July 31, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-2454-IFC, Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz,

Thank you for the opportunity to comment on the interim final rule (IFR), "Community Engagement Requirement for Certain Individuals," published in the Federal Register on June 1, 2026.

Colorado Access (COA) is Colorado's largest and most experienced public sector health plan, serving more than 500,000 Medicaid and Children's Health Insurance Program (CHIP) members. Our work is grounded in person-centered, community-driven approaches to improving health outcomes. We work directly with the individuals, families, providers, and community partners who experience the real-world effects of policy changes. This gives us a firsthand perspective on where implementation succeeds, where it breaks down, and what information communities need to navigate change successfully. That experience gives us both the insights to identify practical challenges and the responsibility to help ensure that policy changes are communicated and implemented in ways that minimize unnecessary disruption.

Guided by this perspective, COA is deeply concerned about the impact of the IFR on access to coverage, given the unprecedented administrative burden it will impose on members, providers, community partners, and health plans. While we understand the goal of supporting our members to achieve economic stability, we strongly disagree with implementing community engagement (work) requirements as a condition of eligibility for health care.

We urge CMS to significantly revise the IFR. The current rule fails to provide sufficient operational details and lead time for states and managed care plans to implement the community engagement requirements in ways that protect eligible individuals. The IFR also restricts exclusions from the definition of medically frail individuals in a manner that risks severe coverage losses for this population. The IFR should also more explicitly address the burdensome documentation requirements that will further imperil access to coverage for compliant, excepted, or excluded members.

We believe the IFR prioritizes compliance and reporting over access to care. We fear that what is outlined will likely result in widespread coverage loss of eligible individuals due to the complex reporting and documentation requirements. The implementation of work requirements, as written in the IFR, will disrupt care, worsen health outcomes, increase uncompensated care, and put additional pressure on Colorado's already strained health care system.

Community Engagement Requirements Will Result in Coverage Losses for Eligible Individuals

The One Big Beautiful Bill Act (H.R. 1), also referred to as the Working Family Tax Cut legislation, reduces federal health care spending by nearly $1 trillion over the next decade by making fundamental changes to Medicaid. Medicaid provides coverage to approximately 1.2 million Coloradans—about one in five residents—and is the largest source of health coverage in the state for low-income children and adults, pregnant individuals, older adults, individuals with disabilities, and other populations.[i]

H.R. 1 requires states to implement community engagement, or "work," requirements as a condition of eligibility for the Medicaid expansion population by January 1, 2027. This population can be broadly defined as adults ages 19-64 who earn up to 133% of the federal poverty level (FPL). The Colorado Department of Health Care Policy and Financing (HCPF) estimates that 375,000 Coloradans could be subject to the new requirements before exemptions are applied.[ii] We estimate that 148,000 of our 500,000 members, or nearly 30% of our membership, may be subject to these requirements.

We are particularly concerned that eligible individuals with the greatest health needs could lose Medicaid coverage because of administrative complexity rather than ineligibility. In

Georgia, where work requirements have been in place since 2023, low enrollment in the program is largely attributed to red tape associated with frequent reporting requirements.[iii] This, when expanded nationally, is deeply worrisome and will likely increase coverage loss, uncompensated care, and strain providers' budgets and capacity to serve their communities.

The implications of coverage loss extend well beyond the individual who becomes uninsured. Coverage disruptions threaten the financial stability and health of families, providers, and community institutions that serve as essential infrastructure. Hospitals, clinics, behavioral health providers, and community organizations depend on stable coverage and financing to sustain services that benefit entire communities. The cumulative effects ripple through local economies and public health, affecting the capacity of communities to care for the most at-risk residents.

We are also concerned that the community engagement requirements do not acknowledge that most Medicaid members already work but may still lose coverage due to the administrative hurdles associated with the law. In addition, removing Medicaid coverage from individuals who cannot find work does not address the underlying barriers to employment; rather, it may exacerbate barriers to employment if members become sick or cannot access treatment for their conditions. We urge CMS to pair this with a requirement for states to have clear processes for referrals to employment and social support resources to help individuals obtain and sustain employment.

CMS Should Eliminate the Work-Impairment Requirement from the Medical Frailty Definition

The IFR includes several unexpected changes from H.R. 1, including the definition of medical frailty. We are disappointed that CMS adopted an unnecessarily restrictive definition. § 435.554(c)(5) adds qualifying language to the conditions, requiring a person's condition to "significantly impair the individual's ability to comply with the community engagement requirement." This interpretation goes well beyond Congress's intent to protect vulnerable individuals who rely on Medicaid to live healthy and productive lives.

The additional qualifying language concerning an individual's impairment suggests that state Medicaid agencies or providers will be required to determine the interaction between

an individual's condition and their ability to meet work requirements because data alone is unlikely to be able to verify "impairment." This is outside both entities' scope of practice and would impose inappropriate burdens on the health care workforce, who are already subject to various other administrative paperwork. This puts providers in the unfair position of deciding whether someone is impaired enough to keep their health coverage and adds more paperwork and processes at a time when uncompensated care is growing among our safety net providers. Providers have also raised concern about bearing responsibility and individual risk for making determinations that impact a practice's financial viability. COA opposes adding this qualifying language and urges CMS to strike this burdensome requirement.

Other Concerns Regarding Medical Frailty

COA asks that CMS consider the following recommendations under medical frailty:

- **Allow categorical exclusions:** While we appreciate that the IFR permits individuals with certain health conditions to submit a statement under penalty of perjury or self-declaration in the initial year of implementation and then once a year subsequently, requiring additional data verification in out years as well as annual verification remains unnecessary and burdensome. This approach does not adequately account for individuals with serious illnesses, lifelong conditions, or complex health needs who may lack the time, support, or capacity to submit additional paperwork to maintain coverage. CMS should allow categorical exclusions for certain conditions—such as cancer, HIV/AIDS, certain behavioral health conditions, and other chronic conditions—to reduce the risk of unnecessary coverage loss when stability is most critical. Individuals who are seriously ill should not have to worry about additional barriers to prove their eligibility for coverage each year, particularly in situations where a condition is unlikely to be resolved within a single calendar year.
- **Clarify interaction with 42 CFR Part 2:** As the entity that administers the Medicaid behavioral health benefit in our state, we are concerned about how data on individuals with substance use disorders (SUD) can be shared to ensure they are appropriately deemed excluded as the law requires. 42 CFR Part 2 protects patient

records to encourage individuals to seek treatment without fear of retaliation. As a health plan, we are left without substantive answers to key questions about how and in what manner patient consent is required, and what additional authorizations Medicaid plans or providers may need to share SUD-related data with states to verify medical frailty exclusions. Without clear guidance, eligible individuals with SUD could be subject to work requirements or lose coverage because of documentation barriers.

CMS Should Allow Self-Declaration in Perpetuity Or, At Least, Additional Years

We appreciate that CMS includes phased implementation, allowing for states to accept enrollee statements or other information related to compliance, exceptions, or exclusions. This should help reduce the risk of inappropriate coverage loss in the short term. We urge CMS to go further and require all states to accept auditable statements or other supporting information related to community engagement in perpetuity for circumstances where documentation does not reasonably exist.

Demonstration of enrollee compliance across multiple categories of eligible activities will be challenging. For instance, tracking caregiving hours is inherently difficult given the often informal and personal nature of this work. Individuals are unlikely to have employer records and/or difficulties sharing reliable information; thus, extended self-declaration would be appropriate to ensure coverage is maintained.

Additionally, information may be difficult to access for individuals actively participating in a substance use disorder treatment program due to federal privacy rules. CMS should require states to permanently accept an auditable statement or other information from individuals in SUD treatment. Without this option, individuals in recovery for multiple years, who had not incurred recent claims or clinical diagnoses related to SUD treatment, may not be identified and properly excluded from the requirements.

We recommend this extended approach rather than the current language, which permits states to accept these statements only in the first year of implementation. We appreciate CMS's regulatory language in this IFR that prohibits disenrollment in cases when documentation is not reasonably available. Given the wide range of documentation challenges for exclusions and compliance, and the lack of specificity regarding

documentation that is not reasonably available, we urge CMS to affirmatively require states to accept auditable self-declarations to prevent unnecessary coverage loss.

If CMS will not accept self-declaration in perpetuity, we strongly encourage the agency to consider allowing this form of verification at least two to three years after initial implementation. Extending self-declaration beyond the first year would reduce confusion, give members time to adjust, and allow the state and partners to communicate changes more effectively. It will also allow states to collect data to illustrate and fully understand the impact of this policy change.

CMS Should Clarify the Role of Managed Care Plans

COA appreciates that the IFR identifies managed care plans or managed care organizations (MCOs) as key implementation partners. We are already working diligently to support our state and members through these policy changes. Since we began tracking in November 2025, COA – as an organization – has spent more than 835 hours on H.R. 1-related work in addition to our normal operations.

The IFR greatly underestimates the burden on managed care plans and the costs of undertaking the permitted activities, including educating members and providers, responding to questions, assisting with compliance efforts, conducting outreach, communicating with members, training staff, and coordinating closely with the state's Medicaid agency. At the same time, the IFR provides little clarity on what responsibilities health plans will need to assume or the resources required to support the successful implementation of work requirements.

While the IFR states that costs associated with community engagement support activities cannot be included in the development of capitation rates, we ask that CMS and states closely monitor the actuarial soundness of these rates to ensure they accurately reflect the additional responsibilities we undertake as well as changes in member acuity. Based on evidence from the COVID-19 public health emergency unwinding, during periods of eligibility disruption, individuals who maintain Medicaid enrollment tend to have greater health needs than those who disenroll, increasing plan acuity.[iv] Our plan's experience confirms this, as well. The extent of these acuity shifts is difficult to accurately forecast and

account for in regular prospective capitation rate-setting processes. We recommend that CMS issue supplemental rate guidance to address this effect.

COA also requests that CMS require states to share relevant data with health plans, including information on exemptions, exclusions, renewal and verification timelines, and notices of noncompliance. Community-serving organizations must not be left to operate without timely information during periods of significant change, particularly when the underlying data already exists. Providing that information enables organizations, like COA, to prepare, communicate effectively, reduce avoidable coverage disruptions, and support implementation for the people and communities we collectively serve.

Specifically, this information would allow plans to conduct targeted outreach, help members understand their requirements to maintain coverage, support members in returning to compliance, and ensure individuals know they may reapply for Medicaid at any time. Additional CMS guidance on proper information sharing with plans will support more efficient implementation.

CMS Should Allow More Good Faith Waivers

H.R. 1 explicitly allows states to apply for a good faith waiver at the discretion of the Secretary of Health and Human Services, which may exempt states from compliance until December 31, 2028. The IFR outlines criteria for determining whether a state's request for a good faith exemption applies.

Given the change to medical frailty parameters, the overall compressed timeline, and the significant resources states have invested in implementing work requirements, CMS should grant delay waivers to all who request them. Colorado alone has set aside $100 million over the next three years for H.R. 1-related costs.[v] Notably, the IFR estimates that 10 states will apply and only two will be approved. This assumption is inappropriate and suggests that waivers should be limited to a small number of states, an assumption not reflected in H.R.1. By signaling in advance, the IFR may discourage states from seeking much-needed relief that would prevent unintended coverage losses. Given the significant implementation burden on states, we request that CMS allow broader use of good faith waivers.

Health plans, states, counties, providers, and community members are working diligently to comply with the changing health care landscape. We are establishing new processes, investing in new technology, and developing plans to comprehensively engage with affected members. We are concerned that the rushed implementation will result in needless errors, potentially leading to additional coverage loss despite our best efforts.

H.R. 1 Creates New Burdens on States

Lastly, the IFR significantly undervalues the administrative and financial burden that states face in implementing work requirements and the unfortunate consequences a rushed timeline and documentation requirements will have on Medicaid members. The current rule fails to provide sufficient operational detail and lead time for states – and managed care plans – to implement the work requirements in ways that protect eligible individuals.

Meeting these requirements will require costly, large-scale changes, including system redesign, eligibility process updates, additional staffing, member navigation and outreach, auditing, and oversight. As we note above, in anticipation of H.R. 1, the Colorado General Assembly allocated $100 million over three years to support system updates, staffing, member navigation and outreach, enhanced auditing, and expanded oversight to address fraud, waste, and abuse during the 2026 Legislative Session.[vi] Unfortunately, we do not know whether this is sufficient given the compressed timeline for planning and executing these new requirements.

Although H.R. 1 was designed to reduce federal Medicaid spending, compliance will require substantial upfront and ongoing state investment. These costs come as Colorado had to close a nearly $1 billion shortfall this fiscal year through a series of funding reductions to maintain a balanced budget and protect Medicaid.[vii] As a result of the cuts in H.R. 1 and the costs associated with implementation, limited state resources will be diverted from services that directly support health outcomes and care delivery.

Conclusion

COA appreciates the opportunity to provide comments on this interim final rule. As currently written, the IFR creates a significant risk that eligible individuals will lose health

coverage due to administrative burden. The rule imposes substantial unfunded requirements on states, managed care plans, and providers. It often goes beyond what was written in statute, most notably in its definitions of medical frailty and the use of good faith waivers. Medicaid is a lifeline for more than one million Coloradans. We have significant concerns about the adverse impact these rules will have on our members and urge CMS to repromulgate this rule and issue additional guidance to reflect these concerns.

If you have any questions, please contact liz.owens@coaccess.com.

Sincerely,

Elizabeth Owens
Chief External Relations Officer
Colorado Access

---

[i] HCPF. (n.d.). *H.R. 1 Medicaid Partner Frequently Asked Questions*. Colorado Department of Health Care Policy & Financing. https://hcpf.colorado.gov/work-requirements-faqs

[ii] HCPF (n.d.). *H.R. 1 Key Changes*. Colorado Department of Health Care Policy & Financing. https://hcpf.colorado.gov/hr1-key-changes

[iii] Alker, J. (2025, October 30). *CMS's Georgia Waiver Extension Underscores the Failure of Medicaid Work Requirements*. Georgetown McCourt School of Public Policy Center for Children and Families. https://ccf.georgetown.edu/2025/10/30/cmss-georgia-waiver-extension-underscores-the-failure-of-medicaid-work-requirements/

[iv] Tazmin-Ewing, A. and Schwarze, A. (October 2024). *Medicaid Unwinding Rate Adjustment Approaches for Changing Acuity*. Wakely, an HMA Company. https://www.wakely.com/wp-content/uploads/2024/11/Medicaid-Unwinding-Survey-White-Paper_20241029_Acuity.pdf.

[v] HCPF (2026, January 2). *S-08 Additional Resources for Compliance with H.R.1, BA-08 Additional Resources for Compliance with H.R.1*. Colorado Department of Health Care Policy & Financing. https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY27%2C%20S-08%20BA-08%20Changes%20to%20Federal%20Policy_Final.pdf

[vi] HCPF (2026, January 2). *S-08 Additional Resources for Compliance with H.R.1, BA-08 Additional Resources for Compliance with H.R.1*. Colorado Department of Health Care Policy & Financing. https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY27%2C%20S-08%20BA-08%20Changes%20to%20Federal%20Policy_Final.pdf

[vii] Colorado General Assembly. (2026 April 30). *HB26-1410: 2026-27 Long Appropriations Bill*. https://leg.colorado.gov/bills/hb26-1410