July 31, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

REF: CMS-2454-IFC

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals; Comments of Catholic Health Association of the United States

Dear Administrator Oz:

The Catholic Health Association of the United States (CHA), Catholic Charities USA (CCUSA) and the United States Conference of Catholic Bishops (USCCB) appreciate the opportunity to submit these comments regarding the interim final rule with comment (IFC) published by the Centers for Medicare & Medicaid Services (CMS) on June 3, 2026, implementing Medicaid work and community engagement requirements under Section 71119 of H.R. 1.[1]

CHA is the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is present in all 50 states and the District of Columbia, with one in every seven patients in the United States cared for in a Catholic hospital each year. As health care providers who directly serve patients with Medicaid, we know that Medicaid coverage is essential for people to be able to receive the medical care they need and to protect patients around the country.

CCUSA is a national membership organization representing 170 independent Catholic Charities agencies and is one of the largest charitable networks in the country. These agencies operate more than 3,500 service locations across all 50 states, the District of Columbia, and five U.S. territories. Together, they assist individuals and families in times of need by providing food and nutrition support, pregnancy support services, emergency rental and utility assistance, rapid

[1] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026) (to be codified at 42 C.F.R. 435), https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals.

housing support, housing counseling, and other critical services. Catholic Charities agencies also provide support that leads to stabilization for individuals and families by offering mental health services, homelessness prevention, job skills training, employment support services, and financial empowerment programs. Last year alone, this diverse network of programs reached more than 16 million people.

USCCB is a non-profit corporation whose members are the United States's active Catholic bishops who lead nearly 200 dioceses across the country. Each diocese includes parishes, schools, and social-service institutions that support those in need, including those served by Medicaid. Informed by society's responsibility to meet the needs of the vulnerable, the USCCB has consistently advocated for policies that protect human life and dignity, encourage and reward work, preserve a social safety net, build public-private partnerships to overcome poverty, and advance diocesan efforts to promote care for the whole person, including medical and mental health.

Pope Leo XIV's apostolic exhortation *Dilexi Te* teaches that society is judged by how it treats those who are poor and vulnerable and calls Catholic ministries to accompany those who often have little voice within complex systems and institutions. As states implement Medicaid work and community engagement requirements, Catholic health care has a responsibility to help ensure that these policies advance human dignity and opportunity without creating new barriers to care for individuals facing serious medical, behavioral health, or social challenges. Consistent with the principles articulated in *Dilexi Te*, we support implementation approaches that emphasize compassion, simplicity, and access to care and that safeguard eligible individuals from losing coverage due to administrative burdens rather than true ineligibility.

We are focused on ensuring states implement work and community engagement requirement programs that patients can navigate as effectively as possible, so eligible people can get and stay covered—just as Congress intended. It is with this in mind that we share our serious concerns with several aspects of the IFC that conflict with this intent and put patients and clients at risk. Among other changes, the IFC adds requirements to the definition of medical frailty beyond the statutory language, adds mandatory documentation requirements for medical frailty in 2028, and undermines the statute's short-term hardship exception framework.

With respect to the medical frailty exclusion, the IFC narrows the statutory definition of medical frailty by requiring not only that an individual has a qualifying condition, but also that the condition significantly impairs the individual's ability to comply with the work and community engagement requirements. This policy will create significant operational and administrative challenges for states, providers, and patients, increasing the risk that eligible individuals lose coverage because of administrative barriers.

States will be rushed to make changes to their policies, design documents, business rules, IT systems, and beneficiary notices/forms to address this new concept of medical frailty. As such, it is unlikely that states will be able to fully implement the IFC's new requirements by the January 1, 2027 deadline. Even for states that can meet the implementation deadline, it is unlikely they

will have sufficient time to fully develop, test, and validate these systems, and to educate individuals about the new requirements.

In addition to setting a more complex and stringent definition for medical frailty that states will have to comport with, the IFC shifts responsibility for establishing medical frailty from state Medicaid agencies to hospitals, treating clinicians and patients when data are not available. As a result, hospitals and clinicians will need to assume significant new, unreimbursed administrative responsibilities to support implementation of the medical frailty exclusion, diverting clinical time and resources away from direct patient care. The IFC also effectively requires clinicians to make judgments about whether a patient's medical condition significantly impairs their ability to comply with work and community engagement requirements—an assessment that is fundamentally different from diagnosing and treating medical conditions and that extends beyond the practice of clinical medicine into Medicaid program administration.

The IFC will likely result in more patients losing coverage due to the work and community engagement requirements than the 5.3 million projected by the Congressional Budget Office under H.R. 1.[2] By narrowing the medical frailty exclusion beyond the statutory language and creating additional administrative and operational barriers for states, providers, and patients, the IFC *increases* the likelihood that eligible individuals will lose Medicaid coverage despite Congress's intent to protect medically frail individuals from the work and community engagement requirements. As a result, the IFC would increase reliance on already overburdened charitable service programs that might struggle to meet an increased demand.

In light of these issues, we strongly urge CMS to (1) issue a final rule that reverts to the statutory description of medical frailty, and (2) provide states with sufficient time to implement the rule's new requirements by delaying the January 1, 2027 implementation date. We outline below specific recommendations and considerations for CMS.

I. Medical Frailty Exclusion Definition

Recommended Changes:

- CMS should revise the medical frailty definition at 42 C.F.R. § 435.554(c)(5) to align with the plain language of Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act (SSA). Specifically, CMS should strike the phrase "significantly impairs the individual's ability to comply with the community engagement requirements in this subpart" from the new 42 C.F.R. §435.554(c)(5)(i), which adds an unnecessary and burdensome functional limitation standard.
- CMS should revise the new 42 C.F.R. § 435.557(b)(2) by removing the medical frailty carve-out, and revise the new 42 C.F.R. § 435.557(b)(2)(i) and (ii) by eliminating the tiered pre-2028 / post-2028 verification hierarchy entirely, replacing both provisions with a single uniform standard that reads: "When there is no reliable information available to the State, or the reliable information available to the State is not reasonably compatible with

[2] Congressional Budget Office Supplemental Cost Estimate (October 28, 2025). Available at https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.

the information provided by or on behalf of the individual, the agency may require documentation or accept other information as provided in § 435.952(c)."

- At a minimum, if CMS retains the IFC's functional impairment standard, it should establish a streamlined pathway for individuals with readily verifiable severe, permanent, or progressive medical conditions to satisfy the medical frailty exclusion without requiring additional individualized functional assessments.

The IFC's Medical Frailty Exclusion Is Overly Narrow.

The IFC adopts a narrower interpretation of the medical frailty exclusion than the statutory framework supports. Under the rule, individuals with certain serious medical, behavioral health, and substance use conditions must demonstrate not only that they have a qualifying condition, but also that the condition significantly impairs their ability to comply with the work and community engagement requirements. By adding this functional assessment, the IFC changes what Congress established as a clinically based exclusion into a more complex eligibility determination. That change increases administrative burden for states, providers, and patients while making it more difficult for individuals with serious medical needs to qualify for an exclusion that Congress established to protect them.

CMS's additional standard therefore appears inconsistent with both Congressional intent and the statutory structure. Congress intended the medical frailty exclusion to operate broadly for individuals with serious physical, behavioral health, developmental, and substance use conditions. Throughout consideration of H.R. 1, lawmakers consistently described these populations as exempt from the community engagement requirement without suggesting that they would be required to undergo a second individualized assessment regarding their capacity to comply with the work and community engagement requirements.

The statute takes a different approach to the medical frailty exclusion. Section 1902(xx)(9)(A)(ii)(V) identifies five clinical categories that qualify as "specified excluded individuals," including individuals who are blind or disabled, have a substance use disorder, have a disabling mental disorder, have a qualifying physical, intellectual, or developmental disability, or have a serious or complex medical condition. Although the statute authorizes the Secretary to define "medically frail or otherwise has special medical needs," it does not expressly require individuals in each of these statutory categories to separately demonstrate that their condition impairs their ability to comply with the work and community engagement requirements.

Congress has demonstrated in other federal statutes that it knows how to require a work-related functional limitation when that is its intent. For example, Congress expressly limits eligibility for Social Security disability benefits to individuals whose medical condition prevents them from engaging in substantial gainful activity. The absence of similar language here supports a broader interpretation of the medical frailty exclusion. This reading is also consistent with CMS's discussion elsewhere in the IFC. In explaining the caregiver exclusion, CMS declined to interpret the term "disabled" as limited to individuals whose disability prevents them from working because the statute includes no such limitation. The same reasoning supports a broader interpretation of the medical frailty exclusion. But by adopting a narrower exclusion than the

best reading of the statute demands, the IFC runs afoul of the Administrative Procedure Act's (APA) bar on agency action "not in accordance with law," 5 U.S.C. § 706(2)(A). Further, by failing to consider the challenges and administrative burdens described below, the IFC's provisions impose arbitrary and capricious standards that also run afoul of the APA. *Id.*

For these reasons, CMS should revise the IFC to allow states to exclude individuals who meet one of the statutory clinical categories without requiring an additional demonstration that their condition significantly impairs their ability to comply with the work and community engagement requirements. This approach better reflects the statutory framework, is consistent with Congress's treatment of work-related functional limitations elsewhere in federal law and aligns with CMS's own discussion in the IFC. It would also reduce unnecessary administrative complexity for states, providers, and patients while helping ensure that individuals with serious medical, behavioral health, and substance use conditions are not subjected to avoidable documentation, verification, and reporting burdens. Excluding individuals based on their medical condition alone would reduce the risk that vulnerable individuals lose Medicaid coverage because of administrative barriers rather than because they are ineligible for coverage.

The IFC Limits the Ability of States to Use Data to Verify Medical Frailty Status.

Consistent with longstanding Medicaid eligibility policies, H.R. 1 directs states to verify compliance with work and community engagement requirements—including via exclusions such as medical frailty—using "reliable information available to the State (such as … encounter data . . . and data on payments . . .) without requiring, where possible, the applicable individual to submit additional information." In the IFC, however, CMS prohibits states from relying on Medicaid claims data older than 12 months when verifying medical frailty or other special medical needs.[3]

This 12-month limit is arbitrary and inconsistent with clinical experience that, for many conditions, including a spinal cord injury, congenital intellectual disability, limb loss, or advanced neurodegenerative disease, a longer period of relevant records is appropriate. These are permanent conditions that qualify the individual for an exclusion from work and community engagement requirements under the statute but may not be evident in the patient's medical records every 12 months.

Elsewhere in the IFC, CMS recognizes that for veterans with permanent disability status, states must rely on the Department of Veterans Affairs' determination that the condition is unlikely to improve. The same principle should apply to the medical frailty exclusion, which should impose limits, if any, rationally grounded in clinical reality. **CMS should amend the IFC to provide that, where reliable records establish that an individual has a permanent, irreversible, or progressive condition satisfying the medical frailty exclusion, the individual should be excluded from work and community engagement requirements—even if these records are more than 12 months old at the time of the eligibility assessment.**

[3] 42 C.F.R. § 435.557(f)(1) (directing states to verify exclusion status using, among other things, claims adjudicated in the preceding 12 months).

The IFC's 2028 Documentation Requirements Shift Burden to Patients and Providers.

While the IFC provides time-limited transitional flexibility for medical frailty attestation in 2027, it fails to provide the ongoing flexibility that SSA § 1902(xx)(9)(A)(ii)(V) requires, instead imposing a verification framework that effectively eliminates attestation as a viable verification method beginning in 2028.

Beginning in 2028, if data are insufficient to verify excluded status or an exception, states must require documentation from the individual if documentation is reasonably available. Only where documentation does not exist or is not reasonably available must states accept other information, such as a reasonable explanation. Even then, the burden falls on the individual to produce the requested information. For medical frailty specifically, beginning in 2028, the IFC limits the ability of an individual to self-attest only once during a period of enrollment even though this limitation is not contemplated by SSA § 1902(xx)(3)(A). After that single opportunity, states must require documentation where data are unavailable; there is no state option to accept self-attestation for subsequent verification cycles.

This framework is more restrictive than the best reading of the statute allows and carries significant and arbitrary operational consequences for patients, providers, and states. Under prior CMS guidance, it was anticipated that claims data confirming a qualifying clinical condition, potentially supplemented by self-attestation, would resolve a significant portion of medical frailty determinations. The IFC's revised definition of medical frailty upends reliance on the sufficiency of claims data for establishing medical frailty by layering on an ability-to-work standard that those data cannot identify. The 2028 documentation requirement then forecloses the self-attestation pathway that might otherwise have bridged the gap, channeling verification into a process requiring medical records or provider certifications that providers are not currently equipped to provide and states' current eligibility and enrollment systems are not designed to administer.

The populations most likely to qualify for the medical frailty exclusion—including individuals with serious chronic conditions, behavioral health disorders, intellectual and developmental disabilities, and other complex medical needs—are also among those most likely to face barriers to obtaining the documentation the IFC requires. Physicians and other clinicians may be asked to prepare medical certifications, complete eligibility forms, respond to documentation requests, or otherwise assess whether a patient's condition significantly impairs the individual's ability to satisfy the work and community engagement requirement. These responsibilities extend well beyond the traditional clinical role of treating providers. Most physicians and other clinicians are not trained to make individualized work-capacity determinations for Medicaid eligibility purposes, nor are clinical workflows designed to support these administrative assessments.

Compounding these challenges, the IFC provides little guidance regarding how providers and states should determine whether an individual's condition "significantly impairs" the individual's ability to comply with the work and community engagement requirement. Without objective criteria or standardized methodologies, providers will be left in the middle.

Experience from prior work and community engagement requirement demonstrations in several states shows that administrative friction, rather than ineligibility, causes many otherwise eligible individuals to lose coverage. Each additional document request, third-party verification requirement, or delay in obtaining records increases the risk that eligible individuals will lose Medicaid coverage for procedural reasons. Once coverage is lost, obtaining the medical care necessary to secure documentation and reestablish eligibility may become even more difficult, creating a cycle of procedural coverage loss among the very populations Congress intended the medical frailty exclusion to protect.

Lastly, The IFC's documentation framework would require hospitals, physicians, federally qualified health centers, and other providers to dedicate significant staff time to supporting beneficiaries through verification processes for the medical frailty exclusion. These activities are largely non-reimbursable administrative functions that divert resources from direct patient care and may further exacerbate workforce shortages and clinician burnout. Catholic Charities agencies and other community service providers, including those administered through Catholic dioceses, will also have to spend time and resources helping clients, particularly those without reliable access to the internet and for whom English is a second language, navigate increasingly bureaucratic systems. This will lead to reduced time spent providing other critical services that benefit both individuals and the broader community. Without access to the important services that Catholic Charities agencies and Catholic dioceses provide, vulnerable populations will continue to struggle to attain self-sufficiency.

II. Short-Term Hardship Exceptions

Recommended Changes: CMS should revise the new 42 C.F.R. § 435.555 by adding the following: (1) If an individual experiences a short-term hardship event described in this section during a month included in the review period under § 435.556, the state may deem the individual to have demonstrated work and community engagement requirements for that month; (2) If an individual experiences a short-term hardship event during the month of application, renewal, redetermination, or reconsideration, the state may deem the individual to have demonstrated compliance with work and community engagement requirements for that month, notwithstanding the individual's compliance status during any prior review month.

Under the IFC, individuals would be potentially required to satisfy a short-term hardship exception in the month preceding the need for the hardship exception, substantially undermining the purpose of the exception. For example, for an individual who is hospitalized in the month she applies for Medicaid and seeks the inpatient hardship exception, her application would be assessed against the prior lookback month, not the month of her hospitalization. Because the hospitalization occurred in the application month and not in the lookback month, the exception will not apply to the lookback assessment, and the individual may be found noncompliant (i.e., not eligible for the hardship exception and not otherwise complying with qualifying activities).

Nothing in the statutory text requires a state to first determine that an individual satisfied work and community engagement requirements during a prior lookback month before applying a short-term hardship exception. To the contrary, the statute authorizes states to deem an individual

to have demonstrated community engagement "for such month"— the month in which the hardship occurs. This language suggests that the exception operates on the individual's work and community engagement requirement obligation for the month in which the hardship occurred, rather than exclusively within a retrospective compliance review.

SSA § 1902(xx)(3)(B) supports this interpretation. While SSA § 1902(xx)(2) establishes the general requirement that applicable individuals demonstrate work or community engagement, Section 1902(xx)(3) directs states to "deem" certain individuals to have demonstrated community engagement when they experience certain exceptions, including short-term hardship events.

Accordingly, we recommend conforming the short-term hardship exception to the statutory text by finding that a short-term hardship exception may satisfy an individual's work and community engagement requirement obligation for the month of the hardship event, including where that month is the month of application or renewal, without requiring a separate showing of compliance during a prior review period.

III. State Readiness and Beneficiary Preparedness

Recommended Changes: CMS should delay implementation of the work and community engagement requirements on a nationwide basis for at least six months to allow states sufficient time to develop, test, and validate their operational systems. If CMS declines to adopt a blanket delay, it should broadly exercise its authority to grant "good faith waivers" where states demonstrate they are not prepared to implement the requirements without risking inappropriate coverage losses.

Ensuring eligible patients can obtain and maintain Medicaid coverage and continue to access needed care should remain the central objective as states implement the work and community engagement requirements. Achieving that goal requires states to have operational systems that are fully prepared before implementation begins and that patients understand what is expected of them to maintain coverage.

The IFC requires states to implement significant new operational processes—including verification systems, reporting processes, beneficiary communications, and workflows to identify exclusions, exceptions, and compliance—within a compressed implementation timeframe. Launching these requirements before states are fully prepared increases the risk that eligible patients will lose Medicaid coverage because of administrative barriers rather than because they are no longer eligible. The resulting interruptions in coverage can disrupt continuity of care, delay access to needed services, and leave hospitals and other providers caring for patients whose coverage was inappropriately lost. These operational demands will also extend beyond individuals subject to the work and community engagement requirements. Diverting eligibility workers and other state staff to implement these new processes will likely increase processing delays and administrative backlogs across the Medicaid program, potentially placing children,

Supplemental Security Income (SSI) beneficiaries, and other individuals who qualify for exclusions or exceptions at greater risk of avoidable coverage gaps or delays in receiving coverage.

State readiness also depends on ensuring that patients understand the new requirements before they take effect. Under the IFC, states must develop new beneficiary communications, including outreach notices explaining the work and community engagement requirements and notices informing beneficiaries when the state cannot verify compliance, an exclusion, or an exception. These communications will be the primary means by which patients learn about their responsibilities and the steps necessary to maintain coverage. CMS should ensure that states have adequate time to develop, test, and validate these communications—including consumer testing to confirm they are understandable, accurate, accessible, and available in appropriate languages—before implementation begins. States should not disenroll beneficiaries until they have demonstrated that notices are effective in helping eligible individuals understand and successfully navigate the new requirements.

We strongly encourage CMS to take steps to ensure state readiness and beneficiary preparedness before the January 1, 2027 implementation date.

IV. Hospital Presumptive Eligibility

Recommended Changes: CMS should revise the IFC to defer application of the work and community engagement requirements until the full Medicaid eligibility determination, rather than incorporating those requirements into hospital presumptive eligibility determinations.

Under Section 1902(a)(47)(B) of the Social Security Act, Medicaid-enrolled hospitals may elect to make presumptive eligibility determinations so that eligible individuals can obtain temporary coverage without waiting for a full Medicaid determination. The IFC requires hospitals to include work and community engagement requirements as a factor of eligibility in the presumptive eligibility determination when an individual appears to be eligible for the Medicaid expansion adult group. Under the IFC, hospitals will need to assess and obtain an attestation as to whether the individual appears to be a specified excluded individual or an applicable individual. For applicable individuals, providers will then need to identify exceptions or compliance with the work and community engagement requirements.

These additional screening steps are fundamentally at odds with the streamlined and time-sensitive nature of hospital presumptive eligibility. They will require revisions to hospital presumptive eligibility applications, eligibility determination notices, and provider training materials. As a result, hospitals will need to retrain staff (e.g., to be able to assess who is an applicable individual and who is a specified excluded individual) and be tasked with making increasingly complex eligibility assessments at the point of care—often when patients are seeking urgent treatment and may be unable to provide detailed information**. We urge CMS to preserve hospital presumptive eligibility as a simple pathway to immediate, temporary coverage and to minimize the community engagement-related determinations hospitals must make as part of that process**. Requiring hospitals to conduct community engagement

screening during hospital presumptive eligibility is inconsistent with the program's purpose of facilitating rapid access to temporary coverage, increases administrative burden and the risk of erroneous determinations, and may discourage hospital participation in hospital presumptive eligibility programs, ultimately limiting timely access to care for eligible individuals.

V. Verification and Reverification

Recommended Changes:

- CMS should issue guidance to encourage expanded data-sharing partnerships between states and Medicaid managed care organizations, as well as other entities who work with Medicaid enrollees; and clarify in such guidance that data-sharing mechanisms should be used to maximize ex parte determinations and minimize beneficiary documentation burdens,
- CMS should revise the IFC to prohibit reverification of additional statuses and conditions that do not change, such as developmental disabilities and certain substance use disorders; preserve state flexibility to rely on self-attestation for exclusions and exceptions consistent with the statute; and eliminate the 12-month limitation on claims and encounter data used to verify medical frailty.

Data Sharing

We generally support the IFC's requirement that states first check available reliable data (ex parte verification) for exclusions, exceptions, and compliance before requiring additional information/documentation from beneficiaries. We also appreciate CMS's clarification that these data-driven verification requirements apply not only at renewal but whenever verification is necessary. Maximizing the use of reliable information already available to states is critical to reducing administrative burdens and preventing avoidable coverage losses among eligible individuals.

CMS should issue sub-regulatory guidance to encourage collaboration with trusted health care partners that have longstanding relationships with Medicaid beneficiaries. This should include Tribes and Urban Indian Organizations, which can play an important role in communicating with and educating their members about the work and community engagement requirements, and preventing disenrollment resulting from misclassification or procedural issues. Such partnerships would build upon successful outreach and eligibility practices employed during the Medicaid unwinding process and help ensure continuity of coverage for vulnerable populations.

We also support CMS's recognition of the role managed care organizations and other Medicaid partners can play in facilitating data-sharing and beneficiary outreach. States should be encouraged to build upon lessons learned during the public health emergency unwinding by notifying managed care plans when they are unable to verify an exception, exclusion, or compliance and subsequently send the notice of noncompliance. Managed care plans can help get in touch with beneficiaries to encourage and support them in submitting the required information to the state and/or by referring them to qualifying activities (such as qualifying work programs), thereby preventing inappropriate loss of coverage. States should also establish data-

sharing arrangements with managed care plans because plans are well-positioned to support states in identifying potential exclusions or exceptions from the work and community engagement requirements; data-sharing arrangements with other agencies administering programs—such as SNAP, TANF, labor, corrections, and other public assistance programs—can similarly help identify eligibility pathways, reduce administrative barriers, and support eligible beneficiaries in maintaining coverage.

However, with respect to the medical frailty exclusion, the effectiveness of these data-sharing approaches is undermined by the IFC's revised medical frailty standard. CMS has provided little guidance regarding how claims, encounter data, or other existing sources of information can reliably demonstrate whether an individual's condition "significantly impairs" the individual's ability to comply with community engagement requirements. Without clear standards, states, providers, and managed care organizations lack certainty regarding what information must be collected, maintained, and shared, reducing the utility of ex parte verification and increasing the likelihood that beneficiaries will be required to submit additional documentation once attestation is no longer available.

Reverification of Conditions and Statuses That Do Not Change

We support CMS's policy prohibiting states from requiring reverification of conditions that are permanent or otherwise unlikely to change, including a permanent disability determination by the Department of Veterans Affairs. This approach appropriately recognizes that requiring repeated proof of a lifelong condition serves little programmatic purpose while increasing administrative burden and creating opportunities for eligible individuals to lose coverage due to paperwork barriers.

CMS should adopt a similar approach for additional categories of individuals whose status is also unlikely to change. For example, developmental disabilities are lifelong conditions that begin before age 22 and generally do not resolve over time. Once a state has verified that an individual has a developmental disability, it should not require ongoing reverification of that status. Similarly, CMS has defined substance use disorder in a manner that excludes individuals in stable recovery for five years or more. Once verified, states should be permitted to rely on that determination for a reasonable period without requiring unnecessary reverification.

Caregivers and Care Recipients

We appreciate CMS's efforts to protect the privacy of care recipients when determining eligibility for the caregiver exclusions. However, the verification framework established in the IFC creates significant practical challenges. Under the rule, starting in 2028, when data is unavailable, states must obtain sufficient documentation to verify that the disabled care recipient meets the applicable disability standard, yet in certain circumstances the care recipient may not consent to sharing information with the state. In practice, this could result in a caregiver of a disabled individual being denied an exclusion and required to meet the work and community engagement requirements or risk loss of health coverage.

The IFC provides limited clarity regarding how these requirements should operate in practice. For example, if a parent is seeking a caregiver exclusion based on the needs of a child over age 14, it is unclear who may provide information necessary to establish the child's disability status if not the parent. Similarly, for adult care recipients, the rule does not clearly explain how a caregiver may demonstrate eligibility for an exclusion when the care recipient is unable or unwilling to participate in the verification process. The lack of clarity in these circumstances reinforces the importance of preserving self-attestation as a reasonable and statutorily authorized verification pathway.

VI. Negative Effects on the Most Vulnerable Populations and the Community Organizations That Serve Them

Catholic health care ministries serve many individuals who would be particularly vulnerable to unintended coverage loss under the IFC's revised medical frailty framework. In communities across the country, hospitals and behavioral health providers care for individuals experiencing homelessness, many of whom live with serious physical health conditions, mental illness, substance use disorders, trauma, or other complex needs that may not be readily apparent through standard eligibility screening processes. Medicaid coverage is often the foundation that allows these individuals to access behavioral health treatment, primary care, medications, and supportive services necessary to stabilize their health and, when appropriate, pursue employment and greater self-sufficiency. By creating a more restrictive and administratively burdensome medical frailty standard, the IFC increases the risk that individuals with significant health needs will lose coverage despite facing substantial barriers to complying with work and community engagement requirements.

The IFC's documentation and verification requirements would also create significant new administrative burdens for providers and community-based organizations that assist Medicaid beneficiaries. Case managers, social workers, financial counselors, and eligibility staff would be required to spend additional time helping individuals obtain, document, and submit information to establish medical frailty or maintain coverage through other exclusions, exceptions, or qualifying activities. At the same time, providers would face increased administrative costs associated with verifying eligibility status and managing disruptions in coverage. Individuals who are unable to demonstrate that they qualify for an exemption or exclusion may lose access to needed health care services, resulting in delayed treatment, worsening physical and behavioral health conditions, and greater reliance on emergency departments for care. These impacts may be particularly acute for individuals facing barriers such as homelessness, unstable employment, transportation challenges, or limited access to affordable childcare, all of which can make compliance with new administrative requirements difficult despite a willingness to work or engage in their communities. Ultimately, these coverage losses would harm patients, increase uncompensated care burdens for hospitals, and undermine the shared goal of promoting health, stability, and economic opportunity.

VII. Conclusion

CHA, USCCB and CCUSA are committed to supporting the implementation of work and community engagement requirements in a manner that is legally compliant, operationally sound, and protective of the patients that the exclusion and exception framework are designed to serve. However, we are troubled by the extent to which certain portions of the IFC are contrary to the statute, and by the significantly increased administrative burden the IFC will impose on providers. But most of all, we are profoundly concerned that requirements of the IFC will result in coverage loss for eligible individuals who rely on Medicaid to address their health care needs and to achieve their highest possible degree of self-sufficiency.

Thank you for the opportunity to provide these comments. We look forward to continued engagement with CMS as implementation proceeds. If you have any questions about these comments or need more information, please do not hesitate to contact Kathy Curran, Senior Director, Public Policy, CHA, at 202-721-6300.

Respectfully submitted,

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