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 an Assistant Attorney General 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 a Preliminary Injunction, pursuant to Federal Rule of Civil Procedure 65.

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 and factual declarations, 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.

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

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.

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

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

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.

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

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

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

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

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.

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

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

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

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

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

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.

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 (NC Medicaid).

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

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.

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

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

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

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.

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

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.

Signed under the penalties of perjury on this 29th day of June, 2026 in Boston, Massachusetts.

/s/ Nita K. Klunder
Nita K. Klunder

CERTIFICATE OF SERVICE

I 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

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.

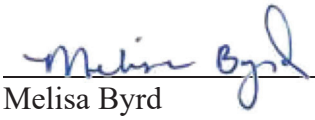
32. With respect to the medical frailty exclusion, the additional "significant impairment" requirement—plus the uncertainty of how to implement it—will require DC Medicaid to rapidly change its operational approach and systems development. In addition to analyzing, developing and implementing new ways 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

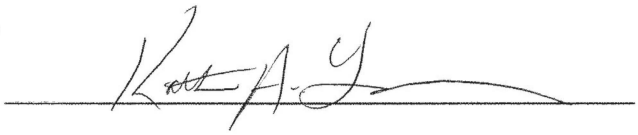
Medical Assistance Program expects poorer health outcomes across Illinois, as fewer people will be able to access appropriate care and manage chronic conditions.

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)(ii)(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)(ii)(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 judgments. 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
Michelle Probert
Director
Office of MaineCare Services
Address: 109 Capitol St, Augusta, Maine
Email: michelle.probert@maine.gov

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
SECRETARY

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.

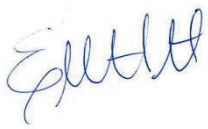
26. Michigan Medicaid enrollees will likely face increased denials and disenrollments, and many of those disenrollments could be of some of Michigan Medicaid's most medically needy. Individuals that are disenrolled from Michigan Medicaid will likely lose access to primary and preventive care, resulting 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

Overview | Current Status | Pending Applications | Processing Time | Eligibility | Managed Care Organizations | Caseloads and Projections | Children Medicaid and CHIP | Office of Analytics Homepage

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

Region Updated

Search

- CLARK
- WASHOE
- RURAL

KEY METRICS

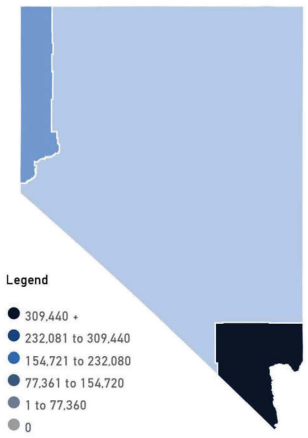
782,900
TOTAL ENROLLMENT
March 2026

750,879
MEDICAID ENROLLMENT

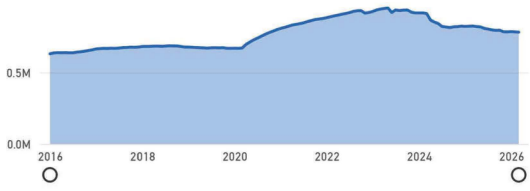
32,021
CHIP ENROLLMENT

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)



TOTAL MEDICAID ENROLLMENT WITH CHIP



REGION	CLARK		WASHOE		RURAL	
DATE	CHIP	MEDICAID	CHIP	MEDICAID	CHIP	MEDICAID
March 2026	25,270	593,599	4,125	86,670	2,626	70,610
February 2026	25,317	595,116	4,188	86,627	2,639	70,863
January 2026	25,565	596,574	4,204	86,734	2,634	70,961
December 2025	25,473	595,577	4,133	86,635	2,610	70,732
November 2025	25,682	595,730	4,209	86,496	2,699	70,772
October 2025	25,985	604,573	4,220	87,428	2,776	71,774
September 2025	26,287	603,361	4,337	87,140	2,828	71,559
August 2025	26,459	605,905	4,321	87,629	2,839	71,548
July 2025	26,916	610,314	4,411	88,074	2,878	71,915

This dashboard is updated monthly. For questions or feedback please email data@dhhs.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.

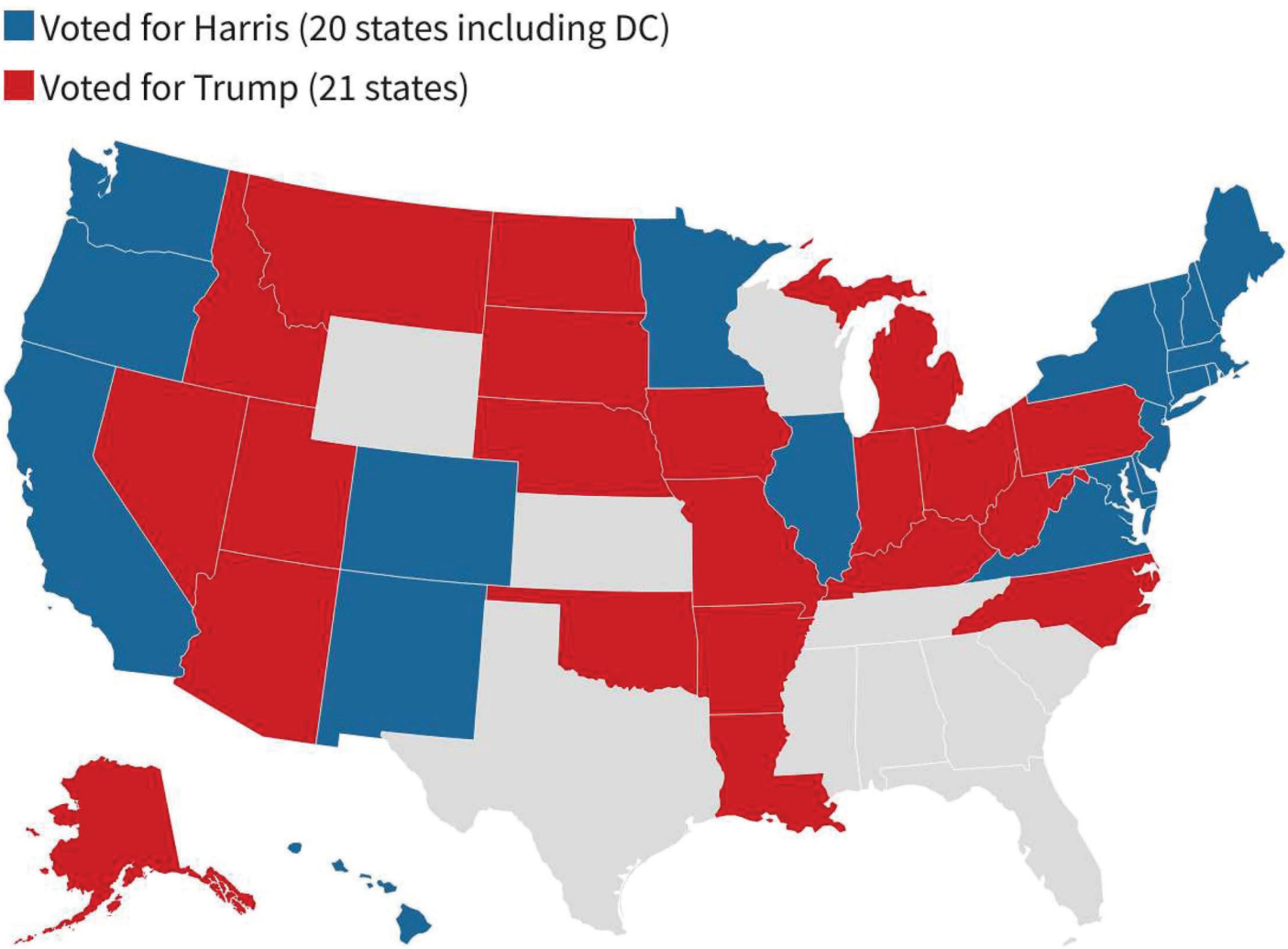
1. Medicaid expansion is widely adopted by both red and blue states.

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.

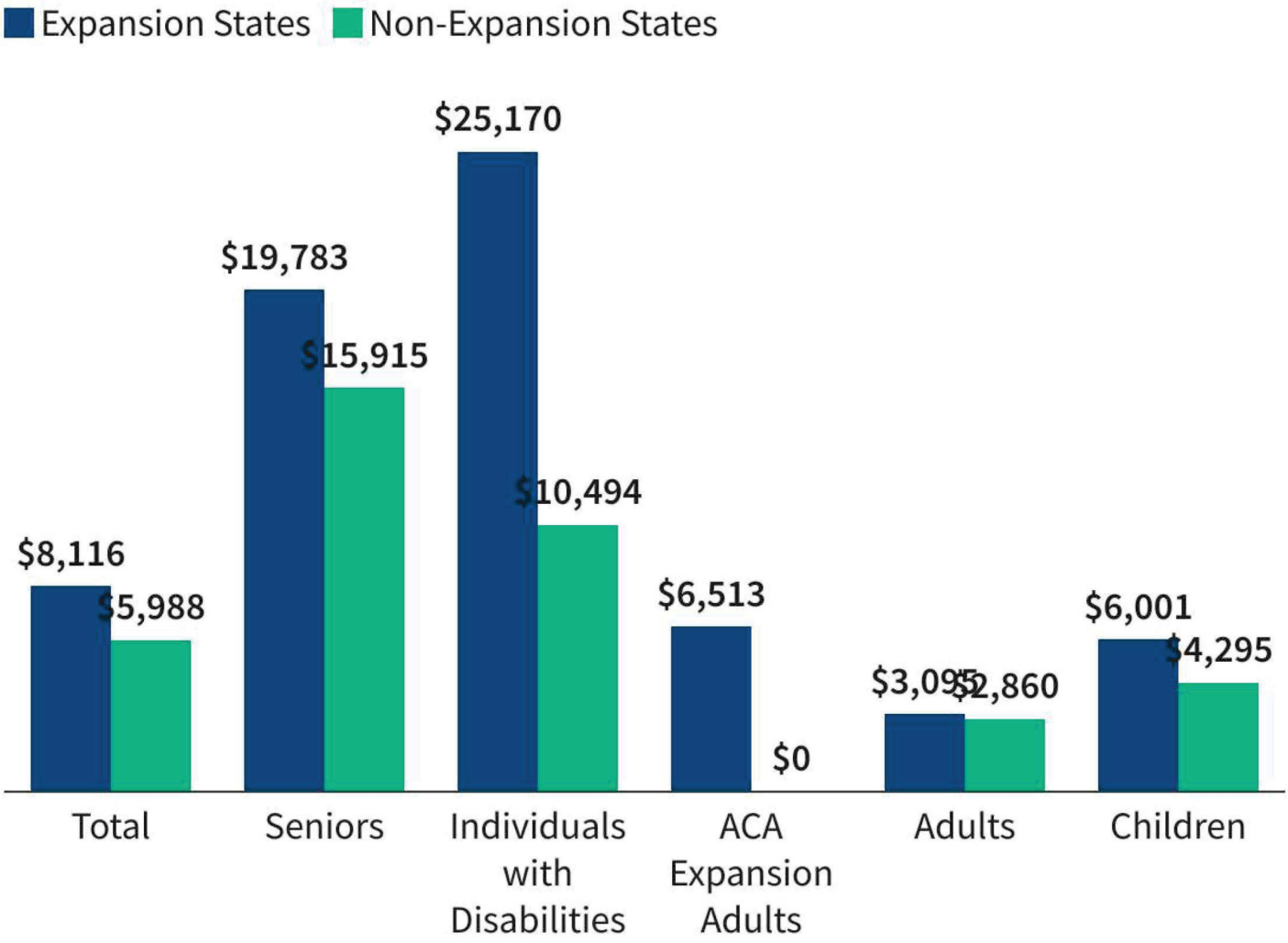
Overall, per enrollee spending for the expansion group was higher than for other adults and children but well below per enrollee spending for enrollees over age 65 and people with disabilities. While some critics of Medicaid expansion have argued that expansion diverts resources away from other groups 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.

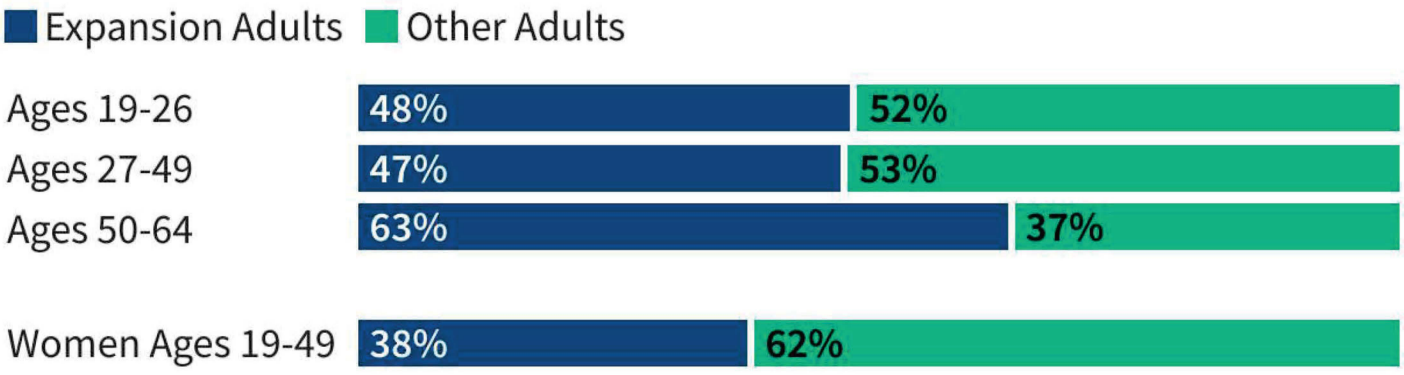
Medicaid expansion provides coverage across age groups for those 19 to 64 (Figure 3). Many expansion adults are working; however, they work for employers and in industries that are less likely to offer health insurance, leaving them without affordable health coverage options. As discussed below, older 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.

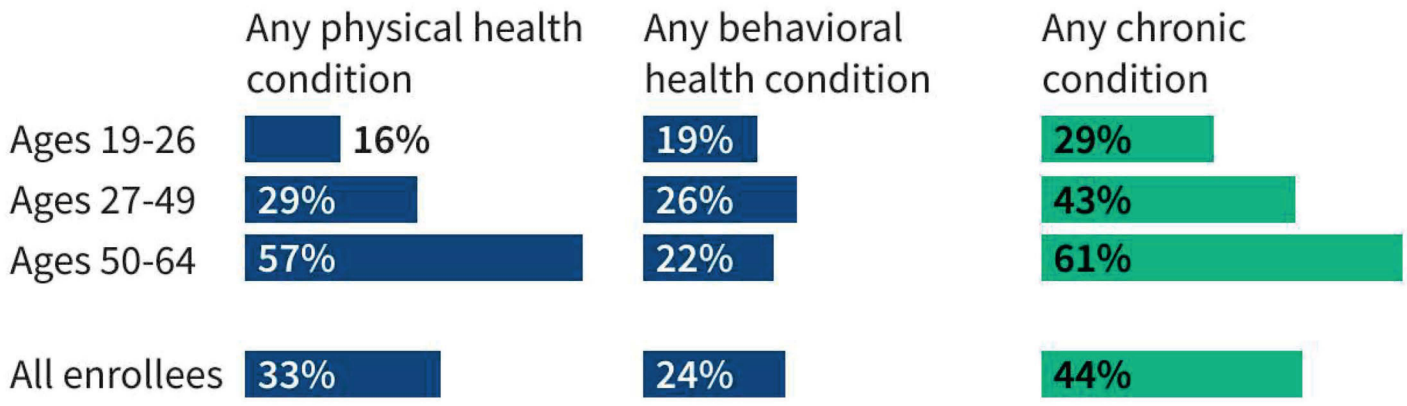
Nearly half (44%) of expansion adults have at least one chronic condition, including 33% that have a chronic physical condition and 24% that have a behavioral health condition. Of Medicaid enrollees with at least one chronic condition, 53% are enrolled through Medicaid expansion (data not shown). Similar 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

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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.

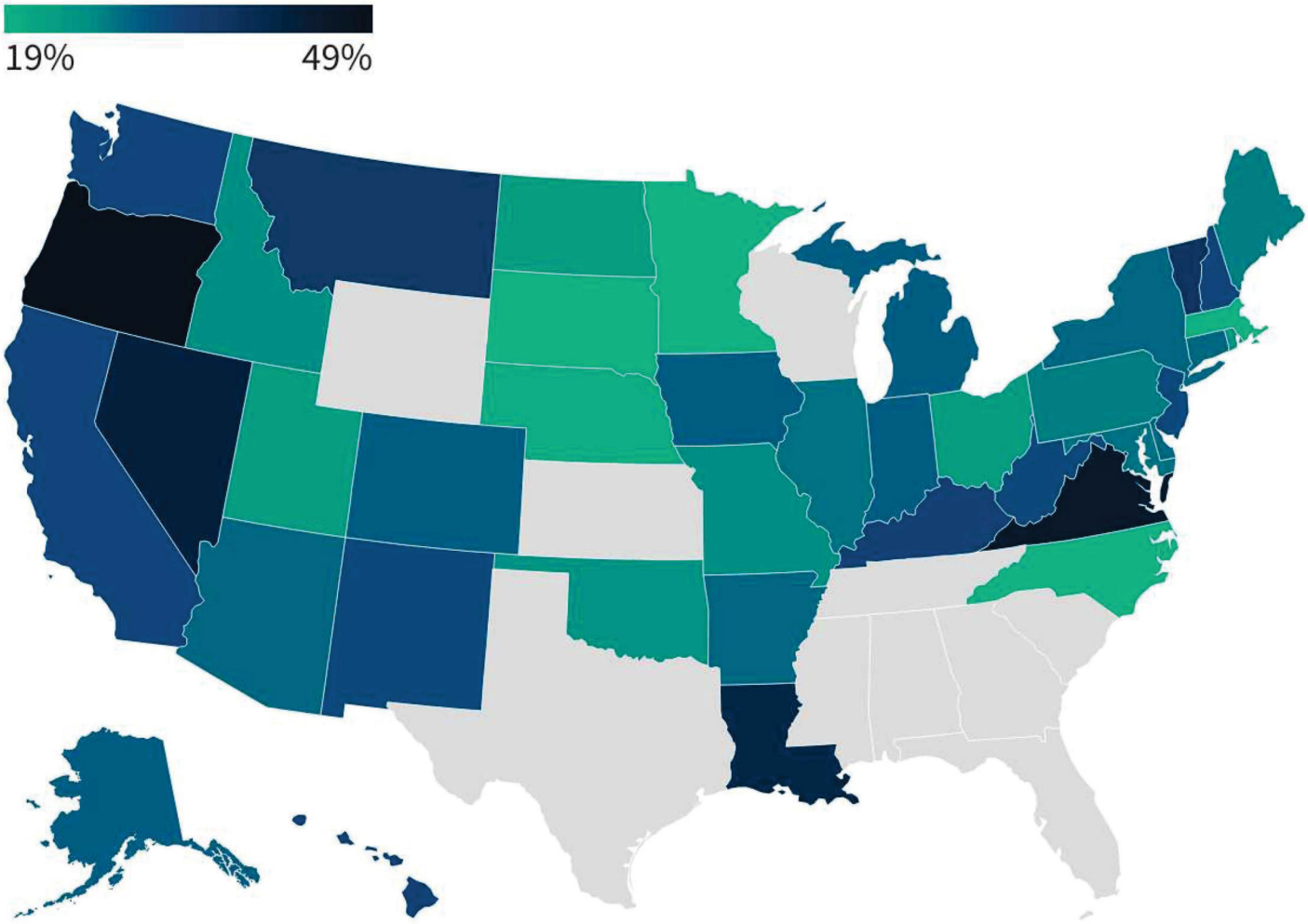
Congress may also consider proposals that would alter the financing for the Medicaid expansion. Any approach to reduce federal Medicaid spending for the expansion would shift costs to states, forcing governors to make tough choices about whether to

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

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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
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

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
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.

Sec. 2. The Office of the Governor.

For the support of the:	2025-2026	2026-2027
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.

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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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Who is Subject to Community Engagement Requirements:

Applicable Populations & Exceptions/Exclusions

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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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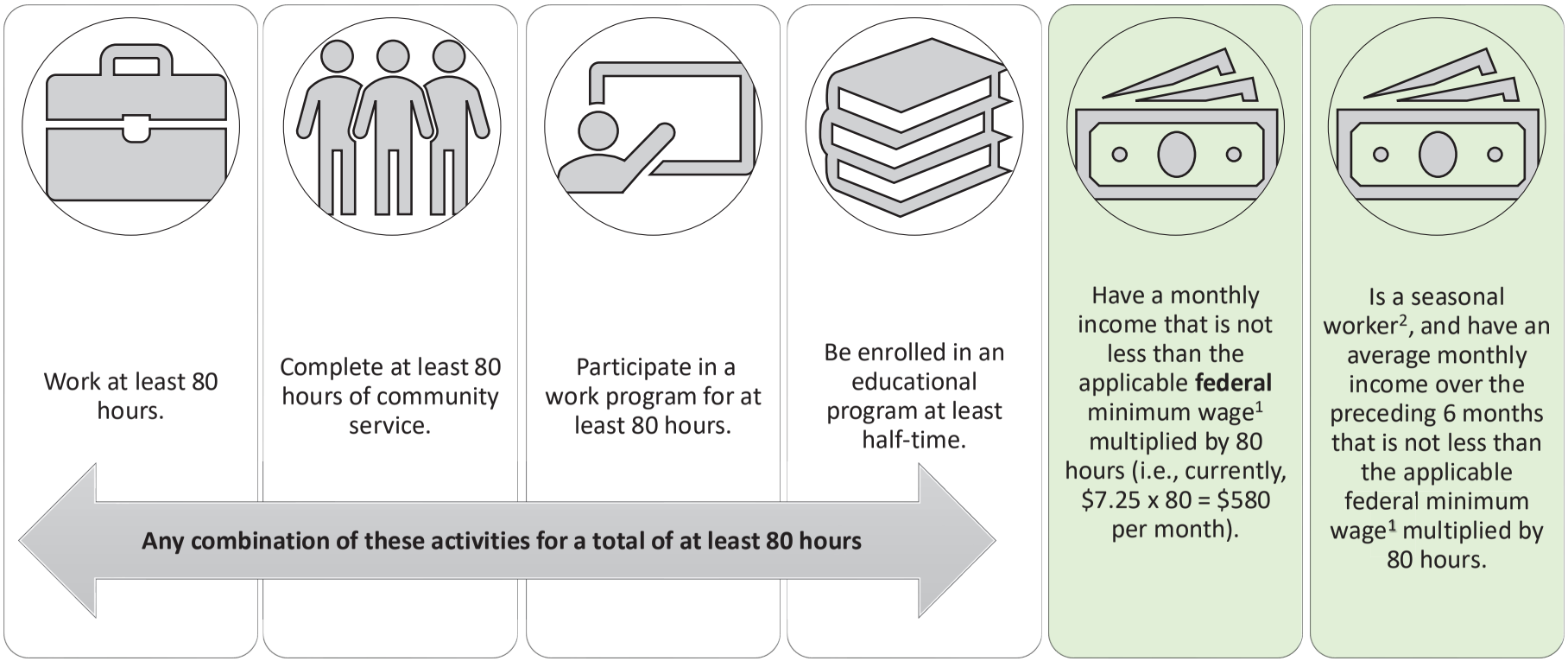
Community Engagement Compliance

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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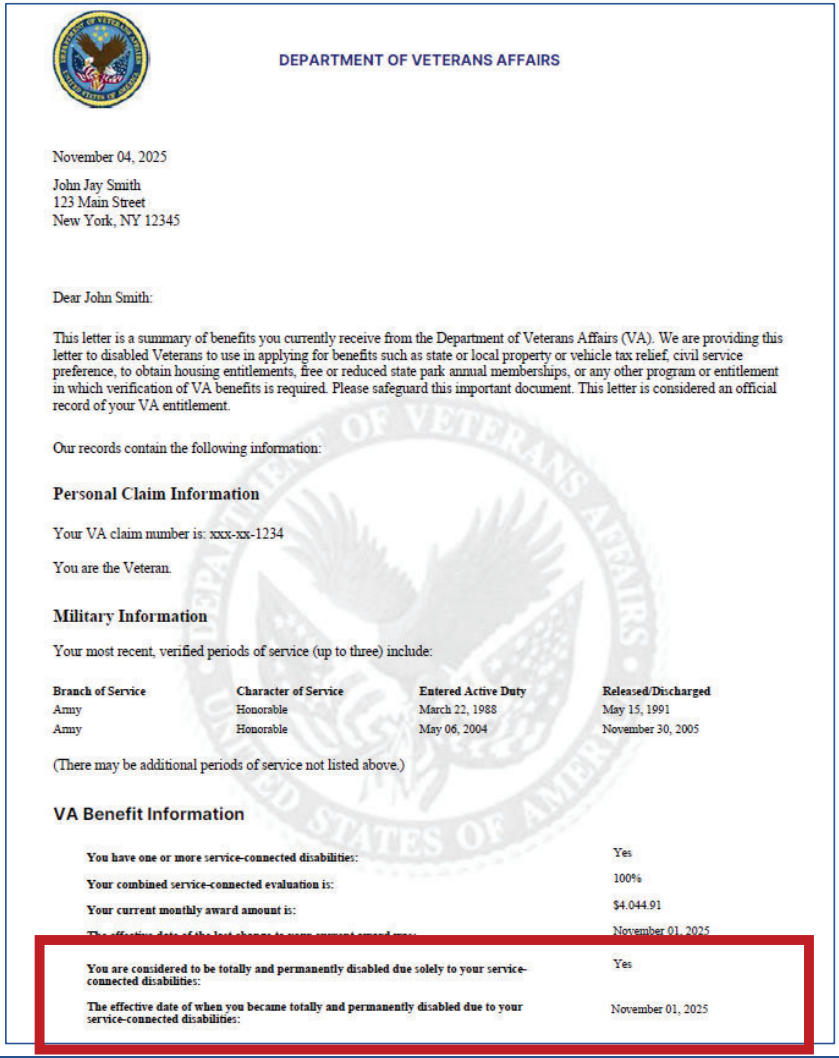
Verifying Exceptions & Exclusions

- 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 or vehicle tax relief, civil service preference, to obtain housing entitlements, free or reduced state park annual memberships, or any other program 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 22, 1988	May 15, 1991
Army	Honorable	May 06, 2004	November 30, 2005

(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
[illegible]	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

- 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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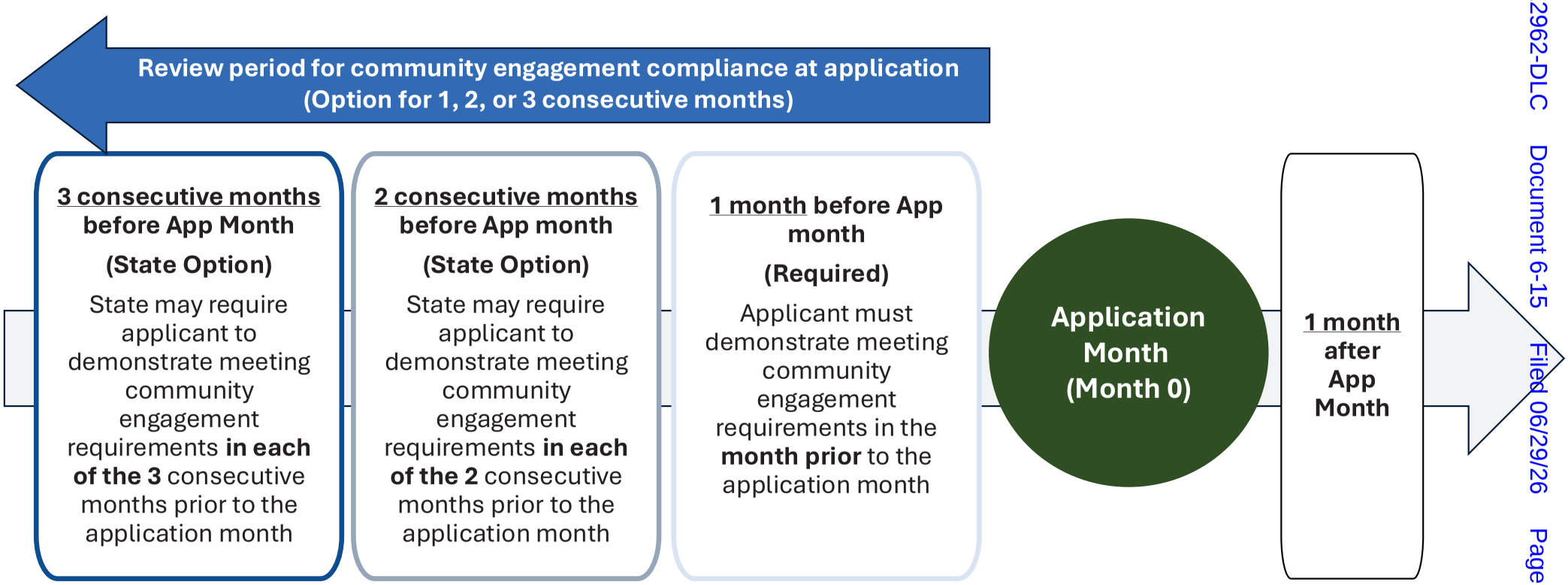
State Review Period for Community Engagement Compliance at Application



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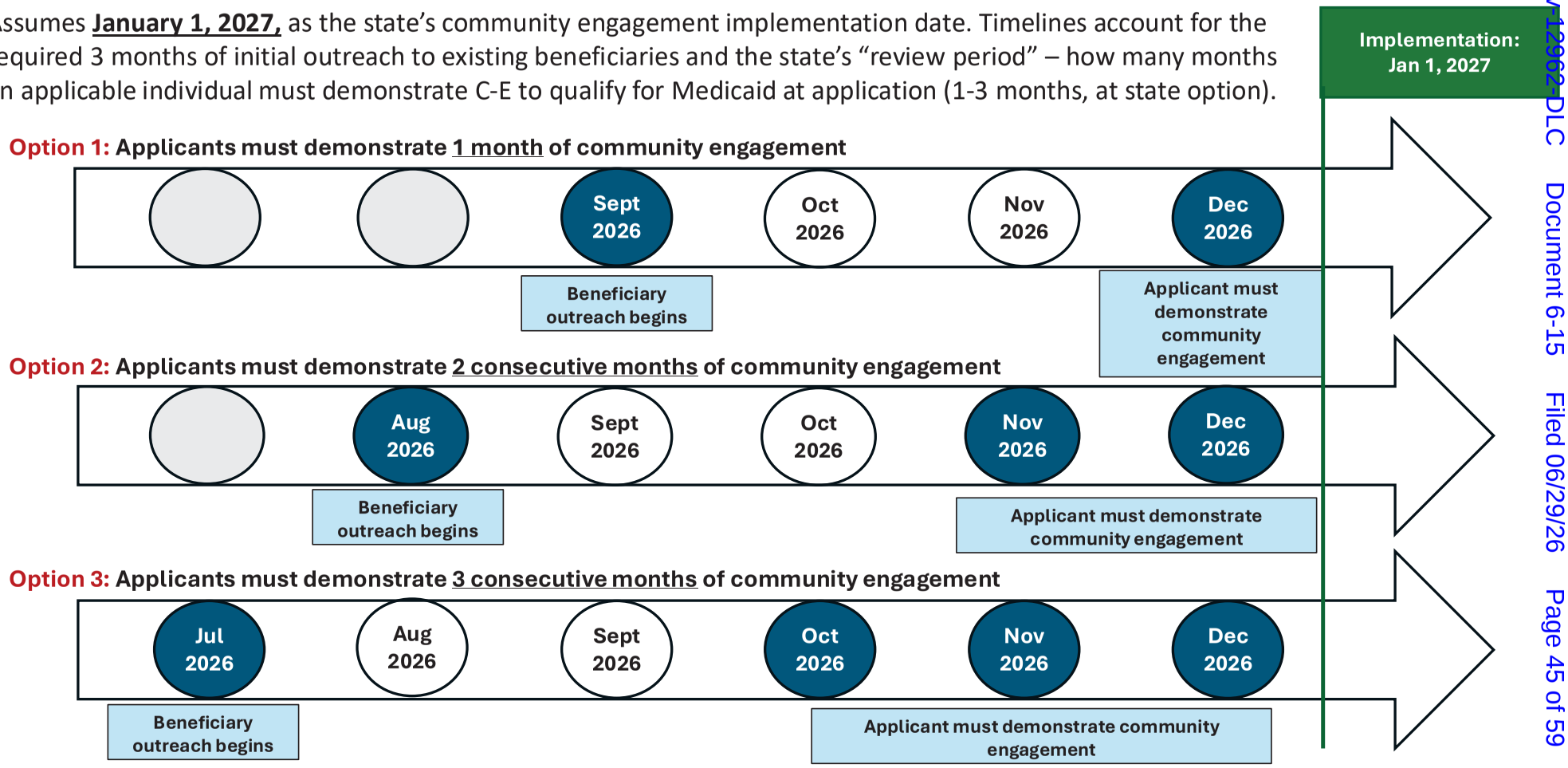
State Options for Initial Beneficiary Outreach & Compliance Review Periods at Application

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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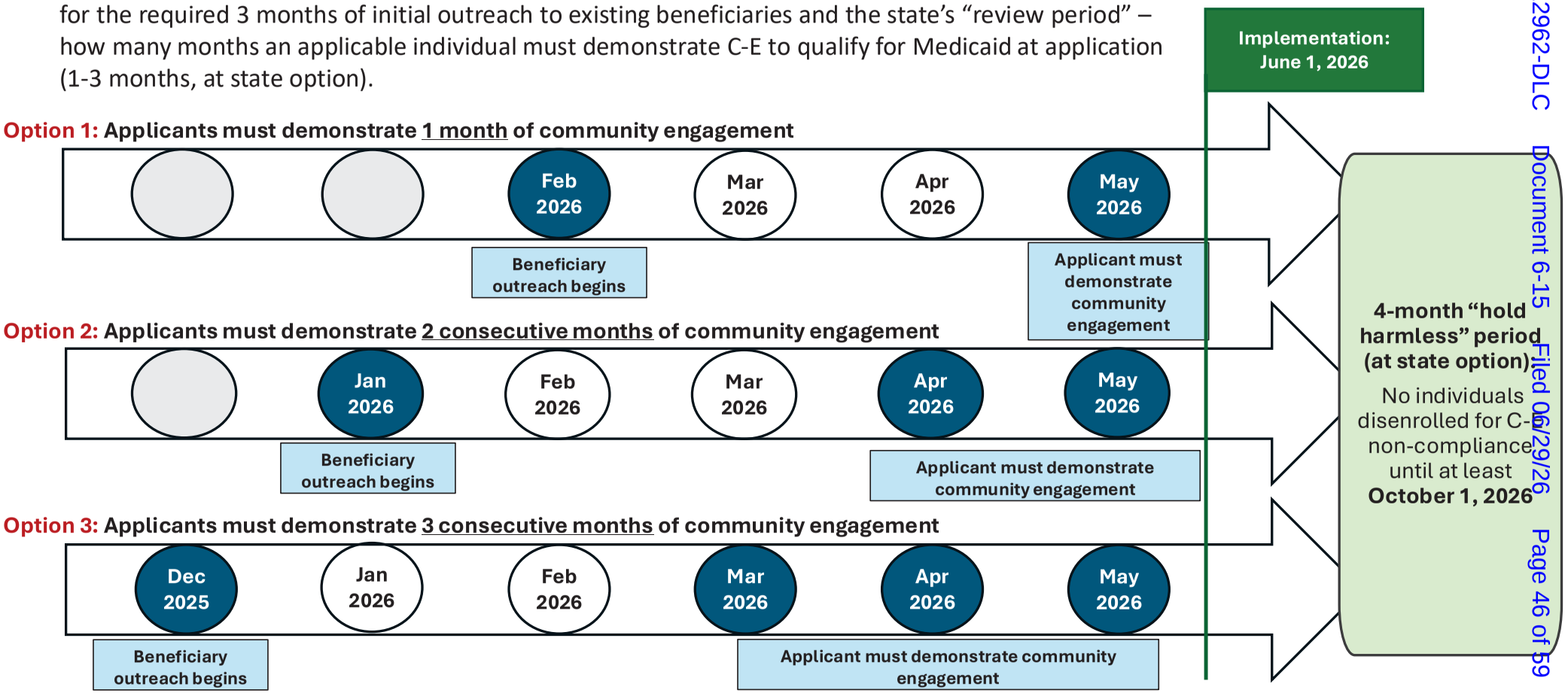
Early Starters: State Options for Initial Beneficiary Outreach & Compliance Review Periods at Application

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.

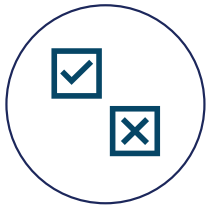
Update eligibility logic, state systems, and worker training to identify applicable population subject to C-E and route them through appropriate determination process.

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.

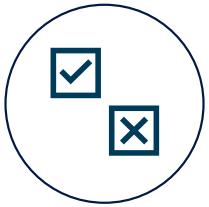
Update eligibility logic, state systems, and worker training to identify applicable population subject to C-E and route them through appropriate redetermination process.

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

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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.

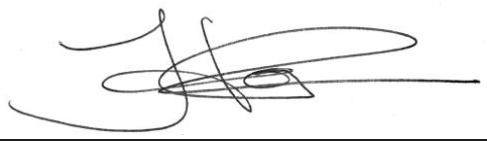
30. Failure to effectively implement clear eligibility processes with community engagement requirements will likely lead to increased strain on DHS' performance tracking and quality assurance functions, financial claims processing and fair hearings and appeals processing.

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.

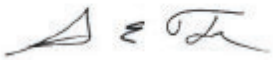
Finally, Virginia is deeply concerned about the operational and implementation impacts of these late-stage policy changes. In reliance on CMS's prior guidance – including written guidance shared in December on states' minimum viable product for 2027 in which CMS explicitly allowed states to accept self-attestation 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
ArentFox Schiff LLP

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
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 8, 2025

FROM: Dan Brillman
Deputy Administrator, CMS
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).

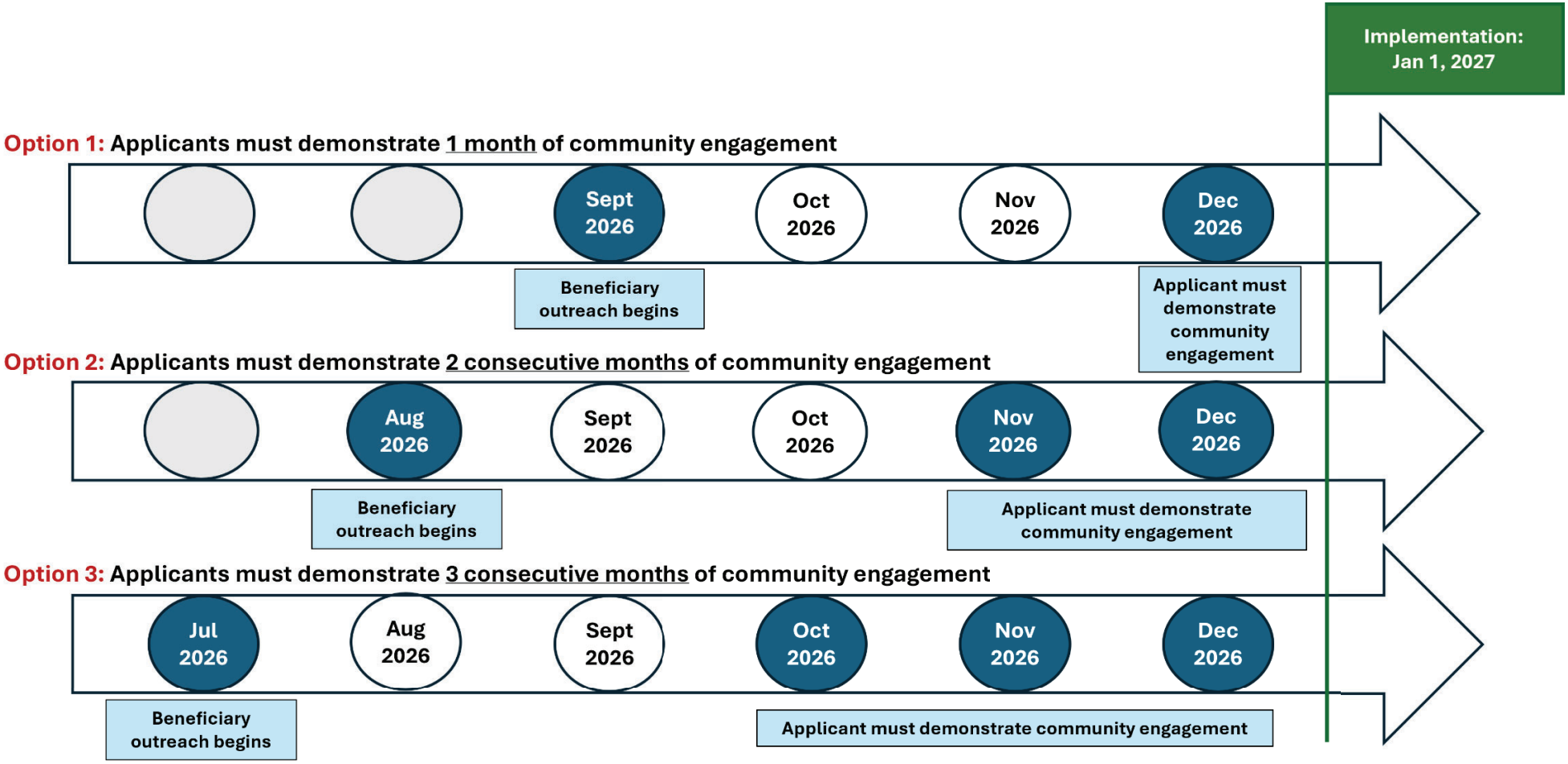

EXHIBIT 28

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.

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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

SICKLE CELL DISEASE PARTNERSHIP

[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
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