The Colorado Health Foundation™

July 27, 2026

Honorable Dr. Mehmet Oz
Administrator of the Centers for Medicare and Medicaid Services
Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically via Regulations.gov

RE: Public comment on the interim final rule, Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Dr. Oz,

Thank you for the opportunity to provide comments on the interim final rule (IFR), *Medicaid Program; Community Engagement Requirement for Certain Individuals*. The Colorado Health Foundation ("CHF" or "the Foundation") is a statewide, nonprofit and nonpartisan philanthropic organization with a mission to improve the health and wellbeing of Coloradans. Through community engagement, research, grantmaking, and private sector investments, the Foundation aims to ensure that everyone in Colorado has what they need to be healthy.

The Foundation strongly opposes this IFR. We respectfully urge CMS to withdraw it and issue a revised rule that implements Section 71119 of the One Big Beautiful Bill Act (H.R. 1) in alignment with Congressional intent and CMS's previous guidance to states. We urge CMS to develop regulations that minimize coverage losses, honor Congress' broad protections for medically frail individuals, reduce administrative burdens and costs, streamline processes for new and renewing Medicaid enrollees, and allow states to proceed with the planning that was already underway – including the use of existing data sources to streamline exemption determinations, as required by H.R. 1.

As outlined below, the Foundation is concerned that:

- The community engagement requirements will make Coloradans – and Americans nationwide – less healthy and economically secure, with disproportionate impacts on communities already facing the greatest barriers to health and well-being;
- The IFR will increase the number of Coloradans and individuals nationwide who lose Medicaid coverage, resulting in even higher coverage losses than CBO estimated when H.R. 1 was passed;
- CMS' approach to medical frailty exemptions – including narrow definitions and the creation of a new requirement that individuals prove their medical condition "significantly impairs" their ability to meet community engagement requirements – will jeopardize health coverage for medically frail individuals whom Congress intended to protect;

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- The IFR is unlikely to achieve the policy's goal of increasing workforce participation, just as similar approaches have failed to do so in Arkansas and Georgia;
- The rule will increase the time, cost, and complexity of implementation for Colorado and other states, making many burdensome good-faith waiver extensions ultimately necessary;
- The regulation as written appears to exceed CMS' authority under Section 71119 of the underlying statute. We are concerned the requirement that medically frail individuals prove that their medical condition impairs their ability to meet community engagement requirements is likely unlawful as it was not created by Congress; and
- The IFR conflicts with prior guidance provided by CMS and the executive branch to states.

Although CMS states in the IFR that implementation of H.R. 1's community engagement requirement will "prioritiz[e] coverage for Medicaid's most vulnerable," the IFR as written would fail to do so. As Colorado, 24 other states, and the District of Columbia argue in *Commonwealth of Massachusetts, et al, v. Oz, et. al.* (filed on June 29, 2026), the rule "creates new requirements that constrain who is exempt due to their medically frail status and forces medically frail individuals in need of health care to jump through unnecessary administrative hoops to get and retain life-saving healthcare coverage." This approach is inconsistent with congressional intent and compounds the harmful impacts of H.R. 1 by increasing coverage losses among some of Colorado's most medically fragile residents while imposing unnecessary – and potentially unlawful – new requirements and increasing administrative costs for states and local governments.

Community Engagement Requirements Will Worsen Coverage Losses

Medicaid community engagement requirements are projected to result in the largest coverage losses of any provision in H.R. 1. The Congressional Budget Office (CBO) estimates that 10 million people will lose Medicaid coverage over the next decade as a result of H.R. 1, with 4.8 million of those losses attributable specifically to the implementation of community engagement requirements. CMS's own estimates, reflected in the interim final rule, project even greater impacts. The agency estimates that 2.3 million individuals will lose Medicaid enrollment in 2027, with annual disenrollment increasing to between 3.1 million and 3.3 million in subsequent years. Independent analysis by the Urban Institute suggests coverage losses could be larger still, estimating that community engagement requirements alone could cause between 3.0 million and 7.0 million expansion enrollees to lose coverage.

Evidence from prior state experiences implementing similar policies demonstrates that these projected coverage losses are unlikely to reflect true ineligibility. Rather, they are expected to result largely from administrative barriers that prevent eligible individuals from successfully documenting compliance or qualifying exemptions. In Arkansas and Georgia, work requirement policies led to eligible beneficiaries losing coverage because of reporting and documentation challenges. At the same time, these policies produced little or no measurable increase in employment. CMS itself acknowledges that states will need

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to continue modernizing their infrastructure for data sharing and eligibility verification to reduce the risk of improper disenrollments. However, the common challenge across populations at risk of losing coverage is not a lack of eligibility, but the inability of state systems to automatically and accurately verify their eligibility.

Research indicates that medically vulnerable populations are particularly likely to be affected by these administrative barriers. Two-fifths of Medicaid beneficiaries live with three or more chronic conditions and face significant risks of worsening health outcomes if they lose coverage. Analyses further show that substantial coverage losses are projected even among individuals who should qualify for exemptions, including adults aged 50 to 64, self-employed workers, students, family caregivers of people with disabilities, and individuals with poor health or functional limitations. Research published in the *Annals of Internal Medicine* found that individuals at risk of losing coverage under national Medicaid work requirements carry substantially greater physical, neuropsychological, and functional burdens than those who would satisfy the mandate. The study identified 8.3 million Medicaid-enrolled adults ages 19 to 64 who worked fewer than 20 hours per week and did not meet the exemption criteria established under H.R. 1, representing more than half of working-age Medicaid enrollees. Notably, one-third of these individuals reported an illness or disability that limited their ability to work despite not qualifying for a formal disability exemption.

Existing evidence also raises concerns about whether community engagement requirements will achieve their stated objective of increasing employment. Previous research has found that Medicaid coverage itself can support workforce participation by improving access to health care and enabling individuals to better manage health conditions that may otherwise limit their ability to work. The research found that among unemployed Medicaid beneficiaries whose health improved after gaining coverage, employment rates nearly doubled. By conditioning coverage on work rather than recognizing coverage as a pathway to improved health and labor force participation, community engagement requirements risk reducing both insurance coverage and employment—an outcome contrary to the policy's stated purpose.

Recommendation: Given the magnitude of projected coverage losses and the uncertainty surrounding the policy's effects on health, employment, and coverage, we urge CMS to adopt the Medicaid and CHIP Payment and Access Commission (MACPAC's) recommendation to develop and publicly implement a transparent plan for monitoring and evaluating Medicaid community engagement requirements. Such a framework should assess the effects of these policies on eligibility, enrollment, employment, health outcomes, and state and federal administrative spending. CMS should also identify reporting metrics that build on existing state data collection processes to minimize administrative burden while improving accountability. Finally, CMS should ensure that evaluation findings are published in a timely and accessible manner so that policymakers, states, and the public can use the evidence to inform future operational and policy decisions.

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Exemptions Exceed Underlying Statutory Authority

The coverage losses described above will be exacerbated by CMS's unnecessarily restrictive approach to medical frailty and self-attestation. Section 71119 of HR 1 requires states to impose work-reporting requirements on Medicaid expansion adults beginning January 1, 2027, while exempting certain groups from those requirements, including individuals who are "medically frail or otherwise have special medical needs." Congress specifically identified several categories that qualify for this exemption, including people with substance use disorders, disabling mental disorders, significant physical or developmental disabilities, serious or complex medical conditions, and those who are blind or disabled under SSI standards.

This IFR goes beyond the statutory language by requiring not only that an individual fall within one of these protected categories, but also that their condition significantly impairs their ability to comply with the community engagement requirement. Individuals can self-attest to this initially, but the IFR limits the use of self-attestation and requires applicants to subsequently provide proof.

This change runs counter to the Congressional intent of the exemption, which was designed to protect those at highest risk of experiencing adverse health effects if they lost their health coverage due to the community engagement requirement. As a result, many people who met the prior definition of "medically frail" will no longer qualify for an exemption, leaving them at serious risk of losing coverage. This group includes people who are currently able to work precisely because they have consistent access to health care to manage their condition(s)—people whose health could deteriorate to the point that they could no longer work if that care were interrupted.

State Implementation Challenges

In addition to the direct harms to Medicaid beneficiaries described above, Colorado and other states did not anticipate and could not have adequately prepared to implement the policies outlined in this IFR because they are not included in the underlying statute. The decision to add new restrictions to the definition of "medically frail" was made by CMS during the regulatory process, not by Congress. Whereas many states planned to use diagnostic codes and other existing data to determine if someone qualifies for a medical frailty exemption, the IFR requires them to gather further documentation that a medical condition "significantly impairs" an individual's ability to work or otherwise fulfill the community engagement requirement. Systems and data to document this requirement are not readily accessible, and in many places do not exist. That means that states and medical providers will need to develop new and costly administrative infrastructure to determine and record exemptions for beneficiaries, necessitating even more time and resources during a short implementation window. The harm caused by limiting the definition and putting additional administrative burden on states is further compounded by the agency's decision to limit the use of self-attestation beyond 2027.

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Recommendation: We strongly urge CMS to revise the IFR and remove the requirement that medically frail individuals prove that their condition significantly impairs their ability to fulfill the community engagement requirement. We urge CMS to instead support states to continue the processes they had already initiated to rely on existing diagnosis and other codes, including those that they compiled into reference lists through processes involving medical experts. Notably, Nebraska took such an approach and already began implementing Medicaid work requirements accordingly as of May 2026. Such approaches will streamline the processes both for states and applicants. Doing so also aligns with Congress' intent and with the policies that Congress agreed to when passing H.R. 1.

Populations with Unmet Medical Needs Will Experience the Greatest Impacts

CMS's approach to medical frailty will make an already harmful policy even worse. By narrowing who qualifies for the exemption, this IFR leaves more people at risk of losing Medicaid coverage due to the community engagement requirement even when they have a serious or complex medical condition. And even among those who do qualify under the new, narrower definition, many will fall through the cracks if states can no longer automatically identify them as exempt and they are left to navigate a confusing and complex process to prove their eligibility on their own. We echo the public comments from the Legal Action Center, which note that this IFR makes a harmful policy even worse by disregarding clear statutory protections that Congress deliberately included to safeguard people with chronic health conditions whose health and stability depend on uninterrupted access to care.

Exemptions only work if people understand the rules, obtain the correct paperwork, submit it on time, and are processed accurately by state and local systems. When individuals lose Medicaid coverage, they can lose access to daily medication, treatment, home care, personal assistance, recovery services, behavioral health care, or the community supports that keep them alive and out of crisis. Sometimes, people can lose their lives as a result of bureaucratic delays or administrative errors. Once Medicaid coverage is lost because of error or bureaucratic confusion, it can take months or even years to restore eligibility, during which time people may experience significant harm to their health, their housing stability, their employment, their independence, and their connection to their communities.

Individuals with disabilities and their caregivers. The National Alliance for Direct Support Professionals has expressed particular concern about the impact on people with intellectual disabilities and autism, their families, and the broader community of people who rely on Medicaid-funded services and supports, noting that Medicaid is the foundation of community living. This program helps people remain in their homes, avoid unnecessary institutionalization, receive needed care, and participate fully in family and community life. We support CMS' choice to use the broader ADA definition of disability to determine who is exempt as a parent, guardian, caretaker relative, or family caregiver. Under this approach, caregivers of a person with a disability of any age qualify, and multiple members of the same household can qualify at once. However, because the definition of "medical frailty" is stricter than the definition of disability used for caregivers, this mismatch will produce many situations where caregivers remain exempt and keep their Medicaid coverage while the disabled individuals who depend on

Medicaid to pay for that same caregiving lose access to the critical care they need, according to the CEO of the American Association of People with Disabilities. To its credit, this interim final rule takes an important step by exempting many family caregivers from community engagement requirements, including those caring for children, adults with disabilities, and aging parents, and by giving states meaningful flexibility in how they verify eligibility as these requirements first take effect. We appreciate CMS's recognition that caregiving is demanding work. We remain concerned, however, that this IFR offers caregivers no clear way to confirm their status through self-declaration, even though CMS itself acknowledges that family caregivers rarely have documentation to prove their role. As the stricter documentation standard takes effect in 2028, eligible caregivers risk losing their coverage not because they fail to qualify, but because of paperwork errors, data-matching problems, and other administrative barriers.

Mental health and substance use disorder. As the nation's largest payer of substance use disorder and mental health services, Medicaid is a cornerstone of the nation's response to the overdose and suicide crises, which together continue to claim more than 350 lives every day. Yet, contrary to the administration's stated goal of expanding access to treatment and recovery services, this IFR—without statutory authorization, and therefore unlawfully—erects new and costly administrative barriers that will make it harder for people to obtain and keep the coverage they need to afford lifesaving care. Even brief disruptions in Medicaid coverage can derail access to treatment, medications, and recovery supports, putting people's lives at grave risk and undermining efforts to address the ongoing overdose crisis.

Maternal health. Medicaid community engagement requirements and related reductions in Medicaid funding could have significant adverse consequences for maternal health, particularly in underserved and rural communities. Although pregnant and postpartum individuals are generally exempt from community engagement requirements, state Medicaid systems may not consistently identify pregnancy status in real time, creating the risk that eligible individuals are incorrectly subject to reporting requirements or experience coverage disruptions due to administrative errors. The additional administrative demands may also strain state Medicaid agencies, potentially delaying enrollment, prenatal care access, diagnoses, and timely clinical interventions. Beyond pregnancy itself, work requirements and other coverage barriers may reduce access to preconception, well-woman, and reproductive health services that are critical to improving maternal and infant health outcomes. At the same time, broader reductions in Medicaid spending threaten the financial stability of hospitals, obstetric units, and community health centers that serve Medicaid beneficiaries. These pressures are expected to disproportionately affect rural areas, where access to maternity care is already limited. With more than one-third of U.S. counties currently classified as maternity care deserts, further service reductions or closures of labor and delivery units could increase travel distances, delay access to prenatal and obstetric care, and exacerbate existing disparities in maternal morbidity and mortality. Together, these factors raise serious concerns that implementation of community engagement requirements could

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undermine access to the continuum of care necessary to support healthy pregnancies, safe deliveries, and postpartum recovery.

This interim final rule would further impede access to high-quality primary care, compounding the negative impact on populations with unmet medical needs. These top-down changes will force states to implement new requirements that will hamper access to preventive services and primary care.

Burdensome Strains on Eligibility and Enrollment Systems

We are highly concerned about the impact of this IFR on Colorado's state and local governments which jointly administer Medicaid eligibility and enrollment systems. Chief among these concerns is a significant increase in administrative costs: implementation is expected to cost the state more than $57 million per year according to the Colorado Department of Health Care Policy and Financing, Colorado's state Medicaid agency. Counties, which administer Medicaid in Colorado's state-run, county-administered system, could need as many as 3,700 new case managers dedicated solely to Medicaid community engagement requirements, nearly doubling the number of county staff currently needed to process Medicaid eligibility.

While counties currently process work requirement-related functions for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF), known as Colorado Works in Colorado, they do not currently perform this function for Medicaid, a much larger program. Medicaid's new community engagement requirements are also distinct from SNAP and TANF, in part due to the requirement in this IFR that medically frail individuals prove their condition significantly impairs their ability to work. Colorado's current funding model for counties does not account for this type of Medicaid-related work, and state analysis shows that counties are already significantly underfunded for the work they currently perform. The state and counties would need considerably more funding to administer the new community engagement requirement and will have to absorb the cost directly, further straining already stretched budgets.

Making changes to the Colorado Benefit Management System (CMS) and Colorado PEAK, the integrated technical platform through which eligibility is processed and online system through which Coloradans apply, is slow and expensive. For each change that must be made to comply with this IFR and other H.R. 1 requirements, Colorado cannot invest in other changes to improve the system for clients and eligibility staff. As a state, Colorado has made significant progress in recent decades to streamline and improve eligibility and enrollment processes. This IFR takes us in the wrong direction by making processes more complex, and thus more costly. Streamlining access to Medicaid is essential for ensuring eligible Coloradans can enroll and remain enrolled as long as they continue to be eligible. Adding additional complexity, including the unnecessary and potentially unlawful complexity of this IFR's interpretation of the community engagement requirement, takes us further in the wrong direction – adding costs to our technical and administrative systems, and making processes unnecessarily difficult for Coloradans.

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Each change must also be accompanied by effective communications to Coloradans who are eligible or potentially eligible for Medicaid. This is already challenging with Section 71119 as written, but Colorado had done significant preparation, including client and provider engagement, during the nearly 11 months between when H.R. 1 was passed and when this IFR was published. This included developing, testing, and raising public awareness about an online screening tool for Coloradans – and the network of community organizations and county staff who help them – to use to determine if an individual is subject to Medicaid community engagement requirements. Since this IFR conflicts with the previous guidance provided by CMS and the executive branch, and includes requirements that were not created by Congress and thus are not included in the underlying statute that Colorado used to prepare for implementation, the value of Colorado's investment in this important tool is impaired. Our state made good faith efforts to create the tools, processes and public awareness necessary to implement Section 71119 by January 1, 2027, as outlined in the statute. The discrepancy between what was known by states and what CMS included in this IFR, however, necessitates significant and rapid changes that were unknown and could not have been planned for. As a result, states likely need additional time to implement these policies. We encourage CMS to approve good-faith waivers to states to extend the timeline for implementation.

Impact on Coloradans

Medicaid community engagement requirements will affect an estimated 377,000 Health First Colorado (Medicaid) members in the state—roughly one in three Coloradans insured through Medicaid. Of these, approximately 100,000 Coloradans are expected to lose coverage altogether. Evidence from Georgia and Arkansas, states that have already implemented similar requirements, suggests that this kind of coverage loss occurs not because people are failing to work or failing to qualify for an exemption, but because they are unable to navigate the complex paperwork requirements the law creates. This is in addition to the fiscal and administrative costs to state and local governments, highlighted above, that further pose risk to Coloradans who rely on Medicaid coverage to meet their healthcare needs.

This regulation's impact on the health care system will be significant, including increased uncompensated care, financial instability for providers, potential hospital closures, greater administrative burdens for state and local governments, and increased demand for care resulting from the rule's limits on self-attestation. Coverage losses will increase uncompensated care and jeopardize the financial stability of the health care system as a whole. As written, this IFR would also increase administrative burden and demand for care beyond what the statute requires because it limits enrollees to using self-attestation only once— requiring them to secure medical appointments to obtain verification or proof before they can renew coverage at the six-month mark. This will place additional strain on an already inadequate provider network statewide. As uncompensated care rises and provider capacity is further strained, the quality of care available to all Coloradans could suffer.

Colorado does not currently have a system in place for providers to attest to a medically frail individual's ability to work, and Colorado providers have expressed concern about this proposed requirement.

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Health First providers are not currently compensated for this type of evaluation, nor do systems exist to collect the necessary data, raising the possibility of a shortage of providers even willing or able to complete these assessments. Moreover, for providers who could take on this work, the requirement would ask them to code in a manner that could be viewed as improper and could expose them to allegations of fraud, waste, and abuse. Providers would, for the first time, be asked to make a determination that could directly affect whether their patient keeps or loses Medicaid coverage—an unprecedented role for them to play. The likely result is increased administrative burden, which ultimately worsens access to care as additional time is required to evaluate and code for ability to work. This is especially concerning given that it could weaken an already vulnerable system that the state of Colorado and its local partners have spent years investing in to expand provider networks so that Health First Colorado members can access the care they need.

This IFR Raises Significant Legal Concerns

The Foundation is particularly concerned that this IFR may exceed the scope of CMS's statutory authority. While CMS has the authority to establish regulations implementing Section 71119 of the One Big Beautiful Bill Act (H.R. 1), the agency does not have authority to impose policy requirements that Congress has not enacted. Congress intentionally created broad medical frailty categories, as outlined in H.R. 1 Section 71119, and did not require individualized-proof that each person's condition impairs their ability to work. To the extent the proposed interim final rule establishes this new individualized-proof requirement, the agency raises serious questions regarding whether such actions fall within CMS' delegated authority.

As described, under the CMS IFR, an individual must:

1. Fall within one of the statutory medical-frailty categories outlined in H.R. 1, and
2. Demonstrate that the condition significantly impairs their ability to work or comply with the community engagement requirement.

Recent litigation brought by 25 states and the District of Columbia, including Colorado, argue that the second requirement is an unlawful addition to the statute. In *Commonwealth of Massachusetts, et al, v. Oz, et. al.*, the plaintiff states make several primary arguments, including:

- **CMS' implementation exceeds the statute** by requiring individuals to prove that their condition renders them "significantly impair[ed]" in their ability to meet work requirements. As the lawsuit states, "Nowhere in H.R. 1 does Congress state that individuals' ability to work must be impaired in order to be "medical frail or otherwise have special medical needs," or to have a "serious or complex medical condition."

- **The IFR renders existing state systems for identifying medically frail individuals unusable.** States had planned to identify these individuals automatically using Medicaid claims, diagnosis

codes, behavior records, and long-term services data. Under CMS' added requirement, states must instead build individualized functional assessments, requiring entirely new administrative systems;

- **CMS' IFR increases administrative burden** by requiring states to redesign eligibility systems, conduct manual reviews, collect additional medical documentation, and create new appeals processes – all on a compressed timeline to meet the January 1, 2027, implementation deadline; and
- **The IFR could increase coverage losses for individuals with serious illnesses** who should qualify for the medical frailty exemption but may instead lose Medicaid coverage because they cannot navigate the additional documentation and verification process CMS created without statutory authority.

These legal arguments are rooted in the Administrative Procedure Act (APA). Per the lawsuit, CMS exceeded its statutory authority, acted arbitrarily and capriciously, imposed requirements inconsistent with congressional intent, and failed to adequately justify the change from prior guidance regarding medical frailty. All four of these are prohibited under the APA.

Moreover, the plaintiff states, including Colorado, argue that the federal government is imposing implementation burdens that conflict with the cooperative federal-state structure of Medicaid. This federal-state partnership is essential, and this IFR as written violates it.

The Foundation shares the concerns expressed in this lawsuit. As the lawsuit underscores, CMS claims its implementation of the community engagement requirements provision will "prioritiz[e] coverage for Medicaid's most vulnerable" but the rule issued by CMS does the opposite: "it creates new requirements that constrain who is exempt due to their medically frail status and force medically frail individuals in need of health care to jump through unnecessary administrative hoops to get and retain life-saving healthcare coverage."

Conclusion

The Colorado Health Foundation strongly opposes the interim final rule as issued. Rather than protecting Medicaid beneficiaries with the greatest health needs, this IFR creates new administrative barriers that will increase coverage losses, undermine access to care, impose substantial costs on states, local governments, providers, and communities, and place medically frail individuals at heightened risk of losing the health coverage Congress intended to preserve.

The evidence from prior state experiences, independent research, and CMS's own projections is clear: community engagement reporting requirements are likely to result in significant coverage losses, largely driven by administrative barriers rather than actual ineligibility, while producing little evidence of increased employment. This IFR amplifies these risks by narrowing exemptions, limiting self-attestation,

and creating documentation requirements that many eligible individuals will struggle to navigate. The consequences will fall most heavily on people with chronic and complex health conditions, individuals with disabilities, family caregivers, people with behavioral health needs, rural communities, and others who rely on stable Medicaid coverage to maintain their health, independence, and economic security.

Accordingly, we respectfully urge CMS to withdraw the current IFR and issue a revised rule that faithfully implements Section 71119 as enacted by Congress. Any revised regulation should preserve broad protections for medically frail individuals, allow states to rely on existing data and streamlined verification processes, minimize unnecessary administrative burden, reduce the risk of wrongful disenrollment, and support continuity of coverage for eligible Medicaid beneficiaries. We further urge CMS to grant good-faith implementation waivers and timeline extensions to states while a revised rule is developed and while ongoing litigation concerning the IFR remains unresolved.

Colorado's health and well-being depend on a Medicaid program that is accessible, efficient, and responsive to the needs of the people it serves. We urge CMS to prioritize those principles and ensure that implementation of Section 71119 protects, rather than jeopardizes, the health and stability of millions of Americans.

The Foundation appreciates your consideration of our comments. If you have any questions, please contact Kyle Rojas Legleiter, Colorado Health Foundation Senior Director of Policy, at klegleiter@coloradohealth.org or 303-953-3618.

Sincerely,

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