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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted electronically

RE: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Interim Final Rule, "Medicaid Program; Community Engagement Requirement for Certain Individuals"

The National Women's Law Center (NWLC) writes to comment on the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Interim Final Rule (IFR), "Medicaid Program; Community Engagement Requirement for Certain Individuals." Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society. We have worked to advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of those who face multiple and compounding forms of discrimination. Through our work to preserve and strengthen Medicaid programs, we have seen their impact on the health and wellbeing of women and LGBTQI+ people, and we firmly believe in the value of robust Medicaid enrollment and access to services.

We urge the Centers for Medicare and Medicaid Services (CMS) to rescind the work reporting requirements interim final rule. It will reduce Medicaid access for eligible individuals, with particular harms for women, women of color, and disabled women.

I. Medicaid coverage is critical for enrollees' health and wellbeing.

For millions of people, Medicaid is a lifeline, offering access to coverage that they otherwise may not be able to afford. Women represented 57% of nonelderly adults enrolled in Medicaid in 2024, with over 17.5 million women between the ages of 19 and 64 receiving coverage through Medicaid.[1] A significant portion of Medicaid-enrolled women are covered through Medicaid expansion and would thus be subject to the work requirements addressed in this IFR. Among Medicaid-enrolled women of reproductive age, four in ten are covered through Medicaid

[1] KFF, *Distribution of Adults Ages 19-64 with Medicaid by Sex*, *Timeframe: 2024*, https://www.kff.org/medicaid/state-indicator/medicaid-distribution-adults-19-64-by-sex (last accessed July 27, 2026).

expansion,[2] representing an estimated 5.7 million women.[3] LGBTQ+ individuals are approximately twice as likely as their non-LGBTQ+ counterparts to receive coverage through Medicaid, with particularly high enrollment rates among cisgender lesbian and bisexual women and transgender people.[4]

Medicaid coverage is vital for improving access to care, health outcomes, and economic stability.[5] Without Medicaid coverage, individuals would have to either incur medical expenses beyond their means or forgo critical care. Medicaid expansion, the primary target of the work requirements, has undisputedly benefited those who qualify through this pathway. The overwhelming weight of research shows that the expansion program has increased access to and utilization of preventive and primary care; decreased reliance on emergency rooms as a source of low-acuity care; and reduced cases of catastrophic out-of-pocket medical costs.[6] This in turn has improved outcomes across health care access, health behaviors, and self-reported health.[7] For example, Medicaid expansion is associated with earlier detection, diagnosis, and treatment of conditions such as breast cancer.[8] And by improving coverage before and after pregnancy, Medicaid expansion has helped combat the maternal mortality crisis that disproportionately affects Black and Indigenous women[9]: Medicaid expansion is associated with lower mortality rates for pregnant women.[10] Indeed, Medicaid coverage has proven critical for reducing maternal mortality and morbidity, not only during and immediately after pregnancy, but before an individual becomes pregnant.

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[2] Jessica Mathers et al., *5 Key Facts About Medicaid Expansion*, KFF (Apr. 25, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-expansion.

[3] Emily Burroughs et al., *5.7 Million Women of Reproductive Age Would Lose Medicaid if States Eliminate the ACA Expansion: National and State Projections for 2026*, URBAN INST. (May 9, 2025), https://www.urban.org/research/publication/57-million-women-reproductive-age-would-lose-medicaid-if-states-eliminate-aca.

[4] Brad Sears, Andrew R. Flores, & Jet Harbeck, *LGBT Adults With Medicaid as Their Primary Source of Health* Insurance, WILLIAMS INST. (May 2025), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-LGBT-May-2025.pdf.

[5] *See* Gideon Lukens & Elizabeth Zhang, *Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage*, CTR. ON BUDGET & POL'Y PRIORITIES. (Feb. 5, 2025), https://www.cbpp.org/sites/default/files/1-16-25health.pdf.

[6] Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021*, KFF (May 6, 2021), https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021; Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020*, KFF (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review.

[7] Guth et al., *supra* note 6; Kevin N. Griffith & Jacob H. Bor, *Changes in Health Care Access, Behaviors, and Self-Reported Health Among Low-income US Adults Through the Fourth Year of the Affordable Care Act*, 58 MEDICAL CARE 574 (Jun. 2020), https://doi.org/10.1097/MLR.0000000000001321.

[8] Justin M. Le Blanc et al., *Association of Medicaid Expansion Under the Affordable Care Act with Breast Cancer Stage at Diagnosis*, 155 JAMA SURGERY 752 (Jul. 1, 2020), http://doi.org/10.1001/jamasurg.2020.1495.

[9] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues*, KFF (Dec. 3, 2025), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them.

[10] Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, 30 WOMEN'S HEALTH ISSUES 147 (Feb. 25, 2020), https://doi.org/10.1016/j.whi.2020.01.005; Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* 7, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMS. (May 2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf.

Comprehensive care before pregnancy improves management of underlying conditions, resulting in better outcomes for pregnant individuals.

Stripping enrollees of their access to Medicaid by imposing work reporting requirements will deny them lifesaving benefits, threatening their health and financial security. Work reporting requirements put a significant portion of Medicaid-enrolled women at risk of losing coverage, including those who face barriers to employment or to obtaining an exemption. In 2023, 40% of women enrolled in Medicaid were not employed for reasons such as an inability to find work, school attendance, illness or disability, or caregiving responsibilities.[11] They were substantially less likely than men to be employed and those who were employed were far more likely to be working part time.[12] These trends are consistent with data demonstrating that women are more likely to experience barriers to job stability—particularly women of color and women with low incomes,[13] who make up an outsized portion of Medicaid-enrolled women.[14]

When people are turned away or disenrolled from Medicaid, they can face severe and lasting harm. Most people who lose Medicaid coverage do not transition to private insurance, and under the IFR they would be precluded from eligibility for tax credits that make Marketplace coverage more affordable. Many who lose Medicaid coverage end up uninsured or experience gaps in coverage.[15] The consequences of losing insurance are multifold. Numerous studies have demonstrated that uninsured individuals are less likely to receive preventive care or access services for major health conditions and chronic diseases.[16] Uninsured women—disproportionately Black, Latina, and Indigenous women—are less likely to have a regular doctor and to receive services like mammograms, Pap tests, and blood pressure checks.[17] They also get less adequate and lower quality care.[18] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[19] to later-stage cancer diagnoses.[20]

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[11] Ivette Gomez et al., *Medicaid Work Requirements: Implications for Low Income Women's Coverage*, KFF (Apr. 30, 2025), https://www.kff.org/womens-health-policy/medicaid-work-requirements-implications-for-low-income-womens-coverage.

[12] *Id*.

[13] *See* Jasmine Tucker & Julie Vogtman, *Hard Work Is Not Enough: Women in Low-Paid Jobs*, NAT'L WOMEN'S LAW CTR. (July 2023), https://nwlc.org/wp-content/uploads/2026/06/%C6%92.NWLC_Reports_HardWorkNotEnough_LowPaid_2023.pdf.

[14] *See* Nat'l P'ship for Women & Fams., *From Maternal Health to Long-Term Care: Medicaid Is Vital for Women's Lifelong Health* (Dec. 2024), https://nationalpartnership.org/wp-content/uploads/medicaid-vital-for-womens-lifelong-health.pdf.

[15] Bradley Corallo et al., *What Happens After People Lose Medicaid Coverage?*, KFF (Jan. 25, 2023), https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage.

[16] Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KFF (June 16, 2026), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[17] KFF, *Women's Health Insurance Coverage* (June 9, 2026), https://www.kff.org/womens-health-policy/womens-health-insurance-coverage.

[18] *Id*.

[19] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health*, CTR. ON BUDGET & POL'Y PRIORITIES (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

[20] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, 40 HEALTH AFFS. 754 (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.

Uninsured adults broadly are more likely to forgo needed care than those who are insured: In 2024, nearly four in ten uninsured people aged 18 to 64 reported that they delayed or did not acquire medical care, approximately twice the rate among insured people.[21] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[22] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[23] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[24] which itself leads to wide-ranging impacts on health and wellbeing.[25]

II. The IFR runs contrary to the Medicaid statute.

CMS is obligated to implement H.R. 1 within the bounds of the overall purpose, structure, and language of the Medicaid statute. The IFR exceeds those bounds by imposing restrictions that thwart the goals of the Medicaid statute and even conflict with its express requirements.

The central objective of the Medicaid statute is clear: Medicaid was established to furnish medical assistance to individuals who are unable to meet the costs of care.[26] As courts have repeatedly emphasized,[27] "[t]he statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care."[28] The adoption of work reporting requirements under H.R. 1 has not altered this core purpose of expanding access to health care and coverage. While Congress may wish to incentivize "secondary benefits" through the Medicaid program, such as those that work reporting requirements purportedly promote, the fundamental objective of providing health care coverage is still the same.[29]

CMS must implement work requirements in the manner most faithful to the program's core objective. Its interpretation of H.R. 1 must therefore maximize access to health care and coverage and, at minimum, resolve any ambiguities in H.R. 1 in favor of mitigating restrictions on enrollment and eligibility. The IFR fails to do so. Instead, CMS has imposed even more severe burdens than what H.R. 1 requires, exacerbating rather than reducing barriers to Medicaid coverage. CMS goes even further than simply exercising its discretion in favor of a more restrictive policy: As detailed in this comment, it imposes new limitations that directly conflict with H.R. 1, something it has no authority to do. CMS has thus adopted a rule that undermines the defining purpose of the statute it is implementing, disregards and contradicts its explicit requirements, and further exacerbates harmful impacts on the individuals it is meant to serve.

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[21] Tolbert et al., *supra* note 16.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, KFF (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[26] 42 U.S.C. § 1396(a).
[27] *Gresham v. Azar*, 950 F. 3d 93, 99-103 (D.C. Cir. 2020) (summarizing prior Supreme Court and circuit court decisions regarding the primary purpose of Medicaid).
[28] *Gresham v. Azar*, 950 F. 3d 93, 100 (D.C. Cir. 2020), vacated and remanded on unrelated grounds sub nom. *Becerra v. Gresham*, 142 S. Ct. 1665 (2022), and vacated and remanded sub nom. *Arkansas v. Gresham*, 142 S. Ct. 1665 (2022).
[29] *See id*.

III. The IFR's work reporting exclusions processes threaten access to Medicaid.

The IFR imposes work reporting requirements and administrative barriers on both states and Medicaid enrollees that go beyond the requirements of H.R. 1. These policies will lead to widespread loss of coverage, especially for those with disabilities or who may qualify as medically frail, caregivers, and others who would otherwise qualify for an exemption, with particular harms for women of color, disabled women, and women overall.

a. Evidence from states already demonstrates the high risk of disenrollment.

Work reporting requirements lead to widespread termination of coverage for eligible individuals, a fact demonstrated by data from other states' attempts to implement similar requirements. For example, Arkansas imposed work reporting requirements in 2018. In the seven months the work requirement was in operation before a federal court stopped the program,[30] over 18,000 people lost coverage—amounting to one in four of those subject to the work requirement.[31] This included many people who were working, qualified for an exemption, or were otherwise eligible.[32] A work requirement in Georgia has had similar impacts since it was launched in 2023. Although 240,000 uninsured people were estimated to be potentially eligible for Georgia's Pathways to Coverage program,[33] only 17,709 were enrolled as of May 31, 2026[34] due to burdensome reporting requirements, difficulty navigating the technical and bureaucratic language, and difficulty obtaining and uploading documents to verify their employment or education.[35] Many who lost coverage did not lose it because they failed to work or qualify for an exemption, but rather because of extensive administrative hurdles, red tape, and confusion.[36] This ample evidence indicates that the IFR will compound harm across the country by creating extensive administrative hurdles, inconsistency across states, red tape, and confusion.

b. The exclusions processes will not prevent widespread disenrollment.

As demonstrated by the experience of other states that have implemented work reporting requirements, many individuals will be unaware of the exemptions or uncertain whether the exemptions will apply to them, and those that are aware will face significant barriers to applying or documenting their eligibility.[37]

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[30] *See id.*
[31] Laura Harker, *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*, CTR. ON BUDGET & POL'Y PRIORITIES (Aug. 8, 2023), https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.
[32] *Id.*
[33] Lukens & Zhang, *supra* note 5.
[34] Georgia Pathways, Current Enrollment, https://www.georgiapathways.org/data-tracker (last accessed July 30, 2026).
[35] Laura Harker, *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care Access*, CTR. ON BUDGET & POL'Y PRIORITIES (Dec. 19, 2024), https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care.
[36] Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements,* CTR. ON BUDGET & POL'Y PRIORITIES (Nov. 18, 2020), https://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf.
[37] *See, e.g.*, Harker, *supra* note 35.

i. The medical frailty exclusion is insufficient and contrary to the statutory text.

H.R. 1 excludes individuals who are "medically frail" from work reporting requirements. Though medical frailty is undefined in H.R. 1, the text includes five categories of conditions that would be considered medically frailties or otherwise special medical needs for the purposes of the work reporting requirements, including individuals having "serious or complex" medical conditions.

But the IFR sets a medically frailty standard that contravenes both the statutory text and logic.[38] The IFR's criteria creates a requirement that the medical frailty "significantly impairs" an individual's ability to work. This is contrary to the text. H.R. 1 does not require proof of such an impairment to establish medical frailty; individuals who are designated as medically frail qualify for an exemption to the work reporting requirement regardless of actual ability to work. It is clear that a medical frailty designation operates as a statutory guardrail: Under H.R. 1, having this status enables individuals to enroll in and maintain coverage regardless of whether they satisfy community engagement requirements in any particular reporting period.

Requiring a determination that a medical condition significantly impairs an individual's ability to work is an unreasonable burden on individuals and states. The mandate that Medicaid agencies or providers or healthcare administrators make these determinations runs contrary to Congressional intent as described above and risks inconsistent evaluations, increased administrative workload, and potential loss of coverage. The IFR does not provide sufficient guidance on what these newly imposed standards would mean, provides no discernable medical or legal basis that medical providers or program administrators can rely on to conduct assessments, and does not provide meaningful guidance for the categories used in H.R. 1 itself. Medicaid agencies, providers, and health care administrators are not equipped to determine whether an individual's condition significantly impairs their ability to comply with the work reporting requirements. Health care providers and state Medicaid administrators will face a significant burden when trying to interpret the standards in any particular case, leading to unpredictable, protracted, and inconsistent processes.

H.R. 1 provides that states "may elect not to require an individual to verify" that they meet an exemption to the work reporting requirements.[39] But in blatant disregard of the statute, the IFR prohibits states from exercising this flexibility after 2027. This unauthorized restriction would impose significant burdens both on the individuals who must provide documentation and the agencies who must assess it. Determining whether an individual qualifies as medically frail under the IFR's definition will require the development of eligibility determination processes, coordination between Medicaid agencies and other stakeholders, and mechanisms for collecting and evaluating documentation. These systems do not currently exist in many states and will require significant administrative resources to establish and maintain. In light of the barriers that many individuals face to obtaining documentation from health providers, the burdens imposed under this IFR would be almost insurmountable, especially when medical visits for the purpose of assessing

[38] Manatt Health, *CMS Releases Interim Final Rule on Medicaid Work Reporting Requirements*, STATE HEALTH & VALUE STRATEGIES (June 15, 2026), https://shvs.org/cms-releases-interim-final-rule-on-medicaid-work-reporting-requirements.
[39] P.L. 119-21, § 71119(a).

eligibility are often not a covered Medicaid benefit and may therefore require unaffordable out-of-pocket expenses.

As a result of this IFR, a significant number of individuals in the Medicaid expansion population would lose coverage despite qualifying for the medical frailty exemption as set out in H.R. 1. Women[40] and LGBTQ+ people,[41] especially, experience high rates of chronic conditions and disability. Women are more likely than men to have more than one chronic condition[42] and the prevalence of chronic conditions only increases with age.[43] Black women are also more likely than other racial and gender groups to experience chronic diseases, including heart disease, stroke, diabetes and cancer.[44]

Despite the greater likelihood that women and LGBTQ+ individuals have heightened medical needs that should qualify them for the statutory exemption, the IFR would instead impose unauthorized criteria and require them to navigate an unclear and burdensome administrative process. The barriers created by the IFR therefore place women and LGBTQ+ individuals with heightened medical needs at substantial risk of losing Medicaid coverage. As discussed above, coverage interruptions can delay access to needed care, including prescription medications, behavioral health treatment, and preventive care. The consequences include potentially worsening underlying health conditions, preventing individuals from maintaining employment, and increasing the likelihood of avoidable emergency care and hospitalization.[45] Interruptions in Medicaid coverage due to administrative barriers and restricted eligibility undermine the purpose of the medical frailty exemption, the purpose of the Medicaid program as a whole, and jeopardize continuity of care for those with the greatest health needs.

ii. The IFR's added restrictions on the exemption for family caregivers will cause individuals to lose coverage.

Congress identified family caregivers as a category of "specified excluded individuals" exempt from work reporting requirements, but the IFR imposes undue restrictions that go beyond and even conflict with H.R. 1. As a result, the IFR makes it more difficult for family caregivers to qualify or demonstrate their eligibility for the exemption.

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[40] Nat'l Acads. Sci, Eng'g, & Med., *Advancing Research on Chronic Conditions in Women* 231-525, (Sep. 25, 2024), https://www.ncbi.nlm.nih.gov/books/NBK604853.
[41] Lindsey Dawson, Michelle Long, & Brittni Frederiksen, *LGBT+ People's Health Status and Access to Care*, KFF (Jun. 30, 2023), https://www.kff.org/report-section/lgbt-peoples-health-status-and-access-to-care-issue-brief/.
[42] Peter Boersma, Lindsey I. Black & Brian W. Ward, *Prevalence of Multiple Chronic Conditions Among U.S. Adults, 2018*, 17 PREVENTING CHRONIC DISEASE 200130 (Sept. 17, 2020), http://dx.doi.org/10.5888/pcd17.200130.
[43] *Id.*
[44] Kara Manke, *Racial Discrimination Linked to Higher Risk of Chronic Illness in African American Women*, U.C. BERKELEY NEWS (Oct. 5, 2018), https://news.berkeley.edu/2018/10/05/racial-discrimination-linked-to-higher-risk-of-chronic-illness-in-african-american-women/.
[45] MaryBeth Musumeci et al., *Reducing Medicaid Churn: Policies to Promote Stable Health Coverage & Access to Care*, COMMONWEALTH FUND (June 11, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage; Nat'l Women's L. Ctr., *Medicaid Work Reporting Requirements Would Harm Women's and LGBTQ+ People's Health & Economic Security to Fund Tax Breaks for the Rich* (Feb. 6, 2025), https://nwlc.org/resource/medicaid-work-reporting-requirements-would-harm-womens-and-lgbtq-peoples-health-and-economic-security-to-fund-tax-breaks-for-the-rich/.

The IFR deviates from the exemption for family caregivers set out in H.R. 1 in several key respects. First, it defines family caregivers to include only those who provide care for children aged 13 or under and for individuals who meet the definition of disability under the Americans with Disabilities Act (ADA). H.R. 1, by contrast, applies the exemption beyond the ADA definition. Relying on the RAISE Family Caregivers Act, H.R. 1 exempts caregivers not only to people with a qualifying disability under the ADA, but to any individuals "with a chronic or other health condition, disability, or functional limitation."[46] While disability under the ADA is broadly defined, the more expansive language of the RAISE Act is not merely redundant: Its clarification of the scope of exempt caregivers is necessary, particularly as many caregivers provide support to individuals whose health conditions may not fit into the common usage of "disability" or who may not consider themselves to have a disability, regardless of whether they meet the ADA definition. The language of the RAISE Act, as incorporated in H.R. 1, also clarifies the scope of the exemption without requiring caregivers, the individuals they support, and program administrators to determine or apply the legal standard under the ADA. The language in the IFR, by contrast, creates confusion about the criteria that must be met, leaving many caregivers and program administrators uncertain of how the exemption is to be applied and increasing the risk of states improperly denying exemptions or requiring irrelevant documentation.

The IFR also conflicts with H.R. 1 by narrowing eligibility for caregivers supporting individuals to whom they are not related. Again drawing from the RAISE Act, H.R. 1 defines "family caregiver" to include "an adult family member or other individual who has a significant relationship with" the person they are supporting. But the IFR replaces the more expansive "significant relationship" standard with a requirement that unrelated caregivers must live with the individual receiving care or provide care to the individual for at least 80 hours each month. These arbitrary criteria appear nowhere in the statute, and CMS does not have authority to superimpose such restrictions on the definition Congress selected. The requirement excludes many forms of caregiving arrangements: Many people with health conditions and disabilities rely on trusted relationships with friends, neighbors, and community members, who may serve as primary caregivers even when they do not live in the same household. Parents of young children also frequently rely on care networks that include non-relatives: About half of children under age 3 are regularly cared for by someone other than a parent, mostly by individual unpaid caregivers.[47] The IFR would require those individuals to document 80 hours of caregiving per month—an especially significant burden as caregivers in these informal relationships may be unable to provide documentation of their caregiving and may provide support based on fluctuating needs rather than predetermined hours.

The frequently unpredictable, changing nature of the time commitment required for caregiving is part of what meaningfully limits family caregivers' ability to participate in work or other community engagement activities. CMS must fulfill the clear text and intent of the statute and remove the minimum hours requirement from the family caregiver definition for all such

[46] Pub. L. No. 115-119, 132 Stat. 23.

[47] U.S. Dep't Health & Hum. Servs. Admin. for Child. & Fams., *National Survey of Early Care & Education: Chartbook – Children's Participation in Child Care and Early Education in 2012 and 2019: Counts and Characteristics* (May 2023), https://acf.gov/sites/default/files/documents/opre/NSECE%20HH%20Chartbook%20CCEE%20Participation__toOPRE_05302023_508_compliant.pdf.

caregivers. In addition, the agency should provide further guidance making clear that individuals who provide care to children under age 14 who do not have a disability are also eligible for the family caregiver exemption. Particularly since the "family caregiver" term is more commonly used to refer to caregivers of adults, it will be important for CMS to offer states, organizations, and potential enrollees additional examples of family caregivers who provide child care to better ensure this population does not erroneously lose coverage.

The IFR sets out states' broad discretion to determine what constitutes sufficient evidence of caregiver status, including allowing states to rely on "other information sufficient" to verify eligibility. Without clear guidance, implementation is likely to vary significantly across states, creating inconsistent access to the caregiver exemption. Because family caregiving is overwhelmingly informal, many caregivers lack formal documentation of their responsibilities. In some cases, documentation verifying caregiver status may not be available or attainable. Reliance on documentary evidence alone may in turn prevent otherwise eligible caregivers from qualifying for the exemption.

Self-attestation, which occurs under penalty of perjury, remains the best way to verify eligibility for the caregiver exemption, which is consistent with several preexisting processes for both Medicaid and the Supplemental Nutrition Assistance Program (SNAP). CMS should remain mindful of the importance of self-attestation to improve program integrity by preventing erroneous coverage losses and denials, including in 2028 and beyond. CMS should also provide additional guidance to states on how to interpret the "reasonably available" standard to ensure that caregivers are not required to generate or obtain documentation solely for purposes of the work reporting requirement, including with the option for individuals to certify to the state that such documentation is not available, as well as non-exhaustive examples of the types of information states might consider as sufficient to demonstrate applicability of the exclusion.

The inconsistencies, ambiguities, and unreasonable restrictions created by the IFR produce challenges that have significant consequences for family caregivers and the individuals who depend on them. In the U.S., 63 million adults provide ongoing care to adults or children with a medical condition or disability.[48] That is almost one in four adults across the country, a proportion that will only continue to grow along with our aging population. Most unpaid family caregivers are women and frequently experience financial hardship resulting from reduced workforce participation and substantial out-of-pocket caregiving expenses.[49]

More than 8 million family caregivers for aging and disabled people rely on Medicaid for their own health insurance (13% of caregivers),[50] and 42% of individual, unpaid child care providers are enrolled in public health coverage, including Medicaid.[51] But in the absence of a robust exemption from work reporting requirements, many family caregivers would lose coverage due to

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[48] Nat'l All. for Caregiving & AARP, *Caregiving in the US: Research Report* (July 2025), https://www.caregivingintheus.org/wp-content/uploads/2026/03/caregiving-in-us-2025.doi_.10.26419-2fppi.00373.001.pdf.

[49] *Id.*

[50] *Id.*

[51] Owen Schochet et al., *A National Portrait of Unlisted Home-Based Child Care Providers*, HHS ACF, ERIKSON INSTITUTE, & MATHEMATICA 4 (Dec. 2022), https://acf.gov/sites/default/files/documents/opre/hbccsq_secondary_analyses_fs1_jan2023.pdf.

the barriers they face to employment. These barriers are especially pronounced for women. Among Medicaid enrollees in the United States, 19% of women did not work due to caregiving responsibilities, compared to only 4% of men.[52] Nearly three in ten (28%) women enrollees with children under the age of 18 were not working due to caregiving responsibilities, seven times the rate among men with children under the age of 18 (4%).[53] CMS must ensure that the exemption for family caregivers is responsive to these realities and consistent with the minimum standards required in H.R. 1, but instead it narrows eligibility and imposes additional, unwarranted administrative burdens, exacerbating the risk that family caregivers will lose coverage.

The IFR also applies inconsistent disability standards to caregivers and the individuals receiving care. As written, a caregiver may qualify for an exemption because they provide care to a disabled individual, while that same individual may not qualify as medically frail under the rule's more restrictive definition. This incongruity creates the untenable potential for scenarios in which caregivers may be exempt from work reporting requirements, but the person they support may not be.

Ultimately, the IFR's medical frailty and caregiver exemptions threaten continuity of care for individuals with disabilities and chronic conditions, children, and the caregivers who support them. Coverage losses among caregivers may reduce their ability to continue providing care, while coverage losses among care recipients may disrupt access to essential health care. These outcomes not only jeopardize the health and wellbeing of caregivers and care recipients but may also increase avoidable institutionalization and overall health care costs.

IV. Conclusion

This IFR will create unwarranted hardships for Medicaid-eligible individuals and enrollees, harming communities that already face disparities in access to care.

We request that the supporting documentation we have made available through direct links in our citations be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS does not intend to consider these materials part of the record as requested, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

For further information, please contact Dorianne Mason, Senior Director of Health Equity, at dmason@nwlc.org.

[52] Ivette Gomez et al., *supra* note 11.
[53] *See id.*