AMERICANS for TAX REFORM

722 12th Street N.W.
Fourth Floor
Washington, D.C.
20005
T: (202)785-0266
F:(202)785-0261
www.atr.org

July 27th, 2026

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

Re: Comments in Support of CMS Interim Final Rule on Medicaid Community Engagement Requirements (CMS-2454-IFC; Docket No. CMS-2026-2047)

Dear Administrator Oz:

On behalf of Americans for Tax Reform, we appreciate the opportunity to provide input regarding the interim final rule implementing community engagement requirements for certain Medicaid enrollees. **We urge CMS to finalize this interim final rule, as it restores the program's original intent, protects against fraud, and promotes self-sufficiency among able-bodied enrollees.**

ATR was highly supportive of the Working Families Tax Cut (WFTC) legislation. The law includes significant changes to the Medicaid program, chief among them being work requirements for able-bodied adults ages 19 to 64, with no dependent children under 13 nor disabled dependents. The law requires that these recipients spend 80 hours per month working for a wage, doing community service, participating in a work program or an educational program, or some combination of these.

Implementing work requirements well is essential to the health of the Medicaid program. Democrats, via the Affordable Care Act, expanded Medicaid eligibility to include *any* adult earning 138% of the federal poverty level (FPL) and below. Suddenly, in the 40 states (and DC) who have adopted Medicaid expansion, able-bodied adults of working age were eligible for a program designed to help the neediest among us.

According to the Foundation for Government Accountability (FGA), 69%[1] of the increased federal Medicaid costs since 2000 can be attributed to Obamacare enrollment increases. A plurality of Medicaid spending has now been diverted to able-bodied adults: 35.9% of spending is on able-bodied adults, 31.4% of spending on individuals with disabilities, 19.9% of spending on seniors, and 12.8% of spending on children.

In 2000, there were 6.9 million able-bodied adults on Medicaid. Today, there are 34 million[2] of them. To make matters worse, most *are not working*. As FGA notes[3], "Across 23 states with responsive records, a whopping 62% of able-bodied adults on Medicaid had no earned income, meaning they were not working at all."

---

[1] Foundation for Government Accountability, *Medicaid Work Requirements: From Welfare to Work*, TheFGA.org, https://thefga.org/research/medicaid-work-requirements-from-welfare-to-work/
[2] Americans for Tax Reform, Able-Bodied, Unemployed Adults Have Overrun the Medicaid Program, ATR.org, https://atr.org/able-bodied-unemployed-adults-have-overrun-the-medicaid-program/
[3] FGA, *supra* note [1]

There is simply no reason a 28-year-old, able-bodied man, for example, cannot devote 20 hours to a job, education, or volunteering. If he refuses, there is no reason taxpayers should subsidize his lifestyle.

The law includes several exceptions for those in precarious situations that may prevent them from finding work. For example, pregnant or postpartum women are excluded, as are incarcerated individuals, those with substance use disorder, disabling mental disorders, complex medical conditions, etc. The law also allows states to make exceptions for those experiencing "short-term hardship events," which include those actively receiving medical or psychiatric care and those who reside in counties in which there was an emergency/natural disaster and/or has an unemployment rate higher than 8%.

Work requirements have 81% support[4] from the public, will save taxpayers $260 billion, and increase labor participation. Further, not only do able-bodied, unemployed adults create a superfluous strain on the Medicaid system, putting its ability to provide for those who need it (and its very existence) in jeopardy, but they also divert care itself away from the most vulnerable.

Newsweek reports[5] that Medicaid patients have and will continue to lose their doctors. Only 65% of doctors said they would continue to take new Medicaid patients, with 8% reporting they would no longer accept them. In another survey, 14% of doctors report trying to limit their Medicaid patient counts. This will only get worse as reimbursement rates fail to keep up with inflation, another result of ever-increasing financial strains on Medicaid (i.e. spending on able-bodied adults).

As a result, Medicaid recipients have had to compete for care, especially in areas without many healthcare providers. FGA reports[6] that over 700,000 "individuals with developmental or intellectual disabilities or other conditions that require special care are languishing on Medicaid waiting lists." Thousands of vulnerable recipients will not receive care because resources have been diverted away to those who, simply put, do not need it. Since the Obamacare expansion, just under 22,000 Medicaid patients[7] in expansion states *died* while on a waiting list.

To maintain the integrity of the Medicaid program and help those it was created for, it is essential that work requirements be implemented strictly and intelligently. Thankfully, that is precisely what the CMS interim final rule does.

The Medical Frailty Impairment Test Is a Necessary Safeguard

We write in strong support of CMS's decision to institute a medical frailty impairment test. Under this rule, medical frailty status depends not only on whether an individual falls into one of the statute's five qualifying categories, but also on whether the underlying condition significantly impairs the individual's ability to meet the community engagement requirement. This is the single most important program-integrity decision in the rule, and we urge CMS to hold this position firmly against the challenges it will inevitably face.

---

[4] Paragon Health Institute, *Paragon Health Policy Survey 2025*, ParagonInstitute.org, https://paragoninstitute.org/medicaid/paragon-health-policy-survey-2025/

[5] Sydney Bradley, *Medicaid Patients Are Losing Doctors Because of Costs*, Newsweek, https://www.newsweek.com/medicaid-patients-are-losing-doctors-because-costs-1927849

[6] FGA, *supra* note [1]

[7] Foundation for Government Accountability, *Waiting for Help: The Medicaid Waiting List Crisis* (Mar. 2018), https://thefga.org/wp-content/uploads/2018/03/WAITING-FOR-HELP-The-Medicaid-Waiting-List-Crisis-07302018.pdf.

The statute identifies five categories of medical frailty: blindness or disability, a physical, intellectual, or developmental disability limiting activities of daily living, substance use disorder, a disabling mental disorder, and a serious or complex medical condition. Some commenters will argue that falling into one of these categories should be sufficient, on its own, to establish medical frailty, regardless of an individual's actual capacity to work, attend school, or otherwise engage with their community. This would defeat the purpose of the exemption Congress created – a safeguard established to protect those who simply cannot comply with the requirement. CMS's interpretation ties the exemption to its evident purpose.

Thankfully, CMS also creates an enforcement mechanism to ensure this interpretation has teeth. States are required to build auditable lists of qualifying conditions and are on notice that a frailty determination made with little to no support for the conclusion that a condition significantly impairs an individual's ability to comply will place the state out of compliance and expose it to financial penalty.

The rule requires states to rely on claims and encounter data no older than 12 months to ensure frailty determinations reflect an individual's current condition rather than an old diagnosis that may no longer describe their status.

Self-attestation is allowed only once, before January 2028, and only when claims data doesn't yet show the condition. After that, documentation is required at every renewal. This keeps self-attestation available as a temporary option – so people don't fall through the cracks – without turning it into a permanent substitute for real proof.

Further, the argument that CMS should treat a diagnosis alone as proof that someone cannot work carries its own troubling assumption that deserves scrutiny. To say that any individual with, say, a mental health condition, a substance use history, or a chronic illness is automatically incapable of working, volunteering, or attending school, regardless of their actual circumstances, is not a compassionate standard. Instead, it is a low expectation that will trap perfectly capable people in dependency cycles.

CMS's impairment test respects the individual by asking the relevant question – not "does this person have a qualifying condition," but "is this person actually unable to comply because of it." That is the more respectful, relevant standard, and we urge CMS to reject any suggestion that presuming incapacity from diagnosis alone is somehow the more humane approach.

Qualifying Community Engagement Activities Reflect Flexible, Workable Standards

The range of activities CMS has recognized as satisfying the community engagement requirement is reasonable, meeting beneficiaries where they are, while still holding the line on real, verifiable engagement.

The definition of work is appropriately broad. By counting paid work, in-kind work, and unpaid work such as internships or trial periods, CMS honors the goal of a program like this – self-sufficiency. The same is true of the decision to count self-employment and independent contracting. A decent share of the working population, especially at lower income levels, works outside conventional employer-employee arrangements, and a rule that ignored that reality would have distorted those essential labor market dynamics.

CMS also drew the right line on community service. Requiring that service be performed through a structured program with real oversight – a public agency or nonprofit that tracks hours and can confirm participation – ensures this pathway can't be reduced to unverifiable claims of informal

favors. Importantly, the rule also excludes partisan political activity from qualifying service. There is no justification for entangling taxpayer-conditioned benefits with campaign activity.

The work program and educational program pathways are also constructed well. Allowing job training programs already recognized under SNAP to count, while capping job-search activity at less than half of a program's hours, ensures productivity while defending against abuse. Likewise, treating half-time or greater enrollment in college, career and technical education, high school, or a GED program as automatically satisfying the requirement also meets productivity and verifiability goals.

Finally, the income-based pathway offers a sensible alternative for beneficiaries whose earnings already demonstrate self-sufficiency without the need for hour-by-hour tracking, and the seasonal-worker income-averaging provision rightly accounts for the reality that not all legitimate work is evenly distributed across the calendar year.

Taken as a whole, this framework gives beneficiaries achievable pathways to compliance while preserving the verification and oversight standards necessary to ensure the requirement functions as intended.

Program-Integrity Architecture Protects Taxpayer Dollars from Fraud

The verification and enforcement architecture CMS has built into this rule is exceptional. This is in keeping with its already great work in the past year cracking down on fraud, saving[8] taxpayers $42 billion.

A community engagement requirement is only as meaningful as its enforcement. CMS learned well from the 2017-2021 state demonstrations[9] and, in this rule, closes off the most likely avenues for both beneficiary-side gaming and state-side under-enforcement.

Most notable from a taxpayer-protection standpoint is CMS's insistence on data-first, ex parte verification. Requiring states to check payroll records, the Federal Data Services Hub, SNAP and TANF data, and the National Student Clearinghouse before ever asking a beneficiary for documentation does two things: it reduces the paperwork burden on people who want to comply and it removes the opportunity to simply assert compliance without a verifiable record behind it.

The rule's aforementioned definitional guardrails serve the same purpose. Requiring that community service occur through a structured program with a real point of contact and tracked hours closes off the most obvious way an individual could claim credit for hours that were never performed. Additionally, capping job-search activity at less than half of a work program's hours similarly prevents a program from becoming a job-search-only formality that produces paperwork but not engagement.

CMS's noncompliance procedures also deserve note. A 30-day window to make a satisfactory showing, followed by disenrollment when that showing isn't made, replaces the ambiguity that allowed earlier state demonstrations to avoid enforcing rules. By working to standardize what counts as "unable to verify" at application, at renewal, and during any more frequent, state-elected

---

[8] Americans for Tax Reform, *Fraudsters Should Be Scared by the CMS' New Approach*, ATR.org, https://atr.org/fraudsters-should-be-scared-by-the-cms-new-approach/

[9] Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KFF.org, https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

verification checks, CMS is closing the exact loophole – vague enforcement standards – that historically gave states cover to under-enforce a work requirement without violating it.

Importantly, CMS did not give states an open-ended excuse to delay implementation. States that request a good-faith-effort exemption from the January 2027 deadline must meet defined criteria, operate under a bounded duration, and submit quarterly reports for as long as the exemption lasts. This prevents "implementation difficulty" from becoming a permanent shield against enforcement.

Taken together, these provisions reflect a rule built to make work requirements stick. We urge CMS to preserve every element of this verification and enforcement framework, and to resist any pressure – through this comment process or otherwise – to loosen the standards that stand between this requirement and the kind of hollow, unenforced program Americans have become accustomed to.

CMS Rule Is Not Unduly Burdensome to States

Inevitably, commenters will argue this rule imposes an unreasonable administrative burden on states asked to implement a new eligibility requirement on a compressed timeline. However, the rule itself reflects a level of deliberate restraint that should ease those concerns.

First, CMS built this requirement on top of infrastructure states already operate rather than asking them to invent new systems. The definitions of work, work programs, and educational programs are drawn directly from existing SNAP and TANF regulations, and the verification approach leans on data sources states already use for those programs (the Federal Data Services Hub, payroll data, SNAP and TANF cross-matches, and the National Student Clearinghouse). States are simply being asked to extend systems and data-sharing relationships that are, in most cases, already in place and functioning.

Second, CMS declined to require states to stand up new programs. States are not required to create new work programs, new community service organizations, or new educational pathways. They are only required to recognize qualifying activity that already exists in their communities and to route beneficiaries toward existing SNAP Employment and Training program infrastructure where applicable.

Third, the rule preserves state discretion in the areas where local knowledge is most relevant. States decide which community service activities qualify in their communities, rather than being bound to a federal list. States retain the choice of whether to conduct compliance verification more frequently than at renewal. Institutions of higher education and schools determine enrollment status, sparing states from having to independently assess academic workload across every school and program a beneficiary could attend.

Fourth, CMS built in flexibility for states that need more time. The good-faith-effort exemption gives states facing implementation challenges a path to additional time. As mentioned, the rule does not allow for this to be an escape from accountability, as it comes with quarterly reporting and bounded duration, but it does reflect CMS's recognition that a January 2027 deadline may be easier for some states than others.

Finally, the ex parte verification requirement itself is a burden-reduction measure as much as a program-integrity one. By requiring states to check available data before requesting anything from beneficiaries, CMS reduces the volume of manual document review, individual outreach, and case-by-case adjudication states would otherwise face. If the rule had instead defaulted to beneficiary self-attestation and document submission, it would have created dramatically more administrative work than one that starts with data states already have on hand.

States with early implementation experience bear this out. Nebraska, for example, has already built a functioning framework – including a detailed[10] index of qualifying diagnosis and procedure codes for the medical frailty exemption – well ahead of the federal deadline, demonstrating that the operational demands of this rule are well within the administrative capacity of a motivated state Medicaid agency.

For these reasons, we do not believe the burden imposed by this rule is disproportionate to its purpose, and we urge CMS to reject calls to delay or dilute implementation on burden-related grounds.

Americans for Tax Reform urges CMS to finalize the Interim Final Rule on Medicaid Community Engagement Requirements. The rule's guidelines around community engagement activities, program-integrity architecture, and the medical frailty impairment test restore Medicaid's original intent, promote self-sufficiency, and save taxpayer dollars.

Onward,

Grover Norquist
President, Americans for Tax Reform

Isabelle Marchese
Director of Health Policy, Americans for Tax Reform

[10] Nebraska Department of Health & Human Services, *Nebraska Medicaid Work Requirements: Medically Frail Exemption Conditions Index*, https://dhhs.ne.gov/Documents/Nebraska%20Medicaid%20Work%20Requirements%20-%20Medically%20Frail%20and%20SUD%20Conditions.pdf