Congress of the United States

Washington, DC 20515

July 30, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2454-IFC

Dear Administrator Oz,

We, the Ranking Members of the Senate Finance Committee and the House Energy and Commerce Committee with sole jurisdiction over the Medicaid program, write to urge you to withdraw the Administration's interim final rule (IFR) implementing the Medicaid work reporting requirements passed by Congressional Republicans and signed into law by President Trump last year in H.R. 1. Work reporting requirements will not increase employment and will instead lead to millions of Americans needlessly losing their health coverage. No variation of this policy is workable and we support full repeal.[1] In the absence of Congressional action, The Centers for Medicare & Medicaid Services (CMS) must delay implementation. States are not prepared to implement the agency's onerous, arbitrary requirements put forward in this IFR.[2] It is families who will suffer, especially the sickest Americans, like those with mental health and substance use disorders, cancer, and diabetes, who most urgently need the health care Medicaid provides.

This rule transforms Medicaid from a health care program into a bureaucratic maze that will fail eligible Americans, by design. It will strip coverage from people not because they are not already working or refuse to work, but because they cannot navigate a complex web of forms, passwords, and deadlines. Implementing ineffective, exclusionary work reporting requirements will create costly administrative barriers and deny Americans access to health care, resulting in poorer health[3], higher mortality[4], and reduced financial security.[5] This rule does little to reduce anticipated harms and makes exceptionally cruel and arbitrary choices with regard to medical frailty, significantly subverting the congressional intent of this particular exemption.

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1 "Wyden, Senate Democrats Introduce Legislation to Reverse Devastating Health Care Cuts in Trumpcare," The United States Senate Committee on Finance, Accessed June 23, 2026, https://www.finance.senate.gov/ranking-members-news/wyden-senate-democrats-introduce-legislation-to-reverse-devastating-health-care-cuts-in-trumpcare.

2 "Newsroom," State of Oregon Governor's Office, Accessed June 23, 2026, https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-organizes-multi-state-pushback-against-chaotic-federal-medicaid-mandate.

3 Melissa McInerney et al., "ACA Medicaid Expansion Associated With Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence from the Health and Retirement Study," *Inquiry : A Journal of Medical Care Organization, Provision and Financing* 57 (2020): 46958020935229, https://doi.org/10.1177/0046958020935229.

4 Sarah Miller et al., "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," *The Quarterly Journal of Economics 136*, no. 3 (2021): 1783 – 1829, https://doi.org/10.1093/qje/qjab004.

5 Luojia Hu et al., "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," *Journal of Public Economics* 163 (July 2018): 99 – 112, https://doi.org/10.1016/j.jpubeco.2018.04.009.

Nearly all adults with Medicaid (92 percent) are already working, going to school, caregiving, or have a disability.[6] Moreover, an extensive body of evidence demonstrates that work reporting requirements do not promote employment but rather increase medical debt, delay care and contribute to poorer health outcomes.[7] In its assessment of H.R. 1, the Congressional Budget Office (CBO) projected an estimated 5.3 million enrollees will lose coverage by 2034, not accounting for the IFR's even more stringent and burdensome requirements concerning the medical frailty exception.[8,9] This evidence was not considered in the drafting of the IFR.[10]

Similarly, the IFR fails to acknowledge or account for states' ineffectual and costly experiences implementing work reporting requirements. When Arkansas implemented similar requirements, 18,000 people lost coverage in just five months. They didn't lose their Medicaid coverage because they suddenly found jobs with health benefits; they lost it because they didn't have internet access, never received the notices, or couldn't log into a glitchy state website.[11] New Hampshire and Michigan were poised to implement these work reporting requirements but paused the programs when they received astronomical coverage loss projections of 17,000 enrollees (40 percent of participants) and 80,000 enrollees (33 percent of participants), respectively.[12] In Georgia, the state spent $91 million in taxpayer dollars to build a "work requirement" tracking system that often experienced technical failures. This translates to $13,000 per enrollee in administrative costs – almost five times higher than total spending on health care benefits for enrollees.[13] Further, a recent study looking at these requirements in Georgia added to the body of evidence that they do not increase employment.[14]

CMS' Onerous Definition of Medical Frailty Subverts Congressional Intent

H.R. 1 includes explicit exemptions for individuals who are determined to be medically frail, including those with disabling mental disorders, substance use disorders, disabilities, or complex medical conditions. In including these exemptions, the statute provided protections for some of the most vulnerable Americans, while preserving states' flexibility to determine how medical

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6 Jennifer Tolbert, "Understanding the Intersection of Medicaid and Work: An Update," KFF, May 30, 2025, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

7 Angela Wyse and Bruce Meyer, "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults," *NBER Working Paper* 33719, May 2025, https://www.nber.org/papers/w33719; Miller et al., "Medicaid and Mortality."; Melissa McInerney et al., "ACA Medicaid Expansion."; Hu et al., "The Effect of the Affordable Care Act."

8 Phillip L. Swagel to Ranking Members Ron Wyden, Frank Pallone, Jr., and Richard E. Neal, "Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act," Congressional Budget Office, June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

9 "Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid," Congressional Budget Office, October 28, 2025, https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

10 "Medicaid Program; Community Engagement Requirement for Certain Individuals: A Rule by the Centers for Medicare & Medicaid Services," Federal Register, June 3, 2026**,** https://www.govinfo.gov/content/pkg/FR-2026-06-03/pdf/2026-11094.pdf

11 Benjamin D. Sommers et al., "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs* 39, no. 9 (2020): 1522–30. https://doi.org/10.1377/hlthaff.2020.00538

12 Elizabeth Richter to Dawn Stehle, Arkansas Department of Human Services, U.S. Department of Health and Human Services, March 17, 2021, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf.

13 Leah Chan, "Georgia's Pathways to Coverage Program: The First Year in Review, Georgia Budget & Policy Institute," Georgia Budget & Policy Institute, October 29, 2024, https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf.

14 Daniel Y. Johnson, et al., "Insurance coverage and employment after Medicaid expansion with work requirements: quasi-experimental difference-in-differences study," *BMJ* 390 (2025), https://doi.org/10.1136/bmj-2025-086792 .

frailty should be defined and operationalized. However, the IFR impermissibly adds extra-statutory restrictions and requirements to this statutory exemption, limiting it to individuals whose disability or condition significantly impairs their ability to comply with the work reporting requirement. By attempting to rewrite the standard from the existence of a condition to its demonstrated impact on an individual's ability to work, the IFR establishes a much narrower pathway to the exemption than H.R. 1 permits.

CMS asserts authority for this expansion through the statutory phrase "as defined by the Secretary," but a limited delegation to define specific conditions is not authority to override the categorical structure Congress enacted. This is regulatory overreach, not a policy choice. And this overreach, if maintained, will have devastating consequences for millions of Americans, states, and health care providers.

Given the IFR's additional restrictions and requirements, states will face significant challenges operationalizing this narrower definition of medical frailty, and individuals will face challenges showing they meet the definition. By shifting the standard from the existence of a condition to its demonstrated impact on an individual's ability to work, the policy establishes a much narrower pathway to the exemption. Consequently, many individuals who would otherwise appear eligible for the exemption based on their circumstances may not qualify or may need to jump through impossible bureaucratic hoops to prove that they qualify for the exemption, increasing the likelihood that people with health conditions lose their coverage.

The new standard will force the Medicaid program to take on completely novel responsibilities that are more akin to workers' compensation than health insurance. States will not be able to rely on automation nor implement the law in a way that protects individuals with health needs, likely – in a matter of months – needing to revamp information technology (IT) systems; add new eligibility staff and call center support; modify applications, renewal forms, and educational materials; and train health care providers on how to assess and document whether someone's condition "significantly impairs" their ability to work, a task that will be brand new to many providers.

The IFR forces vulnerable Americans to quite literally prove they are "sick enough" to deserve health care. In practice, a person in the middle of a mental health crisis or a course of cancer treatment, or someone managing severe substance use disorder, will be forced to secure explicit provider attestations linking their illness to their capacity to work. If they cannot jump through this hoop, the penalty is severe: they are cut off from the very medical care they need to survive.

The Unfair Medical Frailty Verification Requirements Burden Sick Patients and Providers

In addition to the limitations imposed by the medical frailty definition put forth by this rule, the verification and self-attestation requirements impose infeasible expectations on individuals. Beginning in 2028, the rule directs states to implement a stricter documentation verification regime that will drive up administrative costs, overwhelm already-stretched eligibility staff, and push people off coverage. The verification requirements in 2027 compared with 2028 function as a bait-and-switch: implementation is seemingly made to appear manageable in the first year, then procedural barriers and coverage losses spike when the documentation default kicks in. In particular, verification requirements in the rule differ for medical frailty compared to all other eligibility requirements or exemptions/exclusions (e.g., caregiving, being a veteran, or being

incarcerated), requiring significant documentation that goes well beyond self-attestation starting in 2028.

CMS' theory for this verification asymmetry is paternalism dressed as policy. The IFR states that CMS "believe[s] that requiring verification of medical frailty…under penalty of perjury (such as a screening tool) will motivate individuals to access care."[15] This theory assumes individuals with serious conditions who self-attest will then access care, generating claims data the state can use at next renewal. However, it does not consider the scenario in which new enrollees with new conditions won't have 12 months of claims yet, conditions like substance use disorder (SUD) which have special protections for privacy purposes, mental health conditions that may not appear in claims, or conditions managed without ongoing treatment (in remission, stable, controlled). Even if the state successfully verifies through claims at one renewal, the IFR requires reverification at least every 12 months and, at state option, more frequently. If 12 months of claims/encounter data do not show the qualifying condition, the individual loses the exclusion.

We request that CMS provide the public with a stronger justification for the dichotomous verification regime and the more stringent requirements starting in 2028 for proving medical frailty. The phased structure of the requirements suggests the agency itself recognizes documentation requirements are not reasonably achievable for many categories. The expectation that individuals will be able to produce documentation to prove the severity of their illness is just as unrealistic in 2028 as it is in 2027.

The Lookback Period Punishes People for the Timing of Their Medical Crises

H.R. 1 requires applicable individuals to demonstrate compliance with the work reporting requirement, or qualification for an exception, for one to three months, at state choice, before application, and for at least one month since their last renewal. The IFR confirms that specified excluded individuals are not subject to this lookback. However, individuals seeking to qualify through a short-term hardship exemption, including hospitalization, medical travel, or residence in a disaster area, must demonstrate that the qualifying event occurred during the specific lookback month the state has chosen.

This is incoherent. Short-term hardship exemptions exist precisely to protect people during temporary medical crises. Conditioning the exemption on whether the crisis aligned with the state's chosen lookback month defeats its statutory purpose. For example, a person hospitalized in November who applies in February, in a state with a three-month lookback, can qualify. The same person hospitalized in September who applies in January cannot. The protection turns on the calendar, not on the medical event.

The longer the state's lookback period, the worse the problem becomes, and the IFR creates additional harm by extending lookback obligations into months that occurred before the final rule was issued. In a state that elects a three-month lookback, an applicant on January 15, 2027 must demonstrate compliance for October, November, and December of 2026, conduct that occurred before CMS finalized the rule governing it. This retroactive application of unsettled

15 Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 FR 33406, https://www.govinfo.gov/content/pkg/FR-2026-06-03/pdf/2026-11094.pdf

rules is fundamentally unfair to applicants who could not have known what was required during the conduct period being measured.

Year-Round Paperwork Requirements Will Exacerbate Coverage Loss

The IFR creates a new exception to the long-standing 45-day timeliness standard for processing applications when a notice of noncompliance is issued. Through this exception, CMS is explicitly insulating states from beneficiary protection/compliance consequences for slow application processing under work reporting requirements. Acknowledging that states are unlikely to meet these standards is a recognition of the harm to come. This exception is even more harmful to beneficiaries when combined with the H.R. 1 policy that requires states to reverify eligibility for individuals in the expansion group and comprehensive 1115 waivers every six months, in addition to the fact that the law provides States the option to conduct more frequent verifications of compliance with the work reporting requirement.

CMS acknowledges that the IFR creates a nearly impossible timing problem and offers no solution while barreling on with ill-advised policies. Through the IFR, CMS is trapping low-income families in a state of perpetual panic. By combining the six-month eligibility renewal requirement with ongoing work-reporting checks, this rule ensures that families are never *not* in the process of signing up for health care, effectively setting a structural trap. The red tape gauntlet Americans will have to contend with to maintain health insurance coverage will be constant. A family will barely finish submitting documents for one review cycle before the state triggers the next, creating hurdles that are particularly burdensome for hourly workers with volatile schedules, single parents, and individuals with fluctuating health conditions.

This constant demand for documentation will create chronic stress for millions of Americans. Families will live in constant fear of the mailbox, knowing that a single lost piece of mail, a typo by a state eligibility worker, or a late verification form from a doctor means an immediate lapse in life-saving care. This dynamic is compounded by the fact that states can choose to verify work reporting requirements even more frequently than every six months. This regime is set up to ensure people fail and fall through the cracks.

The Rule Enriches and Empowers Eligibility and Enrollment Vendors and Middlemen

The IFR creates even more administrative barriers and paperwork hurdles for individuals attempting to enroll in or keep their Medicaid coverage than the statute permits. This manifests in both more costly and onerous technology requirements for states as well as unnecessary hoops for individuals to jump through.

In H.R. 1, Congressional Republicans provided a total of $200 million for all 50 states and the District of Columbia in fiscal year 2026 to support the system upgrades that they will need to comply with the law. However, in the IFR, CMS itself estimates that each state will spend approximately $15 million on systems changes, totaling nearly $700 million for the 44 states that are required to implement these changes[16], nearly four times the amount provided to states in the law. Recent reporting shows that state estimates of the costs to implement these requirements are significantly higher; North Carolina, for example, expects it will need to spend an estimated

16 Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 FR 33452, https://www.govinfo.gov/content/pkg/FR-2026-06-03/pdf/2026-11094.pdf

$31.2 million annually to enforce these requirements.[17] As the price tag of Medicaid work reporting requirements continues to rise, every dollar spent by states to implement this new red tape is a dollar that could have instead been used to provide health care to vulnerable Americans.

Indeed, the only winners created through the enactment of Medicaid work reporting requirements and the introduction of the medical frailty two-part test are the eligibility and enrollment vendors that stand to gain billions of state and federal dollars to implement these intricate and confusing systems created to kick people off their coverage. Congressional Democrats have sounded the alarm about these companies knowingly selling faulty systems to multiple states even before the implementation of Medicaid work reporting requirements.[18] Now, these companies can charge states any price to implement these new requirements, and states are desperate to implement these changes expeditiously in order to avoid the specter of compliance action by the Trump Administration.

In January, CMS announced that they struck deals with major Medicaid eligibility and enrollment vendors to provide states with $600 million in discounts to implement Medicaid work reporting requirements.[19] However, the release provided no actual details about these so-called "discounts" and no additional information has surfaced to prove that states are reaping the benefits of these deals.

We urge CMS to withdraw this rule to ensure that Medicaid can continue its mission of providing health coverage to low-income Americans. Implementing this rule will worsen Americans' overall quality of health, waste millions of dollars on administrative red tape, and cause preventable health emergencies for all Americans. This rule does not strengthen Medicaid; it dismantles it, turning a program designed to protect vulnerable Americans into a system that systematically denies them care.

Sincerely,

17 Robert King and Alice Miranda Ollstein. "States Balk at the High Price of Medicaid Work Requirements amid Budget Crunch." *Politico*, May 31, 2026. https://www.politico.com/news/2026/05/31/states-medicaid-work-requirements-high-costs-budgets-00943360.

18 Senators Ron Wyden, Elizabeth Warren, Bernard Sanders, Raphael Warnock to Jason Girzadas, Senate Finance Committee, October 10, 2025, https://www.finance.senate.gov/imo/media/doc/100925_deloitte_letter_to_contractors_on_faulty_medicaid_systems.pdf

19 Paige Minemyer, "10 Medicaid Vendors Pledge $600M in Discounted, Free Services to Support Work Requirements, CMS Says," *Fierce Healthcare*, January 29, 2026, https://www.fiercehealthcare.com/regulatory/10-medicaid-vendors-pledge-600m-discounted-free-services-support-work-requirements-cms.

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