly two months before the suspension would have expired had the court not intervened. No one interviewed for this study was surprised by the court's decision, given that the presiding judge had previously halted programs in Arkansas and Kentucky. Most stakeholders were greatly relieved and some even speculated that conservative state lawmakers might also be secretly comforted, because it "gave them cover" from having to continue pushing for a program that was poised to disenroll large numbers of Granite Advantage members. Once the program was halted, DHHS stopped all activities related to the work requirements; they suspended door-to-door outreach, sent letters notifying beneficiaries that work requirements were no longer in place, displayed a prominent banner with the same message on the DHHS website, and reinstated a 90-day retroactive reimbursement for providers. For the time being, at least, upwards of 17,000 beneficiaries were shielded from losing Medicaid coverage.

At the time of our case study, stakeholders had many of the same as-yet unanswered questions as Arkansas stakeholders, including the following: Who could have lost Medicaid? Were they in good or poor health? Were they high or low utilizers of care? How many of the people at risk of disenrollment suffer medical and/or behavioral conditions that prevented them from working? When the work requirements were halted, the state had already spent $6.1 million (GAO 2019). What other needs could that money have been spent on?

For now, this case study's findings provide several insights into the multiple and complex problems surrounding implementation of Medicaid work requirements:

- **Outreach.** Though New Hampshire was eager to avoid repeating Arkansas's implementation mistakes, it succumbed to many of the same outreach errors. The state did not allow enough time to publicize and educate beneficiaries about new work rules before implementation, and outreach efforts were not sufficiently funded. The state relied too heavily on mail- and telephone-based communications that failed to reach a population who is transient, moves frequently, possesses limited-minute phone plans, and faces numerous social challenges related to mental health, substance use, and homelessness. The information conveyed was overly complex and left beneficiaries confused and bewildered about how the rules affected them. Though the state conducted a door-to-door outreach campaign in late June to address the above shortcomings, the effort was largely unsuccessful. Community-based service providers interviewed for this study told us a more effective strategy would have been to fully fund

comprehensive outreach and education, including paying for health and social service providers, who regularly assist these populations, to provide hands-on help. However, one interviewee felt that even if these strategies were adopted, they would not have fully informed and educated this hard-to-reach population.

- **Promoting work.** New Hampshire launched a pilot work support program, Granite Workforce, in tandem with its Medicaid work requirements to help the expansion population gain important skills and to incentivize employers to hire Medicaid enrollees. But the program was crippled by eligibility restrictions because of the TANF funding used to support it—it could only help people between ages 19 and 24 or parents of dependent children under age 18—and the pilot period lasted just six months. Stakeholders, including state officials, agreed that an effective work support effort would need more time to become established and would need to be available to people of all ages. Further, such an effort would have to more rigorously address common barriers to employment, such as lack of transportation, affordable child care, and housing.
- **Reporting work and community engagement.** Here, too, New Hampshire officials tried to avoid mistakes made in Arkansas by designing a no-wrong-door approach to reporting hours spent working, going to school, receiving job training, or participating in other community engagement activities. Under this approach, beneficiaries could report hours online, by mail, over the phone, or in person. But key informants and focus group participants reported that paper forms were poorly designed, the state's web portal was sometimes "glitchy," there could be long wait times when trying to get help over the phone, and staff members at the state's contracted call center were sometimes rude to customers. The state's curing system—which allowed beneficiaries who fell short of the 100-hour threshold an extra month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause—was confusing to stakeholders and consumers alike. Focus group participants and many key informants, including those at community agencies, believed reporting might have been less onerous for beneficiaries if providers and community-based organizations had received funding to support assisters or navigators to provide hands-on help to affected enrollees.
- **Obtaining exemptions**. Like Arkansas, New Hampshire attempted to proactively exempt as many Granite Advantage members as possible from its Medicaid work requirements, doing so for those deemed compliant with or exempt from Supplemental Nutrition Assistance Program or TANF work requirements, disabled, pregnant or fewer than 60 days postpartum, and parents or caretakers of children under age 6. But also like Arkansas, New Hampshire did not use claims

data from health plans or other sources to automatically exempt people with medical frailty, instead requiring beneficiaries to get their health care providers to certify their inability to work. This proved to be the most problematic aspect of the state's exemption system. As noted, beneficiaries with physical and behavioral health problems reportedly struggled when applying for exemptions, often because primary care providers resisted signing forms declaring them unable to work. Meanwhile, parents with school-age children subject to work requirements likely would have faced challenges finding child care, struggled to afford it, and confronted barriers to getting assistance to defray some of the costs. State-based policy researchers, legal advocates, and beneficiaries with whom we spoke agreed that New Hampshire should have made exemptions simpler and more data driven, exempting broader groups from work requirements, including all parents of children younger than 18, homeless people, people with opioid and/or substance use disorders, and people over age 49.

- **Implications of disenrollment.** Medicaid beneficiaries told us their health coverage was critical, that it kept them healthy and able to work, and that losing Medicaid would have been devastating. Providers and health plans, too, said that Medicaid expansion had helped increase people's financial access to care and decreased uncompensated and care. They also expressed concern over how loss of coverage would affect patient health and increase use of expensive emergency room care.

In conclusion, though New Hampshire officials implemented numerous strategies to differentiate their Medicaid work requirements program from Arkansas's, they found themselves at nearly the same end point: on the brink of disenrolling a large portion of the state's Medicaid expansion population. Moreover, New Hampshire reached this point in a fraction of the time; Arkansas disenrolled 18,000 people over six months of implementation, whereas New Hampshire might have disenrolled up to 17,000 after just two months, a startling 67 percent of those subject to the requirements. The unique feature of New Hampshire's program not present in Arkansas's—state authority to suspend the program if undue harm to beneficiaries was expected—was added by the state legislature just in time to save 17,000 enrollees from potentially losing health coverage.

At the time of this writing, no date has been set to hear oral arguments on the federal government's appeal of the lower court ruling that halted New Hampshire's Medicaid work requirements, so the program's ultimate resolution is uncertain. Meanwhile, waivers to implement Medicaid work requirements have been approved in seven other states, and waiver applications from eight more states are pending at CMS (though, notably, implementation of approved programs in Indiana and Arizona has been postponed pending further decisions by the courts, and the newly elected Democratic governor of

Kentucky rescinded the state's waiver to impose work requirements).[34] Still, setting aside the fundamental question about the legality of work requirements, which the courts are currently considering, and based on the experiences of the first two states to implement Medicaid work requirements (using different approaches and under different circumstances), evidence suggests such programs cause significant harm to Medicaid beneficiaries while not appreciably supporting their ability to work.

Notes

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[6] Jason Moon, "N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise," New Hampshire Public Radio, July 9, 2019, https://www.nhpr.org/post/nh-said-its-medicaid-work-requirement-would-be-different-early-numbers-suggest-otherwise#stream/0.

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[10] S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).

[11] S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (as introduced March 14, 2019).

[12] S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).

[13] Jason Moon, "N.H. to Appeal Medicaid Work Requirement Ruling," New Hampshire Public Radio, August 1, 2019, https://www.nhpr.org/post/nh-appeal-medicaid-work-requirement-ruling#stream/0.

[14] S.B. 313, 2018 Leg., Reg. Sess. (N.H. 2018) (enacted).

[15] Emily M. Johnston, Anuj Gangopadhyaya, Genevieve M. Kenney, and Steven Zuckerman, "New Hampshire Residents Who Lose Medicaid under Work Requirements Will Likely Face Limited Employer-Sponsored Insurance Options," *Urban Wire* (blog), Urban Institute, May 13, 2019, https://www.urban.org/urban-wire/new-

hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options.

[16] Moon, "N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise," New Hampshire Public Radio.

[17] This number does not include initial letters and the status change letters sent to people when their circumstances change; it is only for the generic letters sent to participants regarding community engagement compliance. This was calculated by adding the 37,482 letters mailed to Granite Advantage participants subject to the work requirements and the 10,978 letters mailed to those who are medically frail, as reported by DHHS; Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.

[18] *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services, accessed January 27, 2020, https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf.

[19] Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.

[20] *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.

[21] Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.

[22] Meyers, letter to Bradley, RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

[23] For more information, see the New Hampshire Department of Employment Security's Granite Workforce web page, available at https://www.nhes.nh.gov/services/granite-workforce/index.htm.

[24] *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.

[25] Beneficiaries could report both work and community engagement hours online through the NH EASY system.

[26] *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.

[27] This number does not include the 7,466 people deemed compliant through the state's earnings calculation, discussed in the prior section.

[28] *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.

[29] New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.

[30] New Hampshire Department of Health and Human Services, email to Drought, RE: Your right to know request, August 22, 2019.

[31] S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).

[32] See the Rural Health Information Hub's New Hampshire guide, available at https://www.ruralhealthinfo.org/states/new-hampshire.

[33] Center on Budget and Policy Priorities' calculation using CMS's administrative Medicaid expenditure data from the CMS-64 form.

[34] "Work Requirements Tracker," Urban Institute.

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Gina Adams is a senior fellow in the Center on Labor, Human Services, and Population at the Urban Institute and directs the Low-Income Working Families project and the Kids in Context initiative. She is a national expert on factors that shape the affordability, quality, and supply of child care and early education services and the ability of low-income families to benefit from them. Her recent work focuses on the importance of stabilizing families to support healthy child development, the impact of Medicaid work requirements on the child care needs of parents, and strategies to meet the child care needs of parents seeking education and training.

Statement of Independence

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.

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Washington, DC 20024

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EXHIBIT 66

May 29, 2026

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy:

We write as governors committed to the effective administration of our Medicaid programs on behalf of the millions of Americans who depend on them. As our states work diligently to implement the Medicaid work reporting requirements on the ambitious timeline set forth in H.R. 1, we are writing today to respectfully seek the federal partnership necessary to ensure responsible implementation.

Specifically, we request two things: first, we request that your department confirm that, should the forthcoming Interim Final Rule (IFR) introduce substantive policy changes that diverge from states' reasonable working assumptions, an appropriate timeline is afforded states to make these significant policy and technology changes; and, second, we request that your department provide a formal written response to our outstanding guidance requests before June 1, 2026, to support timely state planning.

The Implementation Challenge

Our concern is straightforward: our states are working diligently to implement the Medicaid work reporting requirements enacted by Congress last summer, and we have done so with limited federal guidance. In the ten months since enactment, we have reached out to your department on multiple occasions seeking operational guidance, and while CMS has provided helpful verbal assurances, we have not yet received formal policies. In the absence of final official guidance, and in service of the challenging timeline set out in the law, we have made good-faith operational decisions to revise our state systems. We write today requesting that published, final guidance align as closely as possible with states' working assumptions based on informal policy direction from CMS to date and that states not be required to make significant changes at this stage of implementation.

Implementing Medicaid work reporting requirements is an administratively complex and resource-intensive undertaking. States must make substantial changes to their eligibility and enrollment systems; design new beneficiary notices, reporting processes, and appeals procedures; train eligibility workers and managed care partners; and in many instances make significant technology investments. At the same time, while Congress set an ambitious implementation timeline, our states have been prepared to take every possible step to meet it. To that end, states have built out IT systems, drafted member communications, and developed the guidance and policies necessary to implement these requirements.

We understand that CMS is required to publish an IFR by June 1, 2026, and we appreciate the Department's efforts to meet that statutory deadline. However, the timing of the IFR in relation to the January 1, 2027 effective date creates an operational challenge worth addressing now. If the IFR contains policy guidance that differs in any material respect from the operational choices states have made – whether in the absence of CMS guidance or in reliance on the verbal communications CMS has provided – states may need to revise or revisit significant

portions of their implementation work. Given the timing, that would leave states seven months or less to finalize regulations, update systems, execute data-sharing agreements, issue beneficiary notices, and complete all other required steps before the January 1 compliance date.

This challenge is compounded by a structural reality of Medicaid administration that CMS understands well: many states do not build or maintain their own IT systems. These systems are built, maintained, and modified by third-party vendors operating under multi-year contracts representing tens – and in many cases hundreds – of millions of dollars in state and federal expenditures. Every change must be specified in writing, scoped and contracted with the vendor, reviewed for compliance with federal certification standards, independently tested, and validated before deployment. Vendors typically require six to twelve months or more to complete significant system modifications, even when states provide complete and final specifications from the outset. States are not in a position to direct their vendors to implement requirements that have not yet been defined.

Implementation Timelines Matter for the People This Policy Is Meant to Serve

The administrative record from prior state community engagement pilots offers useful context. When Arkansas implemented similar requirements in 2018, a significant number of eligible beneficiaries lost coverage due to implementation challenges, i.e., system errors, notices that did not reach beneficiaries, and confusion about reporting procedures. Federal courts applying the APA's "arbitrary and capricious" standard subsequently found that beneficiaries' due process rights had been affected not by the policy itself but by gaps in implementation infrastructure and notice – a risk that is meaningfully greater in a simultaneous national rollout undertaken without final federal guidance.

States also face real legal and financial exposure when implementation difficulties result in coverage terminations that are later found to be erroneous. Federal law and the laws of many states entitle Medicaid beneficiaries to restoration of coverage and, in many jurisdictions, to compensation for costs incurred during periods of erroneous disenrollment. In the absence of a final federal regulatory standard, terminations will necessarily be made in reliance on states' reasonable interpretations of the statute – interpretations that may later be second-guessed. The financial and administrative costs of responding to beneficiary claims, including any remediation required, are substantial and fall on state agencies that are already managing significant fiscal pressures.

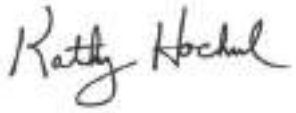
We raise these concerns because we believe addressing them now is in everyone's interest. We are asking for the federal partnership that responsible implementation requires – specifically, appropriate transition timelines for any substantive IFR changes and a written response to our outstanding guidance requests by June 1, 2026.

Respectfully,

Oregon Governor Tina Kotek

Maine Governor Janet Mills

Michigan Governor Gretchen Whitmer



New York Governor Kathy Hochul

New Mexico Governor Michelle Lujan Grisham Washington Governor Bob Ferguson

cc: CMS Administrator
Director of the Office of Management and Budget
Members of the Senate Finance Committee
Members of the House Energy and Commerce Committee

EXHIBIT 67

Kearns, Katherine (AGO)

From: Klunder, Nita (AGO)
Sent: Sunday, August 16, 2026 3:29 PM
To: OIRA_submission@omb.eop.gov; dominic_mancini@omb.eop.gov
Subject: RE: RIN-00938-AV98 - request for original submission

Hi All,

It has been a month since my original request, and I've neither gotten the requested documents (as required pursuant to Executive Order 12866 Sections 6(a)(3)(B), (C), and (E)) nor have I gotten any response whatsoever. Please provide an update on status.

Nita

From: Klunder, Nita (AGO)
Sent: Monday, July 20, 2026 1:25 PM
To: OIRA_submission@omb.eop.gov; dominic_mancini@omb.eop.gov
Subject: RE: RIN-00938-AV98 - request for original submission

All,

Forgive the serial emails, I think I have corrected all typos in the recipient email addresses. Please see below.

Nita

From: Klunder, Nita (AGO)
Sent: Thursday, July 16, 2026 4:53 PM
To: 'OIRA_sumission@omb.eop.gov' <OIRA_sumission@omb.eop.gov>
Cc: 'Dominic_J._Mancini@omb.eop.gov' <Dominic_J._Mancini@omb.eop.gov>
Subject: RIN-00938-AV98 - request for original submission

Hi there,

Pursuant to Executive Order 12866 Sections 6(a)(3)(B), (C), and (E) I'm requesting the original version first submitted to OIRA of RIN-00938-AV98, Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social Security Act. I would also like a redline between that version and the final version with notation of any changes that were made at the request of OIRA.

Thanks very much, and please let me know if you need anything additional from me prior to fulfilling this request.

Nita

EXHIBIT 68

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

- x

COMMONWEALTH OF MASSACHUSETTS, ET AL., :
Plaintiffs, : Civil Action No. 1:26-CV-12962-RGS
v. :

MEHMET OZ, M.D. in his official capacity as director of the Centers for Medicare & Medicaid Services, ET AL., :
Defendants. :
:

- x

BEFORE THE HONORABLE RICHARD G. STEARNS
UNITED STATES DISTRICT JUDGE
MOTION HEARING

Tuesday, July 28, 2026
2:00 p.m.

John J. Moakley United States Courthouse
Courtroom No. 21
One Courthouse Way
Boston, Massachusetts

Linda Horne, CSR, RPR
Official Court Reporter
lindahorne1@charter.net

A P P E A R A N C E S

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P R O C E E D I N G S

THE CLERK: All persons having business before the Honorable Richard G. Stearns, United States District Judge, now sitting at Boston, within and for the District of Massachusetts, may draw near, give their attendance, and they shall be heard. God save the United States of America and this Honorable Court. Court is open. You may be seated.

This is Civil Action Number 2612962, Commonwealth of Massachusetts versus Oz, et al. Would counsel please identify themselves for the record?

MS. KLUNDER: Good afternoon, Your Honor, Nita Klunder for the Commonwealth.

MR. DURAISWAMY: Good afternoon. Shankar Duraiswamy for the State of New Jersey.

MS. KANE: Good afternoon, Your Honor. Ketakee Kane for the State of California.

MS. CANNEY: Good afternoon, Your Honor. Julia Canney for the Commonwealth of Massachusetts.

MS. KEARNS: Good afternoon, Your Honor. Katherine Kearns for the Commonwealth of Massachusetts.

MR. MAZEITIS: Good afternoon, Your Honor. Jake Mazeitis for the State of New Jersey.

MR. MARKS: Good afternoon, Your Honor. Ethan Marks for the Commonwealth of Massachusetts.

MR. GERARDI: Good afternoon, Your Honor. Michael

Gerardi for the federal defendants.

THE COURT: Mr. Gerardi?

MR. GERARDI: Gerardi.

THE COURT: Gerardi. You look alone.

MR. GERARDI: The federal government speaks with one voice, Your Honor.

THE COURT: Thank you, Counsel. The matters before the Court on the motion for injunctive relief, let's see if I can frame the information a little bit so we can get right to the point.

The real issue here seems to me to be the objection to the work requirement aspect of the case, which is where I noticed the medical filings focus on that issue and that issue alone, which makes sense. The others rise and, I think, fall with how we approach that first issue.

Approaching now the case, and you correct me on behalf of the Attorneys General if I'm wrong, the States aren't really looking or objecting to the work requirement. They may not think it's wise policy or the best possible option, but the fact is that Congress mandated it. And when Congress speaks, and sometimes it fails to, but here they spoke pretty clearly about what they wanted to happen with the Medicaid expansion.

Unless I'm wrong, I don't think the States are really asking this Court or anybody else to basically abolish

the requirement. If that's the case, then I go to the practicalities of what is asked for in injunctive relief. As I understand it, by the time I allow everything asked for in the prayers in the complaint, we'd have no work requirement, no alternative suggestive to me of exactly what we would do then.

Congress often doesn't do this clearly. Maybe they didn't do it clearly enough in this case, but there is some pretty clear delegation language in the statute itself. This is not the Chevron Deference Wilbert Bright situation where an agency issues regulations and then tries to interpret its own regulations, which have no real basis in any congressional statute.

Here we have a statute. Then we have interpretation. I think the Government very correctly lays out what is before the Court; that is, Here's the statute, here's what the Secretary -- we know that's -- at least at the moment it's Dr. Oz who is the delegated authority, as I understand it from the way the case is framed.

The issue, then, is whether, as Congress directed, as I understand, the Secretary to do, to come up with regulations implementing the statute, filling in the blanks consistent with the congressional intent, where necessary. The question now is did what the Secretary did in this case, or at least is proposing to do -- the phrase we use under the

arbitrary and capricious standard is exactly that, as we District Courts know with dread the real phrase is abusive discretion. That's a word usually being told we did by an appeals court, but I think the standards are pretty much the same.

So the question then becomes, would a Court look at what the Secretary did and decide it was an abuse of discretion for him to expand or elaborate or explain these statutes in the way he did?

Again, this leads me to the sole question of what does the injunction accomplish if I were to order one. I'll take a simple example. One of the principal objections is to the way in which the Secretary defined blindness as one of the exceptions in the work requirements.

As I understand it, the Attorney Generals think that he made it a more restrictive definition than it should have been or Congress may have intended, which may or may not be the case.

What I don't understand is how I would ever make that decision of what it is the Attorneys General are proposing be put in place to make that kind of decision. I think I know a lot of things. I think I know more about what I don't know. What I don't know is I don't have the medical confidence to make those kinds of judgments. That is ordinarily, if we get there, is what litigation accomplishes,

because then we have the benefit of expert testimony and a more developed idea of what people had in their minds, whether it was congressional intent or the Secretary's elaboration on that content, before we arrive at any kind of decision.

So that, in a sense, is where my thinking is now, is, all right, if I give you what you want, States, what happens next? I don't see what the road map is for the next step in the case after that as opposed to what we'd normally do, and if we did, that would be the case. I am willing to do it as quickly as the parties feel they want it done or can be accomplished. That is not a concern of mine. Time is not a constraint on my part with a case of this importance.

So, again, I have no problem accelerating things. It looks like the kind of dates that were originally being objected to in the original complaint seem a little bit more flexible today than they did back at the beginning of the month.

The whole issue of irreparable harm is one of degree in this case, I suppose, because as I understand it, there is a pretty healthy reimbursement given to the States for the administrative costs incurred in putting out the regulations that they're inquired to implement.

Again, you may want to elaborate on that point too. But I really think the important issue is let's go over the

so-called load-bearing wall of injunctive relief. And that is on the merits. Do we accomplish through an injunction of what really should be being accomplished through litigation in this case? So that's just to give you a glimpse into what I'm thinking.

Now you can explain to me why I'm so wrong about everything, and let's -- I assume you'll be speaking for the Attorneys General.

MS. KLUNDER: Thank you, Your Honor. That was helpful framing. I think in light of that, I want to start where I might otherwise end, which is what the proposed order, which we have at ECF2-1. I think this addresses the question, which we ourselves grappled with, which is if we are the dog that catches the car, what are we left with? What would the Court be ordering with regard to the work requirements? And you're absolutely right. The States are not challenging the work requirement laid out in H.R.1. We want to maintain that sort of intellectual hygiene of what is given, H.R.1 and what is challenged here, which is the IFR.

The challenge, Your Honor, is to the additional requirements layered on top of H.R.1. As I'll get to in my argument, H.R.1 is pretty clear on its face, and CMS worked with the States over a period of months sharing that same understanding of what H.R.1 meant without this significant impairment language, which we'll get to, and only made that

change in May, the month before the IFR was published.

I'm happy to go through any of these provisions in more detail, but we specifically tailored the proposed order to eliminate those add-ons from the IFR. Not so that the States would be left complying with nothing on January 1, 2027, but so that they will be complying with H.R.1 on its plain face and consistent with the understanding that the States and CMS shared for the months leading up to the IFR coming out on June 1st.

With that said, Your Honor, I do want to begin by saying how grateful we are that the Court was able to make time to hear us on such an expedited basis. I hear you saying that time is of no instance in an important matter like this. As I will turn to later, the harms here are significant and imminent, as in they are occurring every day and will significantly worsen by the end of this week when the IFR becomes effective. They're, importantly, also irreparable, which is why we are seeking preliminary relief. Here I'll turn to something Your Honor said before I stood, which is that the dates appear to be more flexible today than they were in our original complaint.

I'm happy to speak to any questions on that, Your Honor. But in our complaint, I think we noticed as well as in our motion that we would reach out to Defendants and see if they were amenable to two requests. The first was, would

they stay enforcement of the August 31st deadline? That is the deadline for all plaintiff states to send notices to Medicaid members telling them what it is this new work requirement requires of them. The second was whether or not they would afford plaintiff states a six-month extension.

Your Honor, this extension was envisioned by Congress. Congress knew that states would be working on this difficult timeline to implement the work requirement. Yes, the implementation deadline is January 1, 2027, but importantly, Congress allowed for those extensions to go through December 31, 2028, a full two years.

We are here today with the same urgency as when we filed our complaint because Defendants have refused both of those requests. In our motion, we offer you two grounds to find in favor of the plaintiffs, in order that these challenge provisions be enjoined or stayed. First, as you pointed out, Your Honor, is the definition of medical frailty, which CMS has added in the IFR. It's contrary to law. It's contrary to what Congress designed in H.R.1, and the same is true for the declared emergency limitation.

Second, all three of the challenge provisions are arbitrary and capricious. This is because CMS has either ignored important information and considerations or has simply provided a cursory explanation that does not rise to the level of reasoned decision-making.

I'll turn first to the medically frail definition. When Congress established the Medicaid work requirement, they specifically excluded nine categories of individuals. Among those categories was a category Congress referred to as medically frail individuals.

When I talk about H.R.1 today, we're mostly going to be talking about 42 USC Section 1396A, subsection xx. I'm going to reference a paragraph within that section, and here we're going to be talking about paragraph 9, which is the definition. You'll see in H.R.1 at big Roman 5, that's where Congress defined what a medically frail -- an individual who is medically frail or otherwise has special medical needs. I'll grant, Your Honor, that there is a parenthetical that says "as defined by the Secretary." But, importantly, following that parenthetical, it says "including an individual." And there are five subcategories there, little A through -- double A through little E. All five of those categories are meant to be included within Congress' definition of what is medically frail.

As you know, the issue here is for you to resolve. The question is, what does "including" mean? As the Supreme Court has long held, including in Loper Bright, when it comes to statutory interpretation, that's a de novo review by the Court. There is no deference afforded to the agency in terms of what the words of the statute mean. We've offered in our

briefing a substantiated and rational explanation for what "including" means here with reference to case law and Black's Law Dictionary, which is Congress afforded the Secretary discretion to add onto the medically frail exclusion.

In other words, Congress set a floor, which they frequently do. And we've provided a relevant example in our briefing from the Ninth Circuit, and that's Safer Chemicals. Three, Congress gave the EPA discretion to determine what, quote, conditions of use meant. But like here, Congress also provided a floor. There the Court found that the EPA had acted contrary to law, where they excluded from review chemicals no longer manufactured where Congress had clearly included those chemicals in the statute.

In our briefing, we also offer the Court canons of statutory interpretation, whereby Congress, in H.R.1, identified functional limitations in certain of the subcategories indicating it purposely did not include them in others. For this proposition, we cite to Barnhart v. Sigmon Coalition, 534 US 438. In particular, subsection AA, that's who is blind or disabled. Disabled is defined by reference to another section of the statute, which has a functional impairment limitation.

Likewise, subsection DD uses the language "significantly impaired" but not as to their ability to comply with the work requirement. It's a significant

impairment to perform one or more activities of daily living, toileting or showering or something like that.

So what this tells the Court is that Congress knew how to use this language, this precise language. And yet it opted not to use it for the remaining subcategories, let alone for the overarching definition of a medically frail individual.

If Your Honor has no questions on the contrary to law piece, I'll move on to the arbitrary and capricious.

Plaintiff are also likely to prevail on the merits because CMS had acted arbitrarily and capriciously in promulgating the challenged provisions. These infirmities fall into two buckets. First is a complete failure to consider important factors in promulgating the provisions.

Second, as to the medically frail definition and the claims period limitation, the purported explanations are so cursory as to not meet the threshold for reasoned decision-making. Here I point the Court to Judge Saylor's recent opinion in Massachusetts versus Department of Ed, which was decided April 3, 2026, where he found that the agency's explanation were of a cursory fashion and would not survive an arbitrary and capricious review.

I think it's helpful to go through a little history of what the parties are dealing with here. So in July 2025, Congress passed H.R.1, which includes the work requirements

about which our litigation is centered.

Both CMS and the plaintiffs were then faced with an incredibly challenging timeline of implementing the work requirements by January 1, 2027. At the time, that was nearly 18 months. Recognizing this challenge, and as you'll see in the dozens of declarations we've submitted, states began working immediately to implement changes, but they did not work alone.

CMS partnered with those states to get this program going. CMS offered guidance in writing and held weekly meetings with the States. CMS acknowledged the complexity of the task and encouraged states and vendors to rely on its guidance. Here I'm referring to the exhibit to the complaint, ECF1-1.

CMS provided guidance through early May, none of which referenced the significant impairment language. CMS now may point to fine print in its slide decks noting that the guidance was interim, but that does not excuse it from considering that reliance in the first instance. The record shows CMS failed to consider that reliance. CMS now seeks to claim that it need not have considered that reliance because it wasn't significant. But having never contemporaneously undertaken that analysis, these post-talk explanations will not suffice. Also, the States' reliance was significant.

Defendants seek to distract the Court with

arguments about whether or not the change in position doctrine applies. They are wrong, but the Court need not decide that. As defendants themselves say on page 24 of their brief, the key consideration is whether this was the type of guidance states, quote, ordered their affairs around. And they did. That is because that is what CMS told them to do. Dozens of declarations talk about the extensive investments of time and money made by states in reliance on both CMS guidance and H.R.1's plain language.

THE COURT: Here's a question about that. You talk about reliance, which is another way of -- I think what you're trying to say is estoppel. Are you suggesting that CMS had the authority to bind the Secretary's ultimate discretion as to how he, or were it the case, she, would interpret the statute?

MS. KLUNDER: No, Your Honor. What we're saying is the point that they promulgated the IFR, the reliance had become such an important part of the rollout that it was a factor CMS was required to consider. Medicaid is a joint state-federal program. It's not just an important aspect of the problem. It is the key gating factor is states' ability to roll out this program. CMS works hand in glove with states because ultimately it is MassHealth, not CMS, that is rolling this program out to members. That was consistent with how CMS conducted itself in this interim period between

when H.R.1 was enacted into law and when the IFR went out.

CMS may have been able to change its mind, communicated that to states, but it had to at least consider the impact that that had on its end users, its end partners, the States. So here it's two things. It's, one, CMS failed to consider the reliance, and the declarations here speak to budgeting. Many legislation sessions don't operate now. These state Medicaid agencies cannot get the additional funding because they went to their state legislatures back in 2025 to get that funding. They hired people. They did training. They hired vendors. These systems that these Medicaid agencies are rolling out are complex systems, which require design implementation and testing, and that simply can't be done on this deadline. That brings me to the second part of it, Your Honor, which is sort of a prospective thinking. CMS was required to consider whether states have the capacity to implement the IFR in the six months remaining to January 1, 2027.

It's two things, Your Honor. They never considered that they asked states to rely on their guidance, that states did rely on that guidance and made path determinative, irreversible decisions in the rollout of their program based on that guidance. And then all of a sudden, sometime in May of 2026, CMS, without disclosing to states, without any communication, reverses course.

I think really helpful to understand that reliance, Your Honor, are the letters that the state Medicaid agencies submitted to CMS pre-litigation. Those are attached. California sent such a letter. Massachusetts sent such a letter. Maine sent such a letter. They talk about how they specifically relied on that guidance. Here California says, California has relied extensively on CMS's preliminary guidance over the last several months to design, build, operationalize major programmatic systems and staffing changes needed to implement with H.R.1 by January 1, 2027. That's Exhibit A to Exhibit 2.

Another factor that CMS failed to consider, Your Honor, and it may be because they implemented this course change so late in the game, is the actual change that their additional restrictions would have on state Medicaid agencies and Medicaid members.

There is a very lengthy regulatory impact analysis in the IFR. The regulatory impact analysis speaks to the impacts of H.R.1, of the work requirement. That is different, and that is not the task assigned to the agency. The agency was meant to assess the impacts of the choices it was making. In this case, and I'll stick with the chief example, medically frail definition. They have added a completely different criteria. So I'll just quickly draw your eye back to H.R.1, where they say an individual is

medially frail if they are blind, substance use disorder, disabling mental disorder, and so on. What CMS has said is you can meet those criteria. You also have to show that it significantly impairs your ability to work. That criteria is nowhere in the statute.

CMS has made no effort to show us where in the statute that comes from. That's somewhat interesting because they derive their ability to provide that definition from the notion that Congress was silent on that point. So they have the discretion to add that completely exogenous, different in character criteria onto this definition. When we get to the arbitrary and capricious analysis, CMS switches track and says, Actually, that's the best reading of the statute.

Again, somewhat cursorily and inconsistently with their earlier argument, but there they provide no evidence or even argument that it's the best reading of the statute. On the contrary, Plaintiffs provide in our brief that these are exclusions, which Congress has drafted broadly.

In fact, if you look at the other nine categories, Your Honor, it's not just medically frail. Other excluded categories include pregnant people and Native Americans, neither of which has anything to do with an individual's ability to work.

Congress is expressly drawing a broad exclusion here, and there is no authority for the Secretary to add this

additional component onto this analysis.

In its haste, CMS also failed to examine relevant data, as is required by State Farm. Most importantly is the fact that states have previously attempted to deploy work requirements. CMS acknowledges that in the IFR, and specifically in the RIA at 91 Fed Reg 33456. They say somewhat inexplicably that those earlier programs involved, quote, different implementation patterns, and then draw the conclusion that there is no direct historical experience from which to derive empirical estimates of how many enrollees will not meet the requirements.

Your Honor, work requirements have been rolled out in Arkansas, in New Hampshire, and any number of other places, but "the data is not beneficial to CMS" is no reason to ignore it. At Exhibit 26, you have a letter from the National Health Law Program, which was sent to CMS in November of 2025 well in advance of promulgating the IFR.

They talk about the experience in New Hampshire, noting that providers were confused or unwilling to sign additional documentation that speaks to an individual's ability to work. As you may have seen in the amicus brief provided, here providers aren't trained to do a functional impairment analysis. There is a slew of other issues that come with that, but I'll leave that for the Amici. CMS also ignored disenrollment data from within the federal

government. The Congressional Budget Office, in October of 2025, estimated that 5.3 million people would be disenrolled by 2034 due to the work requirement. The IFR puts that number at 3.3 million. The CBO data was based exclusively on H.R.1's work requirement. CMS's data should have been based on the additional hurdles imposed by the IFR and should have reflected more people disenrolled, yet it doesn't do that.

The APA requires agencies to do this work when they are promulgating rules of this consequence. I do want to turn to the claims period limitation, Your Honor.

THE COURT: I'm having a hard time understanding how we get from this wasn't the best policy choice or this, in practice, at least in two laboratories, has unexpected result. How did we get from there to arbitrary and capricious? As I remember, I'm old enough to remember, that when President Clinton, I think, imposed a similar -- with the help of Congress, work requirement on welfare recipients, the same arguments were made. But I think a lot of arguments were made that they were bad policy choices or sometimes there were unintended consequences or expectations that no one anticipated.

I don't see how you get from there to saying, Well, failure to anticipate is arbitrary and capricious. What in the Administrative Procedure Act says that you have to pick the best possible outcome?

MS. KLUNDER: I just want to make sure I heard you correctly. Did you say "failure to anticipate"?

THE COURT: Yes. Failure to anticipate a bad outcome or a less than desirable outcome --

MS. KLUNDER: And I want --

THE COURT: That is arbitrary and capricious or that you have to make calculations about -- they're really calculous calculations about various outcomes depending on the variables.

MS. KLUNDER: Here, Your Honor -- and that's why I wanted to be precise as to the language you were using. It's not a failure to anticipate. It's ignoring considerations that at the minimal requirement of the APA for reasoned decision-making for considering important factors should have been in front of the agency. I think that's very clear here on the examples. Right? We extrapolate, the facts there weren't good, but that's not the point. I can withdraw that.

What I'm saying is there were examples. The laboratory of democracy, the States, they tried this before. The evidence of how that rollout worked was available to CMS. But rather than engage with that and say, Maybe we do a 24-month look back period or we have a screener instead of, you know, provider documents or whatever it may be, some of these more granular things that executive agencies are actually well positioned to do. It completely ignored those

data points. The most relevant data points available are how these work requirements have worked in the past.

To be clear, Your Honor, agencies have broad discretion. I'm not standing here saying that they reached the wrong decision, although I am saying it's contrary to law, so that was wrong.

For the arbitrary and capricious piece, they simply failed to do the analysis. They put their heads in the sand, and that's below the bar established by the APA.

So just to be clear, Your Honor, the experience of the other states that had done Medicaid work requirements would have been valuable data. Anyone interested in looking at how this actually rolls out, how this impacts state Medicaid agencies, how this impacts Medicaid members, how this impacts providers, would look at known examples of where that has occurred. CMS didn't to that, and that is arbitrary and capricious.

Does that answer your question, Your Honor?

THE COURT: I understand your position.

MS. KLUNDER: Thank you. May I turn to -- are you interested in hearing about claims period limitation?

THE COURT: About the...

MS. KLUNDER: The claims period limitation.

THE COURT: If you have an alternative that is less arbitrary and capricious than a year.

MS. KLUNDER: Again, Your Honor, I think that goes back to our proposed order, which we would pause that you could sign, and it wouldn't leave states flailing. One thing that has become clear throughout this litigation is that programs of this magnitude need certainty, need predictability, and don't do well with these last-minute changes.

So the claims period of limitation that CMS established is a 12-month look back. Again, I think this sort of amplifies the arbitrary and capriciousness of their decision-making. The only explanation we hear from CMS is in the brief, which, again, post-hoc explanations don't replace congenerous agency decision-making, but they say, CMS says the policy choice of how to balance such losses, meaning disenrollment, with rigorous enforcement was CMS's to make, and it made that choice reasonably.

Again, I think the point here is CMS absolutely has the authority to weigh how many folks are disenrolled against how many months is the appropriate look back. But what we don't see anywhere in the record, nor did the defendants provide it in their briefing after ample opportunity to do so, is that they completely ignored one side of the scale. That is arbitrary and capricious. There you can look at California v. Department of Ed here in the First Circuit, 132 F.4th 92.

The final point that I'll make on arbitrary and capricious is the explanations that were provided. What I've spoken to before are the factors that CMS simply ignored. Again, they were so basic that ignoring those factors is arbitrary and capricious. As to the explanations that were proffered, there is two examples of explanations, both of which are unsupported by reasoned decision-making.

In the first instance as to the medically frail definition, CMS explains that importing the significant impairment requirement is the best reading of the statute. I touched on this earlier in my argument, Your Honor, and tension between their argument with the contrary to law, which is saying that Congress is silent as to whether or not significant impairment is part of the statute. And then in arbitrary and capricious, CMS would have it that it's somehow the best reading of the statute. Those two things can't exist together.

More fundamentally, CMS does not point to anything in the statute supporting its contention that the best reading compels a significant impairment limitation. As I noted on our side of the balance sheet, we've offered an explanation that Congress was intentionally structuring the broad exclusions to ensure continuity of care for vulnerable populations.

CMS has never countered that explanation. Rather,

they argue somewhat circularly, reading the statute without its regulation risks sweeping in those who do not meet its regulation. That is not reasoned decision-making.

On the claims period limitation point, the explanation they offer is that older information may not reflect the individual's current condition. They don't provide any reason why state Medicaid agencies should be barred from determining whether it bears on an individual's current condition, as is the case for people with chronic or permanent conditions such a multiple sclerosis, spinal stenosis, or cerebral palsy.

Just to be clear on the record, Your Honor, this is not uncommon. If someone, say, with quadriplegia goes to the doctor for an ear infection, that claim is for a visit for an ear infection. It doesn't note the patient also has quadriplegia. That is how you get a situation where 12 months of claims data may not reveal a chronic or permanent condition.

This is also intentioned with the requirement of H.R.1 that state Medicaid agencies perform ex parte verification, that is not seek additional information and burden Medicaid members with those requests. Having a longer look back period would enable that.

As to your question, Your Honor, about what it is that we're proposing, the proposed order simply strikes from

the IFR the language for the preceding 12 months. That would bring the claims data and the encounter data in line with the six other areas of data, that reliable information, that States are permitted to look at. So it would just be conforming of those two provisions with the other provisions, right? So payroll data information and the individual's case record, information on the State's eligibility system. None of those are limited to a 12-month look back. We're just asking the Court to sync up subsection 7 and subsection 8 to strike that for the preceding 12 months.

Your Honor, I'm happy to speak to the harms. That was sort of all I had on the merits, or if you have questions on the merits before I proceed.

THE COURT: Well, let's assume there are harms, although I don't think they're quite as what I first understood. I think now I'm clearer that what the reimbursement rates are from CMS for what work the States are required to do to meet the administrative requirements. Let's assume that -- I just want to stay with the merits of the case. I'll give you harm. We may disagree about the scale of the harm but irreparable harm isn't measured in dollars. It's measured by the harm itself. So I think we can let that one go and maybe it's time to let the Government see if they can help with all of this information. When I hear the first side, I always let them know exactly what I

think, and then I hear the other side.

MS. KLUNDER: Certainly, Your Honor, at the risk of stealing victory from the jaws of defeat, I will just note you're exactly right. Irreparable harm is not measured by magnitude. But even with those reimbursement rates, the additional burdens of the IFR, states have estimated that those out of pocket will be in the millions.

THE COURT: I understood that. Thank you.

MR. GERARDI: Good afternoon, Your Honor. I plan to proceed, I guess, by initially kind of starting where you asked us to start with the proposed order, and then I'll try to run though the things my colleagues on the other side addressed. If there's something that I'm missing, feel free to stop and ask me.

I think you're right to focus on the proposed order, and I think it actually illustrates the problem with the sort of architecture of the plaintiffs' claims, in that they're basically asking you to go through the regulation, strike provisions that they don't like as a matter of policy, and come out on the other end of the preliminary injunction process with a new policy that's more amenable to them. And I think that that is fundamentally a policy choice, and I don't think that an arbitrary and capricious review under the APA that's sort of picking and choosing is permitted.

What they're striking is not even internally

consistent with their theory. For instance, they want to strike this condition in the community engagement requirement about the impairment of your ability to meet that requirement, which arises from the context of the overall statute. But their revision would lead in the statute other refinements that the Secretary has made to those categories under subclause 5. One, for instance, there is -- one of the criteria for being medically frail is having a substance abuse disorder. The Secretary narrowed that definition to put out of that definition those who have been in stable recovery for five years or more. He also introduced a definition of the term "series or complex medical condition" that spells out in more detail what that means. It actually also includes to some degree functional limitations on what that term is. But the States' injunction does not disturb that, nor do they challenge it, even though their position is that the Secretary has no authority to impose any sort of refinement on the conditions that follow the including phrase in the medical frailty section of exclusion sections of the statute. I think it underscores why their legal theory doesn't work on the merits and why they are not entitled to a preliminary injunction in this case.

With that in mind, I'm going to try to plow through the points my colleague made and try to address them. With respect to the contrary to law arguments, I think Your Honor

was correct, I think, to start with the delegations and how this statute is read. As to the medical frailty piece, there is two overlapping, mutually reinforcing delegations. At the top of that -- of the exclusions from the community engagement requirement.

It's noted that there are individuals as determined by the State in accordance with standards specified by the Secretary. And that's an -- the reason why that phrase is important is if you look to Loper Bright, one of the key cases it cites in defining what cases fall under it is a case called Batteron v. Francis, which is reported at 432 US 416, decided in 1977. It's another case from -- it's a case arising from another program under the Social Security Act. And at issue in that case was a statutory phrase, in accordance with standards prescribed by the Secretary. The only difference there is "prescribed" versus "specified." And the Court held that that delegations -- by that delegation, Congress entrust the Secretary the primary responsibility for interpreting the statute. So the term "standards" is -- that phrase alone would be, I think, a sufficient authority for the Secretary to act here. But Congress went a step further with "medically frail" or "otherwise have special medical needs" by giving the Secretary an explicit grant of authority to define that term of art.

Plaintiffs' reading of the statute basically effaces both of those express delegations of authority for the Secretary to interpret. On their understanding of the statute, all the Secretary would have authority to do is add additional categories to the list that follows the including phrase. Since one of the categories is a -- since the categories include a serious condition or a complex condition, it's unclear what else in the universe of conditions that could render someone medically frail or otherwise having special medical needs would be swept in. The Secretary, in fact, looked at that question and concluded that there were no other categories to add.

Again, by their definition of it being anything following an including phrase means those categories can come in without any limitation or further interpretation or explanation by the Secretary would result in a -- would sweep a wide group of people into the medically frail exception who are -- who clearly don't qualify for it.

I think we put forward in our brief the example of somebody who has a tobacco addiction disorder. That would be a type of -- that would be a type of substance abuse disorder. We generally don't think of those people as being medically frail or unable to comply with a requirement to work part-time or volunteer part-time or the other things that allow someone to meet the criteria in the statute.

I don't think the word "including" requires the definition that the plaintiffs put forward. I think, at best, "including" means something like more than or equal to and that the delegation to the Secretary should be sort of -- as to the term of art, should be sort of read transitively as to those categories.

And then I really don't think it matters that the Secretary chooses that authority to further interpret the individual categories, which he did, to add categories, which he didn't do, or to add a gloss as to all the categories that elucidates what it means, which he also chose to do. I think the definition is fully within his statutory authority to do and that the regulation is not contrary to law on that basis.

THE COURT: Do I understand what the Secretary was trying to say in elaborating on the statute is medically frail and incapable of working or performing one of the designated tasks to otherwise qualify?

MR. GERARDI: I don't think I would put it that way. Our view, and I think that this is the correct understanding of the statute, is that medically frail or otherwise has special medical needs is a term of art that the Secretary was asked to define. The Secretary has defined it by saying that intrinsic in that phrase is an understanding that you are limited -- you have limitations in your ability to meet the community engagement requirement, which arises

from the context of the statute, which is geared toward getting people who can perform the function, who can meet the requirement, meeting it in order to obtain their benefits. That is the purpose of --

THE COURT: I think what you're saying -- but maybe a little simpler. I think what you're trying to say is what the Secretary was trying to do is explain that people don't categorically, simply because the definition could apply to them, fall into that category.

For example, I started with the issue of blindness. I know many blind people, including colleagues of mine from the courts, who don't consider themselves frail in the sense they're unable to do their jobs. In fact, they probably do their jobs better than I do, because maybe they're more focused than I would be. But then the issue is that who makes that determination? Is that the States? The Secretary? The person themselves? It's a complex -- it's more difficult than it appears on its face. I can, in a sense, understand the impulse that the Secretary would want to elaborate on what was meant. But I'm not sure I'm following if that's what you're saying.

MR. GERARDI: I think we're getting to the same -- I think that we agree. I mean, I think that the point is that ultimately the "who" question in this case, about who gets to decide what the best interpretation is is the

Secretary within his delegated authority to do so. The delegation is broad. It doesn't really -- the conditions on his delegated authority to define the statute are pretty minimal here, and I think that as long as he is acting within the grant of that delegation, as I think he clearly is here, the review of his decision is for -- is a review for arbitrary and capricious action. And that's, I think, typically how we would understand a grant of delegation that's this broad to him. I think it makes sense. Congress wanted swift implementation of this statute and left the Secretary some authority to set standards as to key aspects of the statute and to define especially this key term. And I think we have to take that delegation seriously.

I think that leads here to the conclusion that there may have been other ways to have understood how this term of art is defined. But I think the Secretary's way of defining it is a -- falls within his delegated authority to do so and is reasonable.

I'll turn to the arbitrary and capricious piece, unless you have more questions about that.

THE COURT: No.

MR. GERARDI: I think basically there is two sort of buckets of the arbitrary and capricious piece. There is one that deals with purported reliance interest on the parts of the States, and there is the other that deals with

explanations for reasoned decision-making.

I actually want to start with another aspect of the statute that maybe we've overlooked a little bit. That is the statute's suspension of the notice and common provisions of the APA. So Congress did not just one but two things in directing the procedure that was to be followed here. It directed HHS to proceed with an IFR to promulgate this standard. An IFR is the process where an agency issues a rule that is binding immediately without prior previous -- without going through notice and comment.

It went one step further. It actually suspended the operation of Section 553 of the APA as to this statute. And 553 is the section, that as a whole, describes notice and comment. Especially with the reliance part of plaintiffs' arguments, I -- the claims that are being made are in a sense, I think, trying to create sort of an ersatz notice and comment review standard. So the States are saying that these informal discussions that CMS voluntarily engaged in with them kind of can take the place essentially of a notice-and-comment-type period. I think it's also true with their reasoned explanation arguments as well. We heard invoked materials from Amici, materials from the CBO, letters from the States that were sent to the agency.

In a world in which notice and comment applies, the fact that someone submits a comment and then doesn't address

the concerns that are raised by the comment is a reason to consider the decision-making arbitrary and capricious. But that was suspended here.

And it was because Congress wanted this policy to be enacted in an expeditious manner. I think that the arguments the States make have to be taken in that context. When they, I think they don't have merit in terms of being a basis for enjoining the government under the arbitrary and capricious standard, which I think, as you alluded to at the beginning of the argument, is very deferential.

There is a presumption of the Government -- of -- there's a presumption of validity of the Government's actions and the review of the Government's actions and the review of the Government's actions is highly deferential.

To start with the reliance, my colleague characterized the agency's sort of statement about the limitations of the guidance it was providing as fine print. I would direct you to -- this is ECF1-1. It's attached to the complaint. It's page 6 of that attachment. That slide is not fine print. It was at the very beginning of our presentation. And as our brief notes, it goes through all of the limitations that this guidance -- that the guidance that the States provide in this informal setting has to it.

More to the point, I think there is a few -- there's an -- in terms of the reliance issue, I think there's

a few points we'd say. First, assuming that this could even qualify as a form of guidance material at all, and I think that there is -- the Court has -- the Supreme Court has actually not weighed in on that issue, and I think for ample good reason, because it opens up a wide variety of considerations that would be difficult, I think, to take on in this the preliminary posture.

But even if you align that issue, the States have to reach a very high bar to show reliance interest arising out of a non-change of policy. The statute states when the policy will become effective. The Government was not obligated to engage in these discussions beforehand to sort of preview what the policy was. And the bar for reliance interest arising out of something that is not actually a formalized policy that actually creates rights and obligations is on the tier of decades of experience. What I have seen in the plaintiffs' declaration submissions is that CMS engages in these discussions in other contexts and it has done so over the years, but it does not relate, I think, to decades of reliance as the Court found in -- as the Court recognized in Wages and White Lion was enough to constitute a valid reliance interest.

Again, because the State was -- because CMS was explicitly cautious, I believe, about the advice it gave and not stating that that advice was a final agency judgment and

would be subject to review, I don't think that that rises to the level of the sorts of things that Wages and White Lion recognized would be the basis of a change of policy decision or on the level of a type of reliance interest that the Supreme Court recognized in Regents, where the DACA program actually created a sort of adjudication of sorts for people that they relied upon to stay in the United States.

Here it was very clear, Congress set an IFR date on June 1 as this is the date that the agency is going to release this, and there will be binding obligations. That was very clear.

The plaintiffs are sophisticated actors. They understand, certainly, that regulations go through the EO1288 -- I'm forgetting the number off the top of my head. But the regulation that dictates that agencies submit regulations to OIRA for review in coordination with the executive office, the President, and there is policy arms in coordination with other agencies before they are promulgated that is not just a process to rubber-stamp what agencies do. Sometimes those that are closer to the President and who are working in these formal policy roles have strong views about how things should be changed, and those views filter into policy.

THE COURT: I'm going to ask, because I don't recall. In framing the delegation language in the statute

itself, did Congress acknowledge a role for CMS? Did they acknowledge that it even exists?

MR. GERARDI: So I believe all the delegations are to the Secretary of HHS. I believe by longstanding convention that as to CMS, specific -- as to CMS, that the Secretary delegates his authority to them to engage in various rulemaking and adjudications. I actually believe that the IFR in question was signed by Secretary Kennedy and not by Director Oz.

THE COURT: I don't think it makes a --

MR. GERARDI: I don't think it makes a significant difference one way or the other. I don't think there's an allegation that we've acted outside of a delegated -- that the wrong actor did this.

As to the -- unless you have other questions on the reliance piece, I'll move briefly to reasoned explanation. The agency provided a rather, I think, detailed explanation of why it reached the interpretation it did at CFR -- it's page 33373 of the IFR. I think the explanation goes to that a reading of the language of the statute in the context in which it arises, the agency concluded that the best way to understand this statute is to -- given that the medically frail exclusions, the categories on their face, are quite broad, that some limiting principle should be applied to those categories. And in terms of choosing one, they chose

one that arose from the context of the statutory language. I think that the explanation the agency gave as to why it thinks that explanation is best is more than adequate to survive arbitrary and capricious review.

The claim data -- I'll table claim data and skip next to the loss of enrollment issue. First, as a baseline and the agency had articulated this in line of the statute, that the preference is obviously for ex parte verifications of people. It reiterated that in the exemption, and it has encouraged the States to use ex parte verification to the maximum extent possible so that people don't have to submit verifications in line with the statutory text.

THE COURT: I envision something like workers' compensation claims. The State typically has independent examiners.

MR. GERARDI: I will profess that I'm not an expert in state workers' compensation. I won't -- perhaps it is the case, but I don't want to get out of my --

THE COURT: Just so I'm clear, you mean reviewed by a state mechanism. Not by the Secretary.

MR. GERARDI: Right. When I say "ex parte," I don't mean a shadow process without representation. I mean a process the State does on its own.

THE COURT: An independent inquiry?

MR. GERARDI: Sure. So the agency was far from, I

think, ignoring the phenomenon that when you impose a requirement, some people fail to validate the requirement for procedural reasons. I think CMS was very clear-eyed about that problem. They acknowledge that those who have medical frailty would be among those who have -- who may have to provide information to the State to verify their status. I direct you to page 33434 of the IFR, which discusses an estimate of the burdens on beneficiaries who will have to verify various things.

I'll actually note that compared to those who have to verify completion of the community engagement requirement itself, those who are simply verifying that they are medically frail only have to make that verification -- states can elect to have them do that once a year. I think that's at -- it's at 42CFR435.557F1, little 3, little Roman 3.

The agency approached the issue of disenrollment in the face of significant uncertainty. This is a new requirement. There has been state experience with work requirements in the past. CMS acknowledged that. It explained why it did not believe that the state experience was relevant to that -- was ultimately going to lead to -- result and lead determinatively in explaining how many disenrollments there would be.

CMS has experience with when verification requirements are imposed, whether there are disenrollments as

a -- by the way, for the State, for that state aspect of it at page 33456 of the rule, the Court can see where CMS explained the presence of the state requirements and why it chose another path.

The agency acknowledged the problem. And if you review 33459 and 33460 of the CFR notice, they explain how they came to their estimate of the disenrollment issue. Now, there has been some discussion by my colleagues on the other side of other estimates that are out in the world about the number of disenrollments that will take place as a result of the imposition of this rule. Again, notice and comment was suspended in this case. I don't think that it's correct to say the agency had an obligation to go out into the world, consider whatever other estimates were out there about it, and refute them.

I would note that far from -- even with CMS's lower estimates -- I mean, all of the estimates are roughly on the same order of magnitude of the disenrollments. I say that because the test under the arbitrary and capricious standard is whether an agency -- under this sort of deferential standard that it has, whether it completely missed an important aspect of the problem. I think there may be disagreement about whether CMS's approach, which is an approach -- which is dealing with a new statutory requirement in the face of significant uncertainty about how people will

implement it and respond to it. It's not enough to say that the approaches of -- the methodology of estimations are slightly different or that the numbers are more on -- the higher numbers from CBO or the Amici or whoever else is out there as opposed to CMS. I think it firmly grappled with this problem, and it still chose the policy path that it did in spite of acknowledging the significant number of disenrollments. I don't think that is arbitrary and capricious.

THE COURT: Experience may prove us wrong, but it's not true we didn't explain, is what you're really saying.

MR. GERARDI: Correct. Nobody knows for -- nobody knows for sure what will happen. I think the agency is clear-eyed in not ignoring the fact that when you impose a requirement, sometimes people fail to meet it for procedural reasons and that -- it chose the policy it did anyway.

THE COURT: If we can finish up on the last point. How inflexible is that implementation date? Are you saying that we don't have any choice? Congress made us do it? Is there any option for flexibility?

MR. GERARDI: So Congress set the baseline implementation date. It required the agency to issue the rule for public review on June 1. I think for most states, I think that the go-live date is January 1 of next year. So section -- I think it's subsection 11 of the statute has a

provision for exceptions for those who are in good faith trying to implement the statute but are -- but believe they need more time. I don't have the text here in front of me, but there are factors that the Secretary is supposed to consider.

The States asked the Government, I guess as a make way to try and avoid preliminary injunction practice, to basically grant them that exception. But I don't think -- but I think it was -- I don't think the Government was prepared at that point to say that they are -- that they were entitled to that exemption. More to the point, there's a whole separate section of the statute that deals with the good faith exemption and its application. There is not a challenge here to a denial of a good faith exemption.

THE COURT: I guess what I'm really asking, at the moment, there is nothing that Congress said that says we must by this date? There is a frame of time we have to act in, but right now, that's the date that looks convenient or --

MR. GERARDI: I'm not sure I following. The statute has deadlines and it has one mechanism for changing the deadlines, and the Secretary has not extended it.

THE COURT: A mechanism?

MR. GERARDI: Mechanism.

THE COURT: Okay. I understand. Anything else?

MR. GERARDI: Briefly, on the one-year extension, I

think that gets to what's at issue here, decision-making that falls below the floor of arbitrary and capricious or a policy choice.

Agencies have to engage in this sort of line drawing exercise all the time of, you know, the States think that two years would be better than one as they take one of the declarations they filed with the reply brief to say. Who is to say three is not better than two or five is not better than three or no restriction at all would maybe be the best? But the State -- the Government can make reasonable line drawing exercises in implementing a statute. I think the Government explained that.

And I think it's common sense that the further claim data gets from today, the less bearing it -- the Government said May, it has less bearing on whether somebody is medically frail right now than more recent data. It drew a line at one year.

There is other caveats to that. The first is that it doesn't mean that somebody is shut out completely. They can provide information for other ways to get them into the system, and then they can maybe start making claims to establish their condition. And the rule is not -- the rule is for claims and encounter data. There is a one-year limitation, but there's not such a limitation on other forms of data. It's possible that other forms of data may be able

to fill the gap there.

THE COURT: I think you might have a good argument there in an analogy to statutes of limitation, which we have to confront all the time. Some of them, I think, are unfair and fairly short in the amount of time you're given. But they're drop-dead dates generally. But sometimes we have procedural mechanisms for working around them. I think that would be the analogy I think you're reaching for is that the law is not unfamiliar with deadlines, and if you're going to have a statute of limitation, you have to pick.

MR. GERARDI: I think it's a reasonable policy choice to pick a year. Is not arbitrary and capricious to do so.

THE COURT: We agree that one week would be arbitrary and capricious as compared to 50 years might be arbitrary and capricious? Are you saying one year --

MR. GERARDI: I don't want to have to do that. I don't want to have to kind of consider the fringe or edge case in my head, but let's stick with I think this one is reasonable.

THE COURT: Okay. I want to thank all of you. I have a better understanding where everybody is and I'll move quickly, but I have to think a little bit about what I've just learned.

MS. KLUNDER: Your Honor, if I may have just have a

few minutes. I think there are a few points I'd like to clarify.

THE COURT: Okay. Can you do it quickly, though? I don't want to be unfair to either side.

MS. KLUNDER: Yes. I think Your Honor started today thinking that the contrary-to-law point would be the slam dunk and we wouldn't reach the arbitrary and capricious, so I may have failed in my duties of communicating that clearly.

I just want to say we talked about a delegation of authority, but the key point is this, the statute places a limit on that delegation. The example you raised of your blind colleague is precisely elaborative -- explains that issue. Right?

Congress established a statute that said blind people and four other categories of people are excluded. They need not meet the work requirement. That's not because they're impaired. It has nothing to do with their impairment. It may be, because as plaintiffs pause it in our briefs, that access to consistent medical care is so important for these people that we do not wish to put them through the wringer of showing community engagement work requirements.

So your job, Your Honor, is to simply to look at the word "including." Congress defined the term "medically

frail" to include five subcategories. What CMS has done impermissibly so and contrary to law even before you reach arbitrary and capricious has said, We are adding another factor into that. Meaning, some people who are blind, which Congress intended to be excluded, which the language of the statute exclude, will not be excluded if they can't show significant impairment.

I think if that's the only point I get to make, then I'll settle with that, Your Honor.

THE COURT: I need to give the other side a chance to respond.

MS. KLUNDER: I also want to just clarify the ex parte piece, Your Honor. That was, in part -- the statute requires that state Medicaid agencies not go to individuals to get additional data. This additional requirement, while counsel is correct, in some instances it won't. In their brief, they say someone who has SSDI, you wouldn't need to go to that person. You could use that data. But that's not true for everyone. And what the case law shows here, and the case is Pava v. Kijakazi, K-I-J-A-K-A-Z-I, 704FS 3D 268 D Mass 2023, is that the Social Security Act should be broadly construed and liberally applied in favor of beneficiaries.

The Medicaid requirements sit within the Social Security Act, Your Honor. And while Defendants may complain that our reading of the statute affords them no discretion,

it's just not the discretion they want, Your Honor. It's a floor. They were free to add on. There is some discussion in their briefing about how this language came from the Alternative Benefit Plan language. That was a separate area where Congress gave states discretion to add on to those categories.

Defendants here say, That's no discretion whatsoever, because Defendants here want to limit the number of people that get Medicaid, but that's not what Congress said.

Congress broadly excluded five categories of individuals that qualify as medically frail. It would be like CMS saying, You have to be medically frail and your last name has to begin with the letters A through K. That is not a criteria that Congress envisioned. That's not in the statute. That's not something within their discretion to add.

If you'll give me one second, I'll just check with my colleagues to see if I missed anything. That's all, Your Honor. Thank you for your time.

I will say we still are very much in need of a ruling, if possible, on or before July 31st. We understand that's a very tight timeline. If you would be inclined to rule on the docket with an opinion to follow.

The notices are going out this week, and every day

state Medicaid agencies are implementing programs, hiring communication for that January 1st deadline.

Rest assured, if you sign our proposed order, all of our state plaintiff Medicaid agencies are prepared to roll out the work requirement from H.R.1 on January 1, 2017. It's the IFR work requirement that we take issue with. Thank you, Your Honor.

THE COURT: I think I can accommodate you on the time. Most people think I rule a little too quickly.

MS. KLUNDER: We appreciate that.

THE COURT: Does the Government have anything they would like to add?

MR. GERARDI: Your Honor, unless you have specific questions for me, I don't think I have anything further.

THE COURT: Again, thank you, Counsel. I'm happy to get to work right now. I'll take it under advisement.

(Recess, 3:12 p.m.)

C E R T I F I C A T E

I certify that the foregoing is a correct transcript of the record of proceedings in the above-entitled matter to the best of my skill and ability.

/s/Linda Horne
Linda Horne, CRS, RPR
Official Court Reporter

Dated: August 3, 2026

EXHIBIT 69

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ABOUT THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, referred to as the Affordable Care Act or "ACA" for short, is the comprehensive health care reform law enacted in March 2010.

The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level (FPL).
- Expand the Medicaid program to cover all adults with income below 138% of the FPL. Not all states have expanded their Medicaid programs.
- Support innovative medical care delivery methods designed to lower the costs of health care generally.

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Content last reviewed March 17, 2022

EXHIBIT 70

Congressional Budget Office
Supplemental Cost Estimate

October 28, 2025

Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14
Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid

As enacted on July 4, 2025

	By Fiscal Year, Billions of Dollars											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2029	2025-2034
Increases or Decreases (-) in Direct Spending												
Budget Authority	-45	-16,452	-46,852	-62,843	-93,011	-111,201	-128,216	-140,352	-150,712	-164,976	-219,203	-914,661
Estimated Outlays	-45	-16,847	-46,747	-62,661	-92,944	-111,441	-128,616	-139,659	-150,708	-164,965	-219,244	-914,634
Increases or Decreases (-) in Revenue												
Estimated Revenues	0	-454	-1,460	-2,020	-2,798	-3,289	-3,899	-4,294	-4,588	-5,078	-6,732	-27,880
Increase or Decrease (-) in the Deficit From Changes in Direct Spending and Revenues												
Effect on the Deficit	-45	-16,393	--45,287	-60,641	-90,146	-108,152	-124,717	-135,365	-146,120	-159,887	-212,512	-886,754

Budget authority includes estimated and specified amounts.

As part of the reconciliation process that resulted in the enactment of the 2025 reconciliation act (Public Law 119-21), the House Committee on Energy and Commerce and the Senate Committee on Finance were instructed to recommend legislative changes that met specified budget targets over the 2025-2034 period. This document provides an explanation of CBO's estimate for the budgetary effects of title VII, Finance, subtitle B, Health, chapter 1, Medicaid, of P.L. 119-21, as enacted in July 2025. The amounts shown in the text and tables are the same as those that CBO estimated in July 2025.[1]

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that implementing the provisions in chapter 1 will reduce the deficit by $886.8 billion over the 2025-2034 period. CBO estimates that the combined effects of the provisions in the chapter will increase the number of people without health insurance by 7.5 million in 2034.

Basis of Estimate

This estimate covers the 2025-2034 period and is relative to the January 2025 baseline. Outlays of appropriated amounts were estimated using historical obligation and spending rates for similar programs. Under an agreement between CBO and the House and Senate

1. Congressional Budget Office, estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to title II of H. Con. Res. 14, relative to CBO's January 2025 Baseline (July 21, 2025), www.cbo.gov/publication/61570.

Committees on the Budget to focus analytical resources on reconciliation, this estimate accounts for judicial decisions and administrative actions through April 10, 2025.[2]

Moratorium on Implementing Rules Related to Eligibility for and Enrollment in Publicly Funded Health Programs. The Centers for Medicare & Medicaid Services (CMS) issued two final rules, one each in 2023 and 2024 (referred to in combination as the Eligibility and Enrollment final rule), that addressed publicly funded health programs. Separate sections of chapter 1 prevent parts of those rules from being implemented, administered, or enforced through the end of fiscal year 2034.

Medicare Savings Programs. Section 71101 of chapter 1 blocked parts of a September 2023 final rule that made changes to enrollment requirements and procedures for Medicare Savings Programs (MSPs).[3] Those programs, financed through Medicaid, subsidize Medicare premiums for low-income Medicare beneficiaries and, in some cases, cover their cost-sharing requirements. Because MSPs are funded by Medicaid, new enrollment in MSPs or beneficiaries staying enrolled in MSPs longer results in increases both in Medicaid enrollment and in Medicaid spending, even though the benefits themselves offset Medicare-related costs. Among other provisions, the 2023 rule established processes for states to facilitate MSP applications for people who were eligible for the low-income subsidy (LIS) under Medicare Part D.

Under the LIS-focused provision of the 2023 rule, states were required to use LIS data to identify people who were eligible for MSPs but not yet enrolled. States also were required to provide those people with information about the availability of full Medicaid benefits and to collect any additional information needed to assess their eligibility for full benefits. Based on administrative data, CBO estimated the number of people receiving LIS who are not currently enrolled in an MSP. CBO expects that most of the newly enrolled people would receive assistance with Medicare premiums and cost sharing only; a smaller group would be eligible for full benefits in the Medicaid program.

Increases in MSP enrollment also affect Medicare spending. CBO expected that under the 2023 rule, beneficiaries who received cost-sharing assistance would be more likely to use Medicare-covered services, resulting in higher spending for Medicare. Under section 71101, enrollees who no longer receive that assistance will have higher out-of-pocket costs, which would be expected to curtail their use of Medicare services and reduce Medicare spending.

Because the blocked provisions of the rule were not yet enforceable, and states had made only limited progress in implementation, CBO expects that under section 71101, states will maintain or reinstate earlier administrative practices and that Medicaid enrollment will return to trends in place before the rule was made final.

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2. That agreement supplements a long-standing agreement between CBO and the Budget Committees. See Congressional Budget Office, *CBO Explains How It Incorporates Administrative and Judicial Actions When Updating Its Baseline Projections and Preparing Cost Estimates* (December 2024), www.cbo.gov/publication/60846.

3. Centers for Medicare & Medicaid Services, "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," final rule, 88 *Fed. Reg.* 65230 (September 21, 2023), https://tinyurl.com/2up3bvw4.

CBO estimates that implementing section 71101 will decrease deficits by $66.0 billion over the 2026-2034 period and that the number of people without health insurance in 2034 will not change. Those estimates account for CBO's assessment that most people who are affected by section 71101 will remain enrolled in Medicare, but that Medicaid enrollment among dual enrollees will decrease by about 800,000 people in 2034.

Medicaid and the Children's Health Insurance Program. Section 71102 blocked several provisions of the 2024 rule.[4] Among other changes, the rule specified that states may conduct annual eligibility determinations only for people who are aged, blind, or disabled; that is, less frequently than under some states' practices before the rule was issued. The 2024 rule also specified that states could not require those enrollees to attend in-person interviews for eligibility redetermination. States were directed to provide Medicaid enrollees with clear guidance and adequate time to confirm their continuing eligibility, and to take extra steps before terminating coverage because of returned mail.

CBO estimates that enrollment in each Medicaid eligibility category would have been higher under the April 2024 rule because administrative barriers to enrollment and renewal would have been lower. Using information provided in CMS's analysis of the rule, CBO estimates that eligibility groups other than the aged or disabled populations would have been about 1 percent higher. For populations whose eligibility is determined by age or disability and to project the effect of reducing administrative terminations on those groups, CBO's estimate also incorporates administrative data on the rate at which beneficiaries lose and regain coverage. CBO estimates that enrollment would have been about 1.5 percent higher for those groups.

CBO expects that under section 71102, states will reinstate earlier administrative practices and that enrollment will return to trends in place before the 2024 rule took effect. CBO's expectation for section 71102, as for section 71101, reflects the fact that the blocked provisions were not yet subject to full compliance and that any preliminary steps states may have taken are not likely to result in continued adoption of the new practices once the policies are blocked.

CBO and JCT estimate that implementing section 71102 will decrease deficits by $53.6 billion over the 2025-2034 period. CBO estimates that the number of people without health insurance will increase by 400,000 in 2034.

Eligibility Redeterminations. Section 71107 requires states to conduct Medicaid eligibility redeterminations every six months, rather than annually, beginning in January 2027 for adults who gained Medicaid eligibility under the Affordable Care Act (ACA).

CBO estimates that 10 percent of that group will no longer have coverage after the first 6-month redetermination. That estimate is based on disenrollment probabilities drawn from experience with 12-month redeterminations, adjusted for the effects of more frequent reviews. As a result, some people are expected to be removed from the program earlier than

4. Centers for Medicare & Medicaid Services, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes," final rule, 89 *Fed. Reg.* 22780 (April 2, 2024), https://tinyurl.com/y9ebx2pt.

would have occurred before the 2025 reconciliation act became law.

Drawing from national research and CBO's analyses of the phaseout of continuous enrollment protections during the coronavirus public health emergency, CBO estimates that 30 percent of enrollees who will no longer have coverage under section 71107 will be ineligible for Medicaid at the time of the redetermination. CBO expects that the other 70 percent will no longer have coverage because of procedural reasons (such as missed paperwork), because of problems with communication, or because of difficulty with navigating reenrollment.

CBO and JCT estimate that implementing section 71107 will decrease deficits by $58.0 billion over the 2025-2034 period. CBO estimates that the number of people without health insurance will increase by 700,000 in 2034.

Provider Taxes. Section 71115 prevents states from increasing existing taxes on providers and bars states from creating new tax arrangements for providers. For states that expanded Medicaid coverage under the ACA, the section also reduces what is termed the hold-harmless threshold by 0.5 percentage points annually on taxable amounts that providers collect for certain services. In 2028, the threshold will be reduced from 6.0 percent to 5.5 percent, and it will fall to 3.5 percent in 2032 and subsequent fiscal years.[5]

Almost all states finance a portion of their Medicaid spending through taxes collected from health care providers.[6] Those amounts finance additional payments to Medicaid providers, leaving them at least no worse off (that is, held harmless) than they were before the tax. States also use the revenue to cover additional services or expand enrollment. Provider taxes increase Medicaid spending, which in turn raises federal matching payments. Historically and through 2027, federal law effectively allows states to use such arrangements when the taxes they collect do not exceed 6 percent of a provider's net profit from treating patients, as long as similar types of providers are taxed at uniform rates.

CBO anticipates that implementing section 71115 will reduce the amount of revenue available to states to finance their portion of Medicaid funding and that states will not replace all of the lost revenue with revenue from other sources. Instead, CBO expects that states will reduce spending in the program areas that had been supported by provider tax revenues by reducing payment rates to providers or reducing Medicaid enrollment by revising eligibility policies and procedures. Because the lower threshold on the allowable tax rate affects only the states that expanded coverage under the ACA, CBO estimates an increased likelihood that some states will discontinue that expanded coverage and that none will expand coverage in the future. As a result, CBO estimates that Medicaid enrollment will decrease by 2.4 million people in 2034, mostly adults covered under the ACA, and that 1.3 million of those people will obtain coverage from other sources.

Based on historical provider tax collections, CBO and JCT estimate that implementing

5. In rare situations, CMS allows states to tax providers above the threshold, as long as they ensure that providers are not indirectly held harmless for the tax.

6. Medicaid and CHIP Payment and Access Commission. *Issue Brief: Health Care-Related Taxes in Medicaid* (May 2021), https://tinyurl.com/3acjh37m.

section 71115 will decrease deficits by $182.7 billion over the 2025-2034 period, and CBO estimates that the number of people without health insurance will increase by 1.1 million in 2034.

State-Directed Payments. Section 71116 lowers the upper limit on state-directed payments that managed care organizations can make to hospitals and nursing facilities and for physician services provided at academic medical centers. State-directed payments are also used for other services, including behavioral health and primary care, but payments for those services are not affected by the legislation. State-directed payments often supplement the base rates that providers receive for Medicaid services and make up a growing share of federal Medicaid spending. In 2024, CBO estimated that federal spending was $64 billion for state-directed payments.

Section 71116 reduces the payment limit from the commercial rate to 100 percent of Medicare's payment rates in expansion states and 110 percent in states that did not expand Medicaid under the ACA. Under section 71116, current state-directed payments above Medicare's rates can continue until fiscal year 2028; after that they must be reduced by 10 percentage points annually until they meet the applicable cap.

Using data from CMS, including state applications for state-directed payments, and information from the RAND Corporation on rates paid by commercial insurers, CBO estimates that implementing section 71116 will decrease federal outlays for Medicaid by $149.4 billion over the 2025-2034 period.[7] Federal spending will decline, CBO estimates, because spending on hospitals, nursing facilities, and physician services at academic medical centers will fall as states lower their payments to match Medicare's rates. CBO estimates that implementing section 71116 will not affect the number of people without health insurance.

Community Engagement Requirements. Section 71119 directs states to require certain Medicaid enrollees to spend at least 80 hours each month in activities, such as work, job training, education, or community service, as a condition of eligibility. The requirement applies to able-bodied adults between the ages of 19 and 64 who have no dependents under the age of 14.

Under section 71119, enrollees who do not meet the requirement or qualify for an exception will lose eligibility for Medicaid. Exceptions are mandatory for people who are medically frail, pregnant, recently incarcerated, or members of an American Indian or Alaska Native tribe. States may request exceptions for people who require a stay in a hospital or nursing facility within the month, live in a county with a Presidential declaration of an emergency or disaster, or live in a county with an unemployment rate that is either above 8 percent or 1.5 times higher than the national average. Under section 71119, states may begin imposing the requirement starting on January 1, 2027, but must do so by January 1, 2029.

CBO expects that implementing section 71119 will reduce Medicaid enrollment because some people will not meet the community engagement requirement and some will be unable

7. Christopher M. Whaley and others, *Prices Paid to Hospitals by Private Health Plans: Findings From Round 5.1 of an Employer-Led Transparency Initiative* (RAND, December 2024), https://tinyurl.com/3xch4kvh.

to verify their status. Based on data from the Census Bureau's Current Population Survey, CBO estimates that most Medicaid enrollees who are subject to the requirement either will satisfy it or will qualify for an exception; the rest, about 2.9 million in 2034, will lose coverage.

Based on research and data from states that have implemented community engagement demonstrations, as well as an analysis of the phaseout of continuous enrollment during the coronavirus public health emergency, CBO anticipates that about 2.8 million additional people will lose Medicaid coverage in 2034 because the requirement will add steps to the application process. Applicants will need to provide evidence that they either have met the requirement or that they qualify for an exception, and states will need to verify that information during the application process. States can automate some of the process by using available data on some enrollees' work status and other relevant information, but CBO expects that such information is not readily obtainable for all types of work, community engagement activities, or conditions that qualify for an exception. In some cases, verification will be more difficult for states to administer and for enrollees to navigate. Because of that administrative difficulty, CBO also expects that about 5 percent of the enrollees who could lose coverage because they do not work or qualify for an exemption will keep their Medicaid coverage because of verification errors or less rigorous enforcement in some states.

CBO expects that most people who lose Medicaid coverage under the section will become uninsured. A few will have access to and enroll in employment-based coverage, and, as specified in section 71119, none will be eligible to claim the premium tax credit.

CBO and JCT estimate that implementing section 71119 will decrease deficits by $317.0 billion over the 2025-2034 period. CBO also estimates that the number of people without health insurance will increase by 5.3 million in 2034.

Other Medicaid-Related Effects and Interactions Among Policies. CBO and JCT estimate that implementing the remaining Medicaid-related policies in chapter 1, and accounting for interactions among all of the related policies, will, on net, decrease deficits by $60.1 billion over the 2025-2034 period and, CBO estimates, result in no additional net effects on the number of people without health insurance in 2034.

Uncertainty

CBO's estimates of the budgetary and coverage effects of implementing the Medicaid policies in the 2025 reconciliation act are subject to significant uncertainty.

The changes in policy would affect the reactions of states, employers, insurers, and individual Medicaid enrollees; those responses are generally uncertain. For example, in CBO's estimate, no additional states will expand Medicaid in the future, mainly because of the changes to provider taxes that were enacted in section 71115. If states do expand Medicaid under the ACA in the future, or if more states that already expanded Medicaid decide to withdraw the expansion, federal spending associated with that provision could increase or decrease.

Significant uncertainty surrounds states' implementation of the community engagement requirements in section 71119; to date, only Arkansas and Georgia have implemented similar

requirements. CBO relied on those states' experiences to inform the estimate. To the extent that those states do not represent any practices that will be adopted by other states, the number of people losing Medicaid coverage could be higher or lower than estimated.

Considerable uncertainty also surrounds the degree to which states and providers will respond to the Medicaid-financing changes in the legislation. For example, it is uncertain whether or to what extent states will shift toward other supplemental payment mechanisms in response to the reduced upper-payment limit on state-directed payments in section 71116. If states increase other types of supplemental payments by more or less than expected to offset the reduction in state payments, the budgetary effects of implementing section 71116 could differ from those estimated here.

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EXHIBIT 71

manatt

JULY 2026

CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034

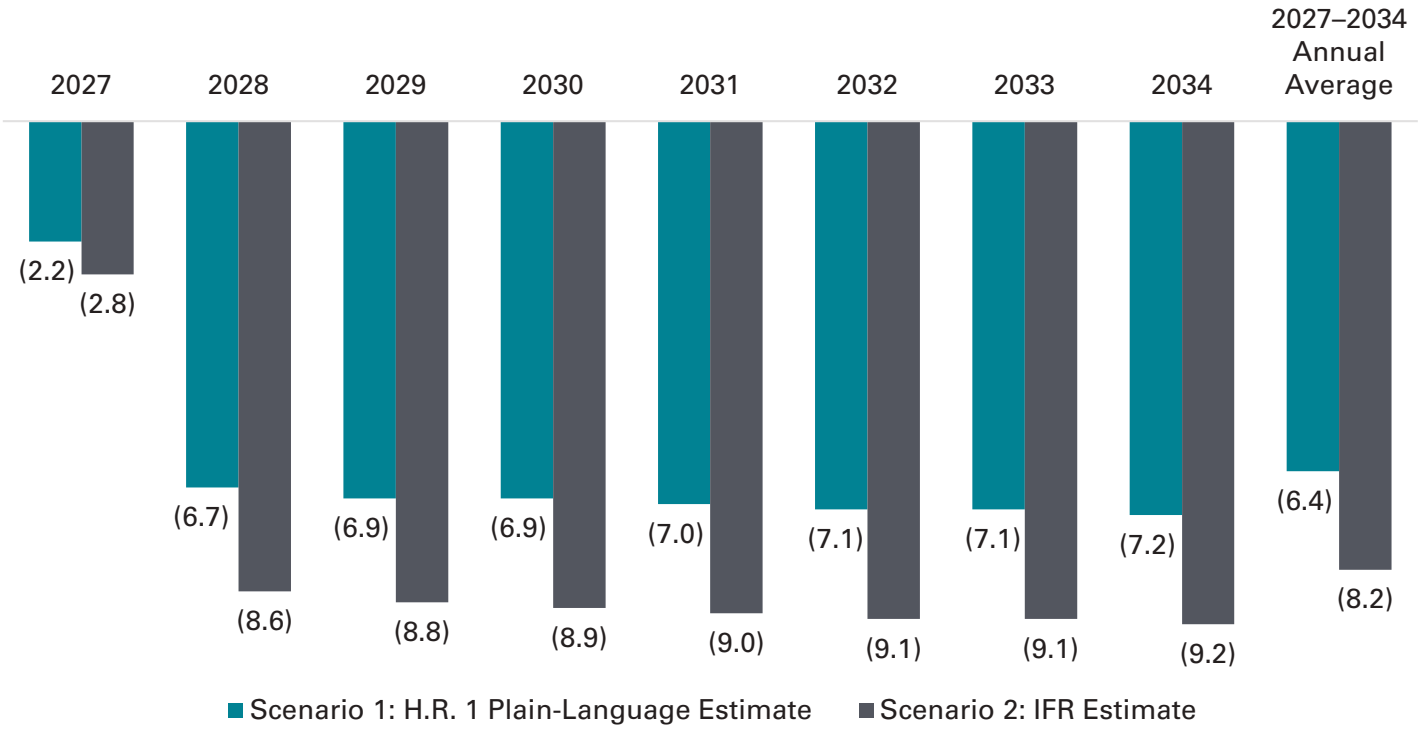
Vital Signs: 50-State Tracking

By Patti M. Boozang, Avi Herring, Adam D. Striar and Elizabeth A. Scott

Key Takeaways

- Beginning January 1, 2027, H.R. 1 makes Medicaid work requirements a condition of eligibility for adults in the Medicaid expansion group and expansion-like waiver programs. To keep coverage, these adults must show that they are working, volunteering, or attending school for at least 80 hours per month—or qualify for an exemption, such as pregnancy, caregiving for a young child, medical frailty, or substance use disorder treatment.
- CMS' June 1 interim final rule (IFR) sets detailed state implementation requirements that, as written, take a narrower approach than H.R. 1's plain language, including by limiting access to medical frailty exemptions and restricting self-attestation of compliance or exemption.
- The IFR is likely to increase coverage loss significantly beyond what would have occurred under a plain-language reading of the statute. As a result, the rule is already drawing legal challenges. On June 29, a coalition of 26 states sued CMS, asserting that the IFR goes beyond the statutory language adopted by Congress, departs from guidance provided to states repeatedly over the last year, and does not adequately inform states about their obligations.
- Manatt Health estimates that the IFR implementation approach would increase average annual Medicaid coverage losses by **1.8 million people**, from **6.4 million** to **8.2 million** between FFY 2027–2034—nearly **1 in 10 Medicaid enrollees nationwide**. The estimate assumes a 40% coverage-loss rate among those subject to work requirements, informed largely by New Hampshire's prior experience implementing work requirements. Coverage losses are projected to grow over time—from **2.8 million** people in FFY 2027 to **9.2 million** people by FFY 2034, when the requirements are fully implemented (see Figure 1).

Figure 1. Aggregate Change in Medicaid Enrollment from Baseline, FFYs 2027–2034 (millions)



This report, a product of ***Manatt Health's Vital Signs: 50-State Tracking***, explains the key provisions in the IFR and Manatt Health's assumptions that inform the projected increases in coverage loss, and estimates expected coverage loss by state and over time.

CMS' Rule Takes a Narrower Approach Than H.R. 1's Statutory Requirements

On June 1, CMS released an IFR on work requirements slated to go into effect on July 31, 2026. CMS is accepting comments on the rule through July 31, 2026 and could make adjustments, but the IFR has the full force of a formal regulation once it goes into effect. In the IFR, CMS adopts a significantly more narrow interpretation of H.R. 1 than it had communicated to states through informal guidance and regular meetings. Specifically, the IFR:

- **Narrows the definition of medical frailty.** H.R. 1 exempts "medically frail individuals" from work requirements. The statute specifies that medically frail individuals include those who are blind or disabled; have a substance use disorder; have a disabling mental disorder; have a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or have a serious or complex medical condition. Early CMS guidance indicated that states could look to patients' diagnoses to determine if they are medically frail, but the final rule adds a new requirement—one that appears nowhere in the statutory language of H.R. 1—that individuals who otherwise would be classified as medically frail must also demonstrate that their condition "significantly impairs" their ability to comply with the work requirements. In practice, this new requirement sharply

narrows who qualifies for the exemption and requires states to verify not just that someone has cancer, multiple sclerosis or another serious condition, but also that their condition significantly impairs their ability to work.

- **Limits the use of self-attestation beyond 2027.** The rule permits states to accept an individual's self-attestation of compliance with work requirements or an exemption through 2027—but this flexibility is temporary. Of particular note, individuals who are medically frail will only be able to attest to this once during an enrollment period, after which states must require documentation. This requirement will create additional operational challenges for enrollees, providers, and state eligibility and enrollment staff, as many individuals will need to get their health care provider to evaluate their ability to work—a task that is not a routine part of medical care, nor for which providers are trained—and submit their determination for documentation purposes.

The more restrictive implementation matters because it can be expected to compound coverage losses that were already projected to be substantial under the plain-language reading of the statute. For context, even prior to the IFR, the Congressional Budget Office (CBO) had projected that H.R. 1 would lead to more than $1 trillion in federal funding cuts and increase the ranks of those without health insurance by 10 million people over the next decade. Of those losing coverage, 5.3 million were projected to do so because of the work requirements. Importantly, approximately half of CBO's estimates reflected coverage losses driven by administrative barriers—eligible people who are unable to navigate the reporting and documentation requirements—rather than actual ineligibility. CBO also appears to have assumed that the requirement will have no meaningful increase on employment, based on its prior research and scoring of previous legislation. Evidence from states' earlier experience aligns with CBO's assumptions that many eligible individuals will lose coverage because of administrative barriers and paperwork burden (see **Figure 2** below for additional detail on state implementation experiences).

Notably, CMS projects in the IFR that the work requirements provision will lead to coverage loss of approximately 3.3 million at full ramp up, substantially lower than CBO and Manatt's estimates even prior to release of the IFR. Unlike both CBO and Manatt, CMS does not appear to account for the evidence from prior state implementation of work requirements, asserting that because prior state work requirement programs involved "different implementation patterns," there is "no direct historical experience from which to derive empirical estimates…" CMS then assumes a much lower rate of "procedural disenrollments"—that is, people who should retain Medicaid eligibility but lose it for administrative reasons—than actual state experience suggests will occur.[i]

What Prior State Work Requirements Implementation Experience Tells Us

Four states—Arkansas, Georgia, New Hampshire, and Michigan—have previously implemented (or begun implementing) Medicaid work requirements, and each saw (or determined that it would have seen) substantial coverage loss among eligible people before courts or state action halted the programs. The losses stemmed largely from administrative barriers, not ineligibility. As Figure 2 below summarizes, these states' comparative design features, particularly their use of automation and self-attestation, directly shaped how many enrollees lost or were at risk of losing coverage.

i. 91 FR 33456.

Figure 2. Comparison of Prior State Work Requirements Implementation Experience

	New Hampshire[ii]	Arkansas[iii]	Michigan[iv]
Population	Medicaid Expansion Adults, ages 19–64	Medicaid Expansion Adults, ages 19–49 Included an initial phase-in for adults ages 30–49 with incomes ≤100% of Federal Poverty Level (FPL)	Medicaid Expansion Adults, ages 19–62
Self-Attestation	For certain good cause exemptions only[v]	Accepted for all exemptions	Accepted for all exemptions
Level of Automation	Medium	High	High
Approximate Number and Share of Enrollees Subject to Requirements Disenrolled/ Projected to Disenroll[vi]	17,000, 41%[vii]	18,000, 29%[viii]	100,000, 14%[ix]

Note: Because of Georgia's limited use of automation, we believe its Pathways program is not an appropriate point of comparison for the federal work requirement under H.R. 1, which requires state to rely on data for verification of compliance and/or exemption. Therefore, we have not included detail on Georgia Pathways in Figure 2.

Manatt Health 50-State Analysis of Additional Coverage Losses Due to CMS Work Requirements Implementation Guidance

To assess how Medicaid work requirements in combination with the new IFR may affect Medicaid coverage, Manatt modeled two scenarios using different coverage loss assumptions:

- **Scenario 1: H.R. 1 Plain-Language Estimate—30% Disenrollment Rate.** This scenario follows Manatt's baseline modeling approach, which assumed CMS would implement H.R. 1 Medicaid work requirements in close consistency with the plain language of the statute and the guidance it provided to states up until release of the IFR. The coverage loss assumption reflects the average experience/projections from state-

ii. Additional information specific to New Hampshire's implementation experience can be found here and here.

iii. Additional information specific to Arkansas' implementation experience can be found here and here.

iv. Additional information specific to Michigan's implementation experience can be found here and here.

v. For example, parents/caretakers of children aged 6–12 who were unable to secure child care were permitted to self-attest to meeting a good cause exemption.

vi. Coverage loss estimates for New Hampshire and Arkansas are rounded to nearest thousand.

vii. See Table 2 here.

viii. For total coverage loss, see Figure 1 here. For percentage coverage loss, see Table 2 here. Percentage estimates are based on the first month of reporting.

ix. See here. We calculate the 14% figure by dividing total projected coverage loss (100,000) by total Medicaid expansion enrollment (700,000).

level work requirement programs in New Hampshire, Arkansas, and Michigan, adjusted for differences between these states' approaches and H.R. 1. Specifically, Manatt assumed that 30% of individuals subject to work requirements in a given month would lose coverage.

Each of these states employed some amount of automation to determine compliance and exemptions, consistent with H.R. 1's requirement that states use administrative data where available for these purposes. Additionally, as described in Figure 2, two of the three states allowed for the broad use of self-attestation.

- **Scenario 2: CMS IFR Estimate—40% Disenrollment Rate.** To assess the impact of the IFR, we updated our assumptions to center on the experience of New Hampshire, which projected coverage loss of approximately 40% in the first month of reporting before the program was suspended by the state (and ultimately blocked in federal court). Unlike Arkansas and Michigan, which broadly permitted self-attestation for exemptions, New Hampshire accepted attestations only for certain good-cause exemptions and required qualifying documentation for most other exemptions, including medical frailty (which required providers to certify that patients had certain conditions). **This more restrictive approach most closely aligns with the IFR's narrower definition of medical frailty and use of self-attestation.**

About Manatt Health's 50-State Medicaid Financing Model

During the 2025 Budget Reconciliation debate, Manatt Health developed a 50-state Medicaid Financing Model to estimate the expenditure and enrollment impacts of key policy proposals. The model estimates the impact of select provisions within H.R. 1 on Medicaid coverage and expenditures annually over a ten-year timeframe (FFY 2025–FFY 2034), with projections at the national and state levels. The model accounts for the interactive effects of specific H.R. 1 provisions including:

- Work reporting requirements for Medicaid expansion enrollees or other expansion-like programs;
- 6-month eligibility redetermination requirements for Medicaid expansion enrollees or other expansion-like programs; and
- New limitations on state-directed payments (SDPs) and provider taxes.

The model leverages data from several key sources, including the Medicaid Budget and Expenditure System (MBES), T-MSIS Analytic Files (TAF), the Congressional Budget Office, and publicly available SDP preprints, among others, to establish a state-specific enrollment and expenditure baseline by eligibility group.

Manatt has continued to update and maintain the Medicaid Financing Model regularly since passage of the law as new data become available and CMS issues rules implementing provisions of H.R. 1.

Model Methodology: Medicaid Enrollment Baseline

The model's Medicaid enrollment baseline is calculated for each state based on publicly available **FFY 2025 average monthly enrollment data from MBES**, available through June 2025. This includes enrollment across states for six eligibility groups—children, expansion enrollees, other adults, aged, disabled, and limited benefit enrollees. Expansion enrollment is sourced directly from the MBES reports; however, because MBES does not report non-expansion enrollment by eligibility group, the model allocates non-expansion enrollees proportionally across eligibility groups using the distribution observed in the **FFY 2024 TAF data**. The enrollment baseline is then uniformly adjusted and trended forward through 2035 based on national Medicaid enrollment **projections from CBO's Medicaid baseline**. For states where Medicaid enrollment has declined substantially since FFY 2025, the model does not yet incorporate those declines into its baseline. Manatt continues to actively monitor Medicaid enrollment trends across states, and will make subsequent adjustments to the model baseline as needed.

Key Findings: Medicaid Coverage Losses Will Grow Under CMS' Rule

National Impact

- **Scenario 1: H.R. 1 Plain-Language Estimate**
  - Medicaid enrollment declines by an estimated **6.4 million people** on an average annual basis between FFY 2027-2034.[x] This represents a **7% reduction in total nationwide Medicaid enrollment** compared to expected enrollment prior to H.R. 1's enactment.
  - Average **enrollment losses in FFY 2027 are approximately 2.2 million, increasing gradually by month** as individuals go through their first eligibility renewal where they will be subject to work requirements.[xi] We assume that all states will choose to follow their existing renewal cadence in CY 2027, meaning some enrollees will not need to demonstrate compliance or an exemption until later in the year.[xii] This will mitigate coverage loss in CY 2027 relative to later years.
  - By FFY 2034, Medicaid enrollment is expected to decline by **7.2 million people** compared to the pre-H.R. 1 baseline.
- **Scenario 2: CMS IFR Estimate**
  - Under this scenario, Medicaid enrollment declines by an estimated **8.2 million people** on an average annual basis between FFY 2027–2034. This represents a nearly **10% reduction in total nationwide Medicaid enrollment**.
  - Average **enrollment losses in FFY 2027 are approximately 2.8 million, increasing gradually by month**. Here we apply the same assumptions regarding renewal cadence as under scenario 1.
  - By FFY 2034, Medicaid enrollment is expected to decline by **9.2 million people** compared to the pre-H.R. 1 baseline.
- Overall, an **additional 1.8 million people lose coverage under Scenario 2 relative to Scenario 1** on an average annual basis from FFY 2027–2034. This represents a nearly **30% increase** in the number of people losing coverage.

x. To calculate average annual coverage loss from FFY 2027–2034, Manatt calculates a simple average of projected coverage losses for each year in the range. For each individual year, the coverage loss figure represents the difference between expected enrollment at a given point in time during the year under H.R. 1 relative to baseline.

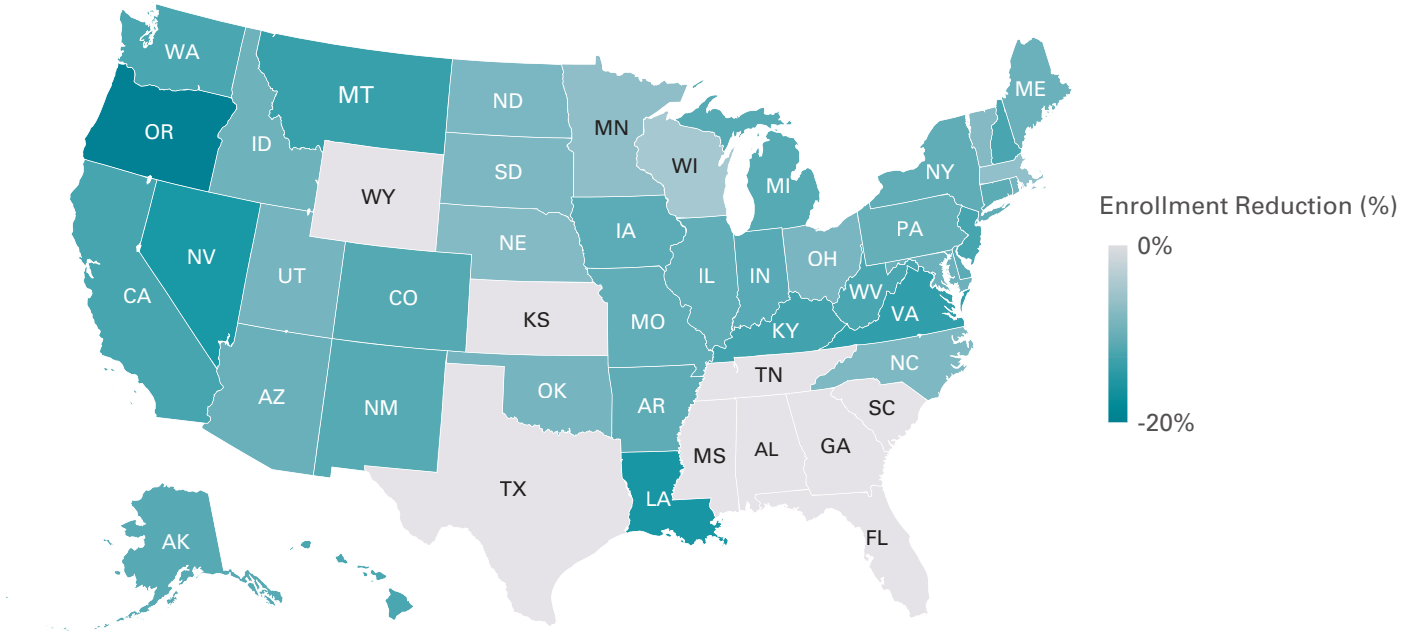
xi. Since we project coverage loss on a FFY basis, we assume no coverage loss during the first three months of FFY 2027 (i.e., October–December 2026), with losses ramping up in each month thereafter.

xii. In a State Medicaid Director Letter issued on March 6, CMS provided states with two options for how to transition to six-month renewal periods required under H.R. 1. One option allows states to implement the change as individuals come up for their already-scheduled renewals during CY 2027. The alternate option allows states to initiate certain renewals earlier in 2027 in order to shorten existing 12-month certification periods and move individuals more quickly onto a six-month cycle. We expect that most states will choose the first option to limit administrative burden.

State Impacts

- Under both scenarios, enrollment reductions vary significantly by state. This is primarily driven by the size of each state's expansion group relative to the size of the overall program. States with the most significant coverage loss **(e.g., Nevada, Louisiana, and Oregon) could see enrollment reductions of 16% or more. These are the states in which Medicaid expansion represents the largest share of total program enrollment.**
- Other states like **Massachusetts, Minnesota, and Wisconsin** would see reductions of **7%** or less since their populations subject to work requirements are smaller relative to their overall Medicaid programs.

Figure 3. Average Annual Percentage Reduction in Total Medicaid Enrollment from Baseline, Scenario 2, FFYs 2027–2034



Source: Manatt 50-State Medicaid Financing Model. © GeoNames, Microsoft, TomTom.

Table 1: Average Annual Medicaid Enrollment Impacts by State, FFYs 2027–2034

State	Scenario 1: H.R. 1 Plain Language Estimate		Scenario 2: CMS IFR Estimate		Difference: Scenario 1 vs. 2
	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands
Total	**(6,381)**	**-7%**	**(8,189)**	**-10%**	**(1,808)**
Alabama	—	0%	—	0%	—
Alaska	(22)	-10%	(29)	-12%	(6)
Arizona	(168)	-8%	(215)	-10%	(47)
Arkansas	(74)	-9%	(95)	-11%	(21)
California	(1,593)	-10%	(2,043)	-13%	(451)
Colorado	(120)	-10%	(154)	-12%	(34)
Connecticut	(100)	-9%	(129)	-12%	(28)
Delaware	(22)	-9%	(28)	-12%	(6)
District of Columbia	(24)	-9%	(31)	-11%	(7)
Florida	—	0%	—	0%	—
Georgia	—	0%	—	0%	—
Hawaii	(43)	-10%	(55)	-13%	(12)
Idaho	(28)	-8%	(36)	-10%	(8)
Illinois	(261)	-9%	(335)	-11%	(74)
Indiana	(176)	-9%	(225)	-12%	(50)
Iowa	(57)	-9%	(74)	-12%	(16)
Kansas	—	0%	—	0%	—
Kentucky	(148)	-11%	(190)	-14%	(42)
Louisiana	(243)	-13%	(312)	-16%	(69)
Maine	(31)	-8%	(40)	-10%	(9)
Maryland	(108)	-8%	(139)	-10%	(31)
Massachusetts	(115)	-6%	(148)	-7%	(33)
Michigan	(232)	-9%	(298)	-12%	(66)
Minnesota	(69)	-6%	(88)	-7%	(19)
Mississippi	—	0%	—	0%	—
Missouri	(110)	-9%	(141)	-11%	(31)

State	Scenario 1: H.R. 1 Plain Language Estimate		Scenario 2: CMS IFR Estimate		Difference: Scenario 1 vs. 2
	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands
Montana	(24)	-11%	(31)	-14%	(7)
Nebraska	(22)	-6%	(29)	-8%	(6)
Nevada	(92)	-12%	(118)	-16%	(26)
New Hampshire	(19)	-10%	(25)	-13%	(6)
New Jersey	(179)	-10%	(229)	-13%	(51)
New Mexico	(80)	-9%	(103)	-12%	(23)
New York	(632)	-9%	(811)	-11%	(179)
North Carolina	(225)	-7%	(289)	-9%	(64)
North Dakota	(8)	-7%	(10)	-9%	(2)
Ohio	(226)	-7%	(290)	-9%	(64)
Oklahoma	(75)	-7%	(96)	-10%	(21)
Oregon	(215)	-16%	(276)	-20%	(61)
Pennsylvania	(263)	-8%	(338)	-11%	(74)
Rhode Island	(24)	-8%	(31)	-10%	(7)
South Carolina	—	0%	—	0%	—
South Dakota	(10)	-7%	(12)	-9%	(3)
Tennessee	—	0%	—	0%	—
Texas	—	0%	—	0%	—
Utah	(26)	-7%	(34)	-10%	(7)
Vermont	(11)	-6%	(14)	-8%	(3)
Virginia	(205)	-11%	(264)	-14%	(58)
Washington	(192)	-10%	(247)	-13%	(54)
West Virginia	(54)	-10%	(69)	-13%	(15)
Wisconsin	(53)	-4%	(70)	-5%	(18)
Wyoming	—	0%	—	0%	—

Note: Figures may not sum due to rounding.

Table 2: Average Annual Medicaid Enrollment Impacts by State, FFYs 2027–2028

State	Scenario 1: H.R. 1 Plain Language Estimate				Scenario 2: CMS IFR Estimate			
	2027		2028		2027		2028	
	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline
Total	**(2,176)**	**-3%**	**(6,706)**	**-8%**	**(2,795)**	**-3%**	**(8,606)**	**-10%**
Alabama	—	0%	—	0%	—	0%	—	0%
Alaska	(8)	-3%	(24)	-10%	(10)	-4%	(30)	-13%
Arizona	(57)	-3%	(176)	-9%	(73)	-4%	(226)	-11%
Arkansas	(25)	-3%	(78)	-9%	(33)	-4%	(100)	-12%
California	(543)	-4%	(1,673)	-11%	(697)	-5%	(2,147)	-14%
Colorado	(41)	-3%	(126)	-10%	(52)	-4%	(161)	-13%
Connecticut	(34)	-3%	(106)	-10%	(44)	-4%	(135)	-12%
Delaware	(7)	-3%	(23)	-10%	(10)	-4%	(29)	-13%
District of Columbia	(8)	-3%	(26)	-9%	(11)	-4%	(33)	-12%
Florida	—	0%	—	0%	—	0%	—	0%
Georgia	—	0%	—	0%	—	0%	—	0%
Hawaii	(15)	-4%	(45)	-11%	(19)	-5%	(58)	-14%
Idaho	(10)	-3%	(30)	-8%	(12)	-4%	(38)	-11%
Illinois	(89)	-3%	(274)	-9%	(114)	-4%	(352)	-12%
Indiana	(60)	-3%	(185)	-10%	(77)	-4%	(237)	-13%
Iowa	(20)	-3%	(60)	-10%	(25)	-4%	(77)	-13%
Kansas	—	0%	—	0%	—	0%	—	0%
Kentucky	(50)	-4%	(156)	-11%	(65)	-5%	(200)	-14%
Louisiana	(83)	-4%	(255)	-14%	(106)	-6%	(327)	-17%
Maine	(11)	-3%	(33)	-9%	(14)	-4%	(42)	-11%
Maryland	(37)	-3%	(113)	-9%	(47)	-4%	(146)	-11%
Massachusetts	(39)	-2%	(121)	-6%	(51)	-3%	(156)	-8%
Michigan	(79)	-3%	(244)	-10%	(102)	-4%	(313)	-13%
Minnesota	(23)	-2%	(72)	-6%	(30)	-3%	(92)	-8%
Mississippi	—	0%	—	0%	—	0%	—	0%

State	Scenario 1: H.R. 1 Plain Language Estimate				Scenario 2: CMS IFR Estimate			
	2027		2028		2027		2028	
	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline
Missouri	(38)	-3%	(116)	-9%	(48)	-4%	(148)	-12%
Montana	(8)	-4%	(25)	-12%	(10)	-5%	(32)	-15%
Nebraska	(8)	-2%	(24)	-7%	(10)	-3%	(30)	-9%
Nevada	(31)	-4%	(97)	-13%	(40)	-5%	(124)	-17%
New Hampshire	(7)	-4%	(20)	-11%	(9)	-5%	(26)	-14%
New Jersey	(61)	-4%	(188)	-11%	(78)	-5%	(241)	-14%
New Mexico	(27)	-3%	(84)	-10%	(35)	-4%	(108)	-13%
New York	(216)	-3%	(664)	-9%	(277)	-4%	(852)	-12%
North Carolina	(77)	-2%	(237)	-7%	(99)	-3%	(303)	-9%
North Dakota	(3)	-2%	(8)	-7%	(3)	-3%	(11)	-10%
Ohio	(77)	-2%	(237)	-8%	(99)	-3%	(305)	-10%
Oklahoma	(26)	-3%	(79)	-8%	(33)	-3%	(101)	-10%
Oregon	(73)	-6%	(226)	-17%	(94)	-7%	(290)	-22%
Pennsylvania	(90)	-3%	(277)	-9%	(115)	-4%	(355)	-12%
Rhode Island	(8)	-3%	(25)	-8%	(11)	-3%	(32)	-10%
South Carolina	—	0%	—	0%	—	0%	—	0%
South Dakota	(3)	-2%	(10)	-7%	(4)	-3%	(13)	-9%
Tennessee	—	0%	—	0%	—	0%	—	0%
Texas	—	0%	—	0%	—	0%	—	0%
Utah	(9)	-3%	(28)	-8%	(12)	-3%	(35)	-10%
Vermont	(4)	-2%	(11)	-7%	(5)	-3%	(15)	-9%
Virginia	(70)	-4%	(216)	-12%	(90)	-5%	(277)	-15%
Washington	(66)	-4%	(202)	-11%	(84)	-5%	(259)	-14%
West Virginia	(18)	-4%	(57)	-11%	(24)	-5%	(72)	-14%
Wisconsin	(18)	-1%	(57)	-4%	(24)	-2%	(75)	-6%
Wyoming	—	0%	—	0%	—	0%	—	0%

Acknowledgments

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About Vital Signs 50-State Tracking

H.R. 1 and other federal actions are driving historic health care cuts. Manatt Health is tracking state responses and analyzing the effects on coverage, affordability, and system stability. Vital Signs helps stakeholders understand near- and long-term impacts to inform policy, accountability, and collaboration.

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EXHIBIT 72

The following documents will be delivered to the Court under separate cover addressed to Jacqueline Martin, Docket Clerk:

- Certification of the Rulemaking Record;
- Index to the Rulemaking Record; and
- Administrative record for the "Medicaid Program; Community Engagement Requirement for Certain Individuals" interim final rule that became available for public inspection on June 1, 2026 and appeared in the Federal Register on June 3, 2026.