DEPARTMENT OF HUMAN SERVICES

July 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

VIA ELECTRONIC SUBMISSION

Dear Administrator Oz:

The Minnesota Department of Human Services (DHS) appreciates the opportunity to comment on the interim final rule, (IFR) which provides guidance to states on implementation of the work and community engagement requirements effectuated by Section 71119 of Public Law 119-21 published in 91 FR 33348 on June 3, 2026, referred to here as HR 1. Under the new law, starting on January 1, 2027, Medicaid enrollees in the adult expansion group authorized by the Affordable Care Act must complete at least 80 hours per month of qualifying work and community engagement activities to maintain eligibility for the program unless they qualify for a medical frailty or other exclusion. Minnesota's Medicaid expansion provides health care coverage to around 205,000 adults who will be subject to community engagement requirements unless they satisfy criteria for a statutory exclusion or meet the short-term hardship exception criteria. Preliminary analysis of the community engagement requirements by DHS staff estimated that 20 percent of enrollees subject to work reporting requirements would have their coverage terminated due to administrative burden or non-compliance.[1] The complex and limiting framework of exceptions as detailed in the IFR will likely increase the expected coverage loss. The coverage loss will include some of the neediest Medicaid enrollees including those with disabilities and chronic health conditions, populations that already contend with numerous barriers to accessing needed care.

The IFR is inconsistent with the HR1 statute, creates a standard for the medical frailty exclusion that is more restrictive than statute and lacks clear operational standards, creates new ambiguities that must be navigated by enrollees and the state, and increases administrative burden on applicants, enrollees, and state Medicaid agencies. The IFR also requires states to verify compliance with community engagement requirements by using data state Medicaid agencies do not hold and have no experience assessing, arbitrarily limits enrollee self-attestation, and adds procedural hurdles for enrollees to produce third-party documentation. The IFR upends implementation work already underway based on CMS's previous guidance. As a result, the IFR will create a costlier Medicaid program and increase the burden on taxpayers as state agencies and enrollees navigate a thicket of bureaucracy. Most importantly, the IFR will likely result in the loss of Medicaid coverage for individuals who are otherwise eligible, thus hurting people who rely on Medicaid to access needed healthcare.

In recent years, CMS has issued several new regulations and guidance requiring significant state efforts that did not contain clear standards at the outset or that were subsequently modified or rescinded by

[1] MN Department of Human Services. Summary of Medicaid Provisions in the 2025 Federal Reconciliation Bill. Published online August 2025. https://mn.gov/dhs/assets/summary-of-medicaid-provisions-in-the-2025-federal-reconciliation-bill_tcm1053-685438.pdf

future administrations. States are either making unnecessary investments or finding themselves subject to ongoing scrutiny without clear communication of when CMS standards have been met. Recent examples include the development of Electronic Visit Verification certification processes, rules regarding home and community-based setting requirements and transition plans, and the 2011 requirements to develop Access Monitoring Review Plans. Given the volume of both the requirements in this IFR and the existing federal mandates awaiting state implementation, we recommend CMS revise the IFR to focus on a limited set of requirements clearly supported by statute and extend implementation timelines. [2]

DHS offers the following comment in response to the IFR issued by CMS.

Urgent Implementation and Ambiguous Requirements

The IFR creates additional challenges to implementing HR1 policies, procedures, and eligibility system changes by January 1, 2027. Given the urgent timelines, DHS began working to prepare for the new requirements immediately following the passage of the bill. States implementing these requirements are relying on eligibility systems that are not built to support community engagement requirements and are not easily configured. DHS transitioned its systems and policy documentation based on HR1 and guidance provided by CMS.

For example, the Informational Bulletin dated December 8, 2025, encouraged states to immediately begin work to procure vendors and program their systems to be ready to apply community engagement requirements to all new applications and renewals starting on January 1, 2027, which DHS has done and is on track to achieve. However, due to the unexpected, incomplete, and ambiguous requirements laid out in the June 2026 IFR, DHS must now revise and re-finalize system requirements and design by early August. Testing must be conducted on an accelerated timeline to meet the January 1 deadline, leaving little time to address any defects that may be identified.

States still need clarity on several critical requirements detailed in the new guidance. The IFR now directs states to evaluate whether someone's medical condition prevents them from being able to carry out work, volunteer, or education activities 80 hours per month. CMS has provided no guidance on how states are to evaluate medical evidence to make such an "employability" determination but has committed to additional subregulatory guidance in the future. States therefore must invest significant time and resources now to develop processes and program their IT systems without such guidance and without knowing whether their work will conflict with future guidance. This impacts not only the state, but also enrollees who may not understand the criteria for this exclusion or understand the documentation needed for compliance.

[2] DHS also incorporates by reference to this comment letter, all pleadings and supporting documentation filed in *Massachusetts, et al. v. Oz, et al.*, Case No. 1:26-cv-12962 (D. Mass). The lawsuit, in which the State of Minnesota is a Plaintiff, challenges portions of the IFR. DHS is writing separately to address issues DHS sees with the IFR as it proceeds with implementation.

The IFR places new obligations on states to verify compliance with community engagement requirements and to verify exclusion criteria using reliable data that the state has or should be able to access. To operationalize these requirements, states will have to seek out and incorporate data Medicaid agencies have never assessed before such as data on community volunteer work or vocational program and school attendance data. The IFR contains no timelines for implementation or details on which data sources states must have implemented by January 1, 2027.

Limited Use of Self Attestation

The IFR permits enrollees to self-attest to meeting community engagement requirements through December 31, 2027. The rule limits self-attestation beginning January 2028, requiring states to build additional data verification capacity. Eligibility systems must be modified to incorporate exclusion criteria and retain auditable records to support exclusion determinations. DHS urges CMS to extend the ability for applicants and enrollees to use self-attestation to demonstrate compliance with community engagement requirements through at least 2028. This extension is needed to allow states time to connect with new data sources to verify the new eligibility conditions and it is particularly important to ensure states are properly identifying and documenting medical frailty.

Confusion for Applicants and Enrollees

DHS has been working to develop the new notices, application forms, and outreach materials since the passage of HR1. The IFR has taken a complicated federal law and made it even more complicated to explain to the individuals and families who rely on Medicaid for health coverage. For example, rather than being able to simply explain who is subject to work requirements and who is not, states will now have to explain the difference between an exclusion and an exception, and all the verification requirements that go along with proving whether a person is eligible for either. The complexity of the IFR and the degree of ambiguity left unresolved by the IFR will make it difficult, if not impossible, for the state Medicaid agency to effectively educate the public about who can and cannot access health coverage through Medicaid. This means an increase in the volume of calls and walk-ins to state and county offices. Long wait times for information and assistance will lead many individuals to choose to forgo health coverage at all. Inevitably, lack of health coverage and access to preventive care and primary care drives up utilization of emergency department services and leads to worse health outcomes.

The Medically Frail Exclusion is Inconsistent with HR 1

The IFR's definition of "medical frailty" is inconsistent with HR 1. It is also far more restrictive than the definition used elsewhere in federal Medicaid law and goes beyond CMS's previous guidance on community engagement. For example, federal law allows states to establish "alternative benefit plans" (ABPs) for the Medicaid expansion population that may offer less robust coverage than that offered in traditional Medicaid. However, states must exempt from mandatory enrollment in the ABP[3] individuals

[3]42 CFR 440.315(f)

who meet the definition of medically frail to receive the traditional Medicaid coverage to ensure they have coverage of needed services. The ABP regulations give states significant discretion to define medical frailty, while the IFR restricts flexibilities to the definition of "medically frail."

Guidance provided in CMS facilitated workgroups and All-State Calls regarding the community engagement requirements suggested that "medical frailty" would be defined as a chronic condition that requires ongoing care, and that states would retain flexibility similar to that permitted in defining medical frailty for the ABP exceptions. But the IFR surprised states by adopting a more restrictive definition of medical frailty, which requires a clinician to evaluate and document whether a person can satisfy community engagement requirements regardless of their specific health condition. This definition is closer to a medical-vocational evaluation determining fitness for employment, and the shift is disruptive to states designing systems and policy to verify medical frailty. The practical result is that the same individual classified as medically frail for purposes of the ABP exemption may not qualify for an exclusion from the new community engagement requirements.

The IFR attempts to justify this narrower definition by stating that, "*The phrase 'medically frail or who otherwise has special medical needs' connotes diminished functional capacity that significantly impairs an individual's ability to meet ordinary demands*." But research over the last decade demonstrates that a significant share of non-elderly adults with Medicaid who have a disability,[4] or who have serious health limitations,[5] have not received a determination of disability from the Social Security Administration. The process of documenting and verifying these individuals' "*functional capacity*" will be challenging and will likely have a chilling effect on eligible applicants.[6]

The IFR's New Construct of "Medical Frailty" is Likely to Cause Churn

The term "churn" is generally understood to refer to short-term loss of coverage for reasons such as failure to complete requested paperwork or to provide requested verifications.[7] The IFR's new definition of medical frailty imposes significant challenges that are likely to result in a person losing Medicaid coverage or being denied Medicaid coverage not because they are statutorily ineligible but solely due to their inability to navigate the new federal paperwork requirements. The addition of a medical-vocational test significantly increases the complexity of Medicaid eligibility and renewal determinations, which in turn will increase federal and state costs.[8]

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[4] KFF, "How Might Medicaid Adults with Disabilities Be Affected By Work Requirements in Section 1115 Waiver Programs?", January 26, 2018

[5] "Medical Frailty Rule Contravenes HR 1, Burdens The Health Care System, And Threatens Public Health | Health Affairs Forefront,"June 12, 2026

[6] Brookings, Reducing Poverty Among Older and Disabled Adults By Increasing Participation in SSI and SNAP, Wendell Primus and Chole Zilkha, July 8, 2024

[7] KFF, Corallo et. al., Medicaid Enrollment Churn and Implications for Continuous Coverage Policies (Dec. 2021)

[8] For some evidence of likely delays DHS cites the 2-3 year average time frame for an award of disability. *See* Average number of days from SSI application to reconsideration decision in 2023 was 213.1 days according to SSA Open Data Portal, US-GOV-SSA-1768, last updated March 8, 2024. And in Minnesota it

And, as discussed above, confusion and frustration about these new requirements are likely to increase costs and cause people to lose Medicaid coverage. Individuals who have a disability application or appeal pending may become so frustrated that they choose to abandon their applications or to have their applications denied due solely to the individual's inability navigate the new application and renewal paperwork procedures. It is well established that churn leads to wasted money and negative impacts on health. For example, key findings from a 2021 Issue Brief by the Assistant Secretary for Planning and Evaluation for U.S. Health and Human Services (ASPE),[9] include:

- Disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.
- Beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.
- One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month).

This churn contributes to worse health outcomes for enrollees, such as delays in care leading to increased emergency department visits and hospitalizations, lack of access to prescription medications and increases in medical debt.[10,11] Administrative burdens can be especially difficult for people with mental health conditions, disabilities, unstable housing, limited internet access, or low literacy or limited English proficiency, as well as for people living in rural areas, making these individuals more susceptible to coverage loss.[12,13]

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takes approximately eight months for a person to get a disability hearing. SSA, Hearings and Appeals, Average Wait Time Until Hearing Held Report (June 2026)

[9] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy, Sugar *et.al.* Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (April 12, 2021)

[10] Banerjee, R., Ziegenfuss, J. Y., & Shah, N. D. (2010). Impact of discontinuity in health insurance on resource utilization. BMC health services research, 10(1), 1-10. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-195

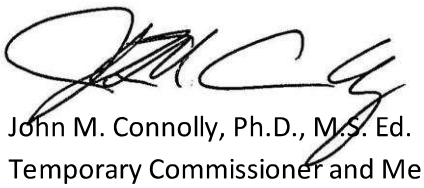
[11] Sommers et al., "Medicaid Work Requirements — Results from the First Year in Arkansas." NEJM, June 19, 2019

[12] Erzouki F. Lessons From Unwinding Offer Opportunities to Streamline Medicaid, Improve Efficiency. April 3, 2025. https://www.cbpp.org/research/health/lessons-from-unwinding-offer-opportunities-to-streamline-medicaid-improve

[13] Wikle S, Wagner J, Erzouki F, Wagner J, Sullivan J. States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity. July 19, 2022. https://www.cbpp.org/research/health/states-can-reduce-medicaids-administrative-burdens-to-advance-health-and-racial

DHS urges CMS to revise the IFR to focus on the requirements explicitly supported by statute, provide states with guidance necessary for implementation, and use its discretion to afford states time to properly implement this change. We appreciate the opportunity to comment on this regulation.

Sincerely,



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