PHI QUALITY CARE THROUGH QUALITY JOBS

July 31, 2026

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC), 91 Fed. Reg. 33348 (June 3, 2026), as corrected at 91 Fed. Reg. 39028 (June 29, 2026)

Thank you for the opportunity to respond to the interim final rule with comment period (IFC), *Medicaid Program; Community Engagement Requirement for Certain Individuals*. These comments address the rule as revised by the June 29, 2026 correction, which republished §§ 435.557 and 435.558 in their entirety.[1] **PHI strongly opposes this IFC and urges CMS to withdraw it or supersede it with a substantially revised rule to minimize unnecessary coverage loss.** As detailed throughout these comments, the IFC makes a series of consequential and discretionary policy choices—several of which depart from the text of Public Law 119-21 (HR 1)—that will strip Medicaid coverage from working people, including many of the nation's direct care workers, through administrative challenges, burdens, and errors.

About us. PHI is a national organization committed to strengthening the direct care workforce by producing robust research and analysis, leading federal and state advocacy initiatives, and designing groundbreaking workforce interventions and models. For 35 years, we have brought a 360-degree perspective on the long-term care sector to our evidence-informed strategies. **As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.**

Summary. Approximately one-third of the nation's 5.4 million direct care workers—the home care workers, residential care aides, and nursing assistants who make the long-term services and supports (LTSS) system function—rely on Medicaid for their own health coverage.[2] Yet the strict provisions of this IFC place many of them at serious risk of losing coverage because of the characteristics of direct care jobs themselves: variable and unpredictable hours, multiple employers, decentralized home-based employment, sudden client-driven gaps in

work, high rates of occupational injury, and extensive unpaid family caregiving responsibilities.[3] The stakes of an erroneous determination are severe: individuals denied or disenrolled for noncompliance are treated as having minimum essential coverage and are therefore locked out of premium tax credits through the Health Insurance Marketplace—meaning they are likely to become uninsured.[4] By placing direct care workers at risk of losing coverage, the IFC's provisions will further destabilize this workforce and compromise access to care for the millions of older adults and people with disabilities who depend on it.

We have organized our recommendations in each section of these comments into two distinct levels: (1) revisions to the rule—provisions that should be changed, broadened, removed, or added in the regulatory text itself; and (2) CMS implementation—actions CMS should take, or refrain from taking, as these requirements come into force, including the guidance, technical assistance, and implementation plan review through which CMS should direct and support protective state implementation choices.

Our top recommendations are:

1. Withdraw or supersede the IFC after considering the complete comment record or, at a minimum, stay the disputed provisions and prohibit adverse actions until CMS has issued responsive revisions and states have demonstrated readiness to implement.

2. Conform the family caregiver and medically frail specified exclusions to the terms of the statute, including restoring the RAISE Act caregiver definition.

3. Require an ex parte verification sequence that determines applicability, specified exclusions and exceptions, income, and qualifying activities before requesting information or documentation from an individual.

4. Permanently require states to accept reliable information other than documentation where documentation does not exist or is not reasonably available and prohibit negative inferences from incomplete data.

5. Require public reporting on procedural outcomes, reinstatements, occupation, and LTSS workforce and access effects, coupled with corrective action.

Background on the Direct Care Workforce and Medicaid. Direct care workers are the foundation of our nation's LTSS system, providing essential hands-on assistance that enables older adults and people with disabilities to live with dignity, independence, and connection in their homes and communities and across residential and nursing home settings. This workforce comprises approximately 5.4 million workers—including home care workers, residential care aides, and nursing assistants—and is one of the fastest-growing occupational groups in the country.[5] Yet among other job quality challenges, direct care workers earn low wages and often lack access to employer-sponsored health insurance. As a result, approximately one-third of these workers rely on Medicaid for their own health coverage, and more than 10 percent have no health insurance at all.[6]

The characteristics of direct care jobs make this rule's design particularly harmful to direct care workers. Nearly two in five direct care workers work part-time, and hours can fluctuate widely in response to client needs—especially in home care, the largest and fastest-growing segment of this workforce.[7] Home care workers are vulnerable to sudden, unforeseeable employment gaps when a client is hospitalized, moves, or passes away, and all direct care workers face elevated risks of occupational injury that can require recovery time away from work.[8] Many workers hold multiple jobs across multiple employers; turnover is high; and home care employment is decentralized, which makes consistently documenting hours difficult even for workers who far exceed the 80-hour monthly threshold.[9] Twenty-five percent of direct care workers provide unpaid care to older adults and 29 percent have minor children at home.[10] Twenty-nine percent of direct care workers are immigrants and 17 percent report limited or no English proficiency.[11] Each of these characteristics makes the workforce especially vulnerable to barriers in successfully reporting their work hours under this rule's design.

Work Requirements Cause Coverage Loss Among Working People. Every state experience with Medicaid work requirements tells the same story: people lose coverage because of documentation problems, not because they are refusing to work.

In Arkansas, nearly 17,000 adults lost Medicaid coverage within months of implementation in 2018, and most of those who lost coverage were already working or qualified for an exemption.[12] When a federal court halted the program, coverage losses reversed and no employment gains ever materialized.[13]

In New Hampshire, two-thirds of those subject to the requirement were on track to lose coverage after just two months, forcing the state to suspend the program.[14] In Georgia, enrollment after two years remained a small fraction of the eligible population, while administrative costs ran roughly double what was spent on health care.[15] Across these and comparable programs, 25 to 50 percent of targeted enrollees lose benefits, with no meaningful employment effects.[16]

Work requirements can be particularly harmful for the direct care workforce. These workers are employed in essential jobs that the LTSS system cannot function without. When a working population is subjected to a documentation burden that its jobs are structurally ill-suited to satisfy, the resulting coverage losses are an avoidable failure of program design. The Congressional Budget Office estimates that the work requirement will reduce Medicaid enrollment by approximately 5.7 million people by 2034 (including 2.9 million who do not satisfy or cannot verify the requirement and 2.8 million who lose coverage because of additional application steps), while the Urban Institute estimates losses of 3 to 7 million depending on how states implement the policy.[17] In other words, the choices CMS makes on the questions addressed in these comments will determine, within a range of millions of people, how many Americans lose the health coverage to which they are entitled.

CMS Should Reconsider Its Discretionary Policy Choices and Delay Adverse Actions Until It Has Considered the Public Record. The rule takes effect on July 31, 2026, the same day the public comment period closes. As a result, states will be obligated to implement the program according to the IFC's terms before CMS has considered comments on a lengthy, technical rule that makes numerous consequential, discretionary policy choices extending well beyond straightforward implementation of HR 1. While Congress authorized CMS to issue an interim final rule on an expedited basis, nothing requires the agency to resolve every discretionary question against coverage before considering public input.

The timeline compounds the problem. States must implement the requirements by January 1, 2027, barely seven months after the rule's publication.[18] Standing up new eligibility processes, data matching, verification workflows, notices, and reporting systems on this schedule all but guarantees rushed systems, inaccurate data matching, and improper disenrollments. In addition, several governors have indicated the IFC departed materially from CMS's preliminary guidance and from

months of communications on which state Medicaid agencies relied in their implementation planning.[19]

Recommendations—revisions to the rule: CMS should withdraw or supersede the current IFC after considering the public comments. At minimum, CMS should stay the effective date of the disputed provisions and prohibit adverse actions under them until it issues responsive revisions.

Recommendations—CMS implementation: CMS should issue implementing guidance and technical assistance quickly; liberally approve good-faith-effort exemption requests under § 435.560; and not penalize states that cannot responsibly meet the timeline. Through its review of state implementation plans, CMS should also direct states to demonstrate that applicability screening, exclusion identification, and ex parte verification are functioning before any noncompliance action is taken; require end-to-end testing before adverse actions; and direct states to document their good-faith efforts contemporaneously in support of exemption requests.

CMS Should Explicitly Account for the Direct Care Workforce.

Nowhere does the IFC acknowledge that among the "applicable individuals" subject to this requirement are millions of workers whose labor underpins Medicaid's own LTSS programs. Direct care workers support older adults and people with disabilities with the daily activities that make health, independence, and community living possible. And their work is predominantly financed by Medicaid itself: direct care workers are the bedrock of Medicaid-funded LTSS, even as this rule places their own Medicaid coverage at risk. When these workers lose health coverage, research and experience show the consequences ripple outward: workers' untreated health conditions worsen; injured or ill workers leave the field; recruitment and retention—already at crisis levels—deteriorate further; and LTSS consumers experience care gaps and unmet needs.[20] Coverage loss among direct care workers is thus not only a harm to workers but a direct threat to access to care for Medicaid's core populations, and to the state LTSS systems that CMS oversees.

Recommendations—revisions to the rule: CMS should amend the rule to make LTSS workforce impacts a required element of state implementation planning under §§ 435.559 and 435.560, and to include occupation and industry data among the required reporting elements under § 435.562.

Recommendations—CMS implementation: CMS should issue guidance and technical assistance to help states identify direct care workers within existing data sources (including EVV data, Medicaid-participating agency payroll data, fiscal intermediary data, and managed care and LTSS program data) and should assess LTSS workforce effects as part of its own monitoring and evaluation of this rule. CMS should further direct states, through implementation plan requirements, to identify segments of their caseloads with high concentrations of direct care workers at the outset; to consult LTSS agencies, providers, worker organizations, and consumers in implementation planning; and to track LTSS workforce and access effects as implementation proceeds.

States Should Screen for Non-Applicability Before Assessing Compliance (§ 435.551). Before any compliance question arises, states must correctly determine who is an "applicable individual."[21] The requirement applies only to adults ages 19 through 64 enrolled through the expansion group or certain section 1115 demonstrations who are not pregnant or postpartum, not enrolled in or entitled to Medicare, and not eligible through another mandatory eligibility group. Many direct care workers will fall outside the requirement on one or more of these grounds. As one example, one in ten direct care workers is age 65 or older and should be automatically identified as not subject to the requirement, rather than asked to prove compliance.[22] Yet, rushed implementation risks states routing everyone enrolled in the adult group into community engagement verification by default.

Recommendations—revisions to the rule: CMS should require states to determine, ex parte and before any compliance assessment, whether an individual is properly classified as an applicable individual, including whether available information indicates potential eligibility through another Medicaid pathway.

Recommendations—CMS implementation: CMS should require state implementation plans to describe the applicability-screening step and its data sources and should monitor the share of individuals routed into compliance verification who are later found non-applicable. CMS should also direct states to build applicability screening as the first step in their processes and should prohibit states from sending community engagement notices to individuals whose case records already indicate a basis for non-applicability.

Build on the Income Pathways Already in the Rule (§ 435.552). Many direct care workers will meet the 80-hour requirement every month yet struggle to prove it. Inconsistent monthly hours, multiple jobs and employers, decentralized home care employment, high turnover, and short-term gaps caused by client needs or health-related absences all make hours-worked documentation unreliable for this workforce even when in full compliance.[23]

The IFC offers part of the solution, and we urge CMS to build on this strength. The rule provides that an individual whose verified monthly household Modified Adjusted Gross Income (MAGI)-based income exceeds $580 has met the requirement through income alone; it permits income below $580 to serve as a proxy for hours; and it allows seasonal workers to demonstrate compliance based on average monthly income over the preceding six months.[24] These income pathways use verification infrastructure states already operate and should be the primary route to confirming compliance for working people. Income-first verification would deem the great majority of direct care workers compliant without requiring them to submit extra documentation.

Recommendations—revisions to the rule: CMS should require states to first check whether verified household MAGI-based income more than $580 per month before requesting any hours documentation. CMS should also require states that have elected a reasonably predictable changes methodology under § 435.603(h)(3) to apply that methodology consistently when determining income for community engagement purposes and should encourage additional states to elect it. The rule should preserve the income-to-hours proxy below $580 and make that conversion mandatory whenever it would benefit the individual and when reliable hours information is unavailable. CMS should also require aggregation of all qualifying activities, including unpaid caregiving that constitutes qualifying unpaid work when the individual has not already been identified as a specified excluded family caregiver.

Recommendations—CMS implementation: CMS should issue workflow guidance and systems specifications for income-first verification; clarify aggregation rules across multiple employers and activity types; provide model calculations for the income-to-hours conversion and reasonably predictable changes methodologies; and encourage states to adopt those methodologies for workers with variable income. CMS should also use its implementation plan review to confirm that states configure eligibility workflows to check income before hours; aggregate hours across employers using wage, payroll, and EVV

data; and design reporting channels that allow workers to combine partial activities without navigating multiple disconnected processes.

Non-Applicability, Exclusions, and Exceptions Should Be Applied Automatically and Broadly (§§ 435.551, 435.554–435.555). PHI supports broad, automatic identification of individuals who are not applicable, are specified excluded individuals, or qualify for an exception or deemed-compliance pathway. Direct care workers may fall within these categories through distinct provisions addressing family caregiving, medical frailty or disability, parenting, satisfaction of specified Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) work requirements, and short-term hardship, among others. For example, more than a quarter of direct care workers are enrolled in SNAP, making accurate SNAP data matching particularly consequential.[25]

We also note, and strongly support, the IFC's own requirements on this point. Section 435.557(c)(2), as corrected, provides that the agency "must determine that an individual is a specified excluded individual whenever the agency has sufficient information to determine the individual qualifies as such, regardless of whether the individual also demonstrates community engagement… ."[26] This is exactly right: employment and exclusion status are not mutually exclusive. A home care worker who also cares for their disabled mother should be excluded as a family caregiver—automatically, based on information the state already holds—not funneled into monthly hours documentation because they happen to also work. We likewise support the corrected rule's requirements that individuals be enrolled promptly while potential exclusions are verified post-enrollment (§ 435.557(c)(3)), and that verified exclusion status not be re-verified between regularly scheduled redeterminations absent information indicating a change (§ 435.557(d)(4)).[27]

Recommendations—revisions to the rule: CMS should preserve § 435.557(c)(2), (c)(3), and (d)(4) as written; extend the same exclusion-first principle expressly to medically frail determinations; and add an explicit prohibition on requiring individuals to document information the agency already possesses or can obtain through data matching.

Recommendations—CMS implementation: CMS should publish guidance cataloging the data sources states can use for automatic identification—e.g., SNAP and TANF program data, claims and encounter data, home and

community-based services (HCBS) waiver enrollment, Social Security Administration data, and the LTSS-specific sources identified above—and should monitor rates of non-applicability, specified exclusion, and each exception or deemed-compliance pathway, flagging states for corrective action where rates fall well below expected prevalence. CMS should also use its implementation plan review to confirm that applicability and exclusion screening run before any compliance verification; that states use all available program data with appropriate accuracy safeguards; and that verified exclusions are carried forward across compliance periods rather than re-verified when stable or permanent.

The Family Caregiver Exclusion Departs from the Statute and Should Be Fixed (§§ 435.554, 435.557). One-quarter of direct care workers provide unpaid care to older adults—many of whom have disabilities or functional limitations and who would qualify as "disabled individuals" under the rule's Americans with Disabilities Act (ADA)-based definition—compared with 19 percent of the total U.S. labor force.[28] The direct care workforce is thus disproportionately comprised of exactly the family caregivers Congress chose to protect.

The IFC narrows the statutory definition. HR 1 excludes family caregivers "as defined in section 2 of the RAISE Family Caregivers Act" of a dependent child or disabled individual.[29] PHI does not dispute that CMS may align the care-recipient population with the statute's reference to dependent children age 13 and under and disabled individuals, but the IFC goes well beyond that: it adds three gatekeeping criteria that appear nowhere in the RAISE Act definition or in HR 1. Under the rule, a caregiver qualifies only if the caregiver (1) primarily resides with the care recipient, (2) is a relative of the care recipient, or (3) neither resides with nor is related to the recipient but provides at least 80 hours of assistance per month.[30] All three pathways require that assistance be "not solely incidental" in nature, and the first two require that it occur "on a regular basis"—qualifiers that likewise appear nowhere in the statutory text.

Congress incorporated the RAISE Act definition as a whole and did not authorize CMS to replace the Act's express inclusion of an "other individual" with new kinship, co-residence, or hours thresholds. Where Congress has spoken by cross-referencing a specific statutory definition, CMS is not free to add eligibility criteria Congress did not impose; the agency's stated concern with avoiding overbroad application of an exclusion Congress itself created is not a lawful basis for rewriting that exclusion. The departure is all the more striking because CMS's

own December 2025 guidance told states that family caregivers would be excluded using the RAISE Act definition; states, providers, and caregivers have relied on that representation.[31]

The verification framework compounds the problem. Unpaid caregiving is largely invisible to state data systems: there is no wage record, no employer, and frequently no documentation at all of the care that a family caregiver provides. Yet the IFC does not permanently require states to accept self-attestation of caregiver status, leaves verification pathways largely unspecified, and will generally require documentation beginning January 1, 2028, for a status for which documentation typically does not exist. The IFC separately requires states to verify the monthly hours of non-resident, non-relative caregivers, importing an hours-documentation burden into an exclusion category.

The definitional mismatch creates internally inconsistent results. The IFC defines the "disabled individual" receiving care using the ADA disability definition, while the separate medically frail exclusion requires that a condition "significantly impair" the individual's ability to comply with the requirement.[32] A direct care worker could therefore be excluded as the caregiver of a person with a disability while the very person he or she cares for—if enrolled through the expansion group—fails the medically frail test and remains subject to the requirement. Nothing in the statute compels this incoherence.

Recommendations—revisions to the rule: CMS should delete § 435.554(c)(3)(i)(A)–(C) and apply the family-caregiver definition in § 435.554(a) without the added residence, familial-relationship, regularity, incidental-nature, and 80-hour conditions. The rule should permanently require states to accept reliable information other than documentation, including self-attestation, and should specify in regulatory text the range of acceptable verification sources (including care recipients, health care providers, HCBS case managers, managed care plans, employers, fiscal intermediaries, and community-based organizations).

Recommendations—CMS implementation: CMS should issue model attestation forms and verification guidance recognizing the full range of verifiers above; should decline to approve state verification procedures that require caregivers to repeatedly re-prove the same caregiving role; and should monitor caregiver-exclusion denial rates as an early indicator of improper implementation. CMS should further direct states to treat self-attestation as the

default pathway for this exclusion; to flag verified caregiver status in eligibility systems so that it persists across compliance periods; and to use ex parte data from sources such as HCBS programs and fiscal intermediaries to identify family caregivers—including the many direct care workers who serve as a paid caregiver for one person and an unpaid caregiver for another.

The Medically Frail Exclusion Exceeds the Statute and Should Be Fixed (§ 435.554). HR 1 defines the medically frail exclusion through five distinct categories, including individuals with "a serious or complex medical condition."[33] Congress used a significant-impairment concept in one subcategory addressing limitations in activities of daily living but did *not* apply an ability-to-comply test to the other categories, including serious or complex medical conditions and substance use disorders.[34] The IFC nonetheless defines a medically frail individual as one "whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement" *and* who falls within a statutory category—layering an inability-to-comply test over the entire definition and emphasizing that a diagnosis alone is never sufficient.[35]

This approach contravenes the statute and is unworkable in practice. As leading Medicaid legal scholars have detailed, the rule "contravenes the clear terms of the statute," strips out the law's built-in guardrails, and imposes an evaluation burden on state Medicaid agencies that are not disability determination agencies and on safety-net clinicians who are not trained in occupational medicine.[36] Medicaid medical directors have recommended that medical frailty determinations rest on clinical criteria rather than an ill-defined ability-to-work assessment.[37] More than 40 percent of Medicaid enrollees ages 40 to 64 live with serious health limitations, yet fewer than 40 percent of non-working enrollees with such limitations receive Supplemental Security Income (SSI)—meaning millions of people with serious conditions will be forced to go through individualized impairment assessments.[38]

This is particularly harmful to direct care workers, who experience elevated rates of occupational injury and chronic health conditions.[39] Meanwhile, LTSS consumers themselves are at risk: expansion enrollees receiving HCBS are not clearly excluded under the rule and would face individualized frailty determinations—and roughly one in ten HCBS users under age 65 is enrolled through the expansion group.[40] Coverage loss among LTSS consumers compounds the instability of the workforce that serves them.

Recommendations—revisions to the rule: CMS should delete the "significantly impairs" test, at minimum as applied to the "serious or complex medical condition" category, and ground determinations in clinical criteria as the statute provides. The rule should deem existing disability determinations sufficient to establish medical frailty where the individual is otherwise subject to the requirement and should deem receipt of Medicaid-covered HCBS or state plan personal care services sufficient evidence of special medical needs or functional limitations warranting exclusion. The rule should authorize diagnosis-based state condition lists with individualized review available as a supplement rather than the default and should resolve the definitional mismatch between the ADA-based caregiver exclusion and the medically frail standard.

Recommendations—CMS implementation: CMS should create a rapid review pathway and model templates for state diagnosis-based condition lists and clarify in guidance that states should identify medically frail individuals ex parte using claims and encounter data. Through guidance and implementation plan review, CMS should also promote broad, clinically grounded state diagnosis lists; the use of claims and encounter data to identify qualifying conditions before contacting individuals; alignment of frailty and caregiver screening so that households are assessed once rather than serially; and provider-documentation pathways that minimize burden on safety-net clinicians.

Short-Term Hardship Exceptions Should Be Universal and Automatic (§ 435.555). The rule's short-term hardship exception is optional for states, though a state that elects it must make all statutory hardship categories available rather than picking among them.[41] This exception matters distinctly for direct care workers, whose compliance may be interrupted by exactly the events the statute contemplates: their own occupational injuries and health episodes, inpatient care, and extended travel for medical treatment (for themselves or the family members they care for).

Recommendations—revisions to the rule: CMS should make the short-term hardship exception mandatory.

Recommendations—CMS implementation: CMS should strongly encourage all states to elect the exception, promptly approve unemployment-based hardship requests, and provide model processes that keep medical and similar-acuity hardship requests simple and non-document-intensive. CMS should also direct electing states to design the request-based hardship categories

so that a hospitalized worker, or one traveling for treatment, is not asked to assemble paperwork mid-crisis.

Verification: Ex Parte First and No Documentation Cliff (§§ 435.556, 435.557). PHI strongly supports robust ex parte verification and agrees with the IFC's general instruction that states must attempt to verify applicability, compliance, exceptions, and specified excluded status through reliable available data before requesting documentation from individuals.[42] Worker-submitted documentation should never be the primary verification mechanism: direct care workers face barriers of time, technology access, literacy and language access, and complex employment arrangements, and the Arkansas experience demonstrates how quickly reporting burdens translate into coverage losses among eligible people.[43]

Our central concern is the rule's phased verification framework. Through December 31, 2027, states have flexibility to accept self-attestation and other information, but beginning January 1, 2028, states generally must require documentation whenever it is "reasonably available."[44] We acknowledge that the corrected § 435.557 requires states to accept reliable information other than documentation where documentation is not reasonably available, and prohibits denying or terminating eligibility solely because an individual cannot produce documentation where none exists.[45] But the same provision permits states to establish their own criteria for what information is "sufficient" in documentation's absence, and leaves "reasonably available" undefined. For the circumstances most common in direct care (e.g., variable-hour work across multiple employers, unpaid family caregiving, and informal employment arrangements), documentation frequently does not exist at all, and there is a substantial risk that state-defined sufficiency criteria will resolve undocumented caregiving and informal work against coverage. The corrected rule states the right principle, but it should be permanent, prominent, and generously applied.

Recommendations—revisions to the rule: CMS should permanently require states to accept reliable information other than documentation whenever documentation does not exist or is not reasonably available—expressly including variable-hour work, family caregiving, and informal employment. The rule should require states to exhaust all reliable data sources (including Medicaid, SNAP and TANF, unemployment insurance, payroll, EVV, fiscal intermediaries, and managed care and LTSS programs) before contacting the individual; should provide that missing or inconclusive data triggers outreach rather than a

noncompliance finding; and should require, or at minimum strongly encourage, states to elect the one-month minimum compliance period at application and renewal.[46] Two related clarifications belong in the rule as well. First, while LTSS data sources such as EVV should be used to verify compliance and exclusions, missing or incomplete LTSS data (including absence from EVV records) should not be treated as evidence of noncompliance, because EVV does not capture all direct care work, all settings, all payment arrangements, or all compensable hours. Second, a longer compliance period should not convert an ordinary client-driven employment gap into a coverage termination for a worker whose client was hospitalized or passed away.

Recommendations—CMS implementation: CMS should accelerate development of federally available data; broker state access to payroll and wage data sources; set and monitor ex parte match-rate expectations; review state verification plans under § 435.945(j) for the adequacy of the data sources identified; and make explicit in guidance that a failed data match is a data problem to be addressed through outreach rather than an automatic basis for a noncompliance notice. CMS should also discourage states from electing verification more frequent than renewal and should expect any state electing longer application review periods or more frequent verification to first demonstrate high ex parte match rates, multiple reporting modalities, and safeguards against adverse action based on missing or stale data. Where states do elect more frequent verification, CMS should hold them to the corrected rule's requirement to re-check exclusion status before each compliance assessment (§ 435.557(d)(2)).[47] In reviewing state verification plans, CMS should also expect states to build the full data-source hierarchy identified above before launch and to adopt safeguards against acting on outdated or inaccurate matches.

Noncompliance Procedures Should Protect Eligible People from Procedural Disenrollment (§ 435.558). The evidence reviewed above shows that the dominant harm of work requirement programs is procedural disenrollment of eligible, working people. The IFC's noncompliance architecture will determine whether that history repeats at a national scale. We note with appreciation the rule's clarifications that a notice of noncompliance is not a final determination, that individuals must remain enrolled during the 30-day response period, that states must evaluate all other bases of eligibility before termination, that states may not restrict reapplication after a denial or termination, and that disenrolled individuals who later submit the requested information receive a

reconsideration period.[48] But the rule also permits states, at renewal or more frequent reviews, to issue noncompliance notices immediately upon a failed data match, rather than first seeking information through the renewal process—a choice that will generate avoidable notices, confusion, and terminations.[49]

Missing a notice, failing to navigate a portal, or lacking a pay stub should not cost a direct care worker their health coverage. In Arkansas, that is precisely what happened to people who were working.[50]

Recommendations—revisions to the rule: CMS should require (not just permit) states to seek information through renewal processes and existing verification procedures before issuing a notice of noncompliance. The rule should require terminations to pause whenever an individual submits partial information, requests assistance, or indicates possible eligibility for an exclusion or exception; and should require states to report procedural disenrollments separately from substantive noncompliance. The rule should also require multiple notices across modalities before any adverse action is taken, and require states to offer phone, paper, online, and in-person channels for reporting and for responding to notices.

Recommendations—CMS implementation: CMS should publish model plain-language notices in multiple languages; monitor procedural disenrollment rates with defined corrective-action triggers; and decline to approve state processes that send noncompliance notices automatically upon data match failures. CMS should also direct states to train eligibility staff to treat partial submissions as engagement rather than noncompliance, and to build reinstatement and reconsideration processes that operate quickly and reliably.

Outreach and Assistance Should Reach Direct Care Workers Where They Are (§ 435.561). Outreach is essential to preventing improper coverage loss, and the population at issue here is distinctly hard to reach through general-purpose channels. Many direct care workers hold multiple jobs and have limited time to navigate complex eligibility systems; many, as noted above, are immigrants or have limited English proficiency; about half have a high school education or less; and home care workers in particular are disconnected from centralized employment systems (so there is no single worksite through which to reach them).[51] We support the rule's requirements that outreach begin before implementation, use mail plus at least one additional modality, and explain exceptions, exclusions, and the consequences of noncompliance.[52]

Recommendations—revisions to the rule: CMS should establish minimum outreach standards in regulatory text—covering frequency, modalities, language access, and accessibility for people with disabilities—rather than leaving these wholly to state discretion. CMS should also require states, as part of their implementation plans, to develop targeted outreach plans for direct care workers and other low-wage working populations.

Recommendations—CMS implementation: CMS should fund and disseminate model multilingual materials that clearly explain who is and is not subject to the requirement; provide toolkits for trusted-messenger partnerships; and treat the adequacy of state outreach as a condition of implementation readiness. CMS should also direct states to partner with the trusted messengers who already reach direct care workers (e.g., employers, unions, worker organizations, fiscal intermediaries, training programs, and community-based organizations) and to deliver outreach in multiple languages and in both digital and non-digital formats, beginning well before implementation and continuing throughout the year.[53]

Implementation Timing, Readiness, and Good-Faith Exemptions (§§ 435.559, 435.560). No one should lose coverage because a state's systems were not ready. The compressed timeline discussed above makes system failures a near-certainty in at least some states: eligibility system changes of this magnitude ordinarily take years, and the experience of states such as Pennsylvania confirms that even well-resourced agencies are racing to redesign applications, renewal processes, and caseworker workflows on this schedule.[54] The statute's good-faith-effort exemption exists precisely for this situation, and CMS's own criteria appropriately look to state efforts, barriers, and remediation plans.[55]

Recommendations—revisions to the rule: CMS should condition any adverse action against Medicaid beneficiaries on demonstrated operational readiness (e.g., functioning ex parte verification systems, accessible reporting channels in multiple modalities, and adequate outreach) and should codify expansive good-faith-effort exemption standards with clear readiness benchmarks in required state implementation plans.

Recommendations—CMS implementation: CMS should review state implementation plans rigorously and withhold sign-off where systems are not demonstrably working; grant good-faith exemptions liberally, particularly for the first compliance cycles; publish its readiness criteria so states are clear on

expectations; and refrain from compliance actions against states that delay adverse actions in order to protect eligible enrollees. Because states are simultaneously racing to meet the operability deadline, CMS should provide implementation plan templates and technical assistance so that planning requirements support states' good-faith exemption requests rather than functioning as an additional compliance exercise. CMS should also require states to test their systems end-to-end (including data matching accuracy, notice generation, and reporting channels) before taking any compliance action; to phase in verification before enforcement; and to request good-faith exemptions early, documenting readiness gaps as they arise rather than after harm occurs.

Monitoring, Reporting, and Evaluation (§ 435.562). Aggregate enrollment reporting will not reveal whether this rule is working as Congress intended or failing the way every predecessor program has failed. The IFC's data requirements—covering enrollment totals, processing timeliness, determination outcomes, and populations subject to the requirement—are a start, and we support CMS's stated intention to require corrective action where reported outcomes suggest compliance problems.[56] But the reporting framework must be specific enough to detect procedural disenrollment of eligible people and disaggregated enough to detect concentrated harm to identifiable workforces and communities.

Recommendations—revisions to the rule: CMS should codify a complete reporting set including: (1) the number of individuals subject to the requirement; (2) the number deemed compliant by pathway; (3) the number of exclusions by category, including the family caregiver and medically frail categories; (4) procedural versus substantive disenrollments; (5) reinstatements following appeal, reapplication, or late submission; (6) demographic data including race, ethnicity, age, gender, disability status, and language; (7) occupation or industry data where available, including direct care categories; and (8) LTSS access indicators such as workforce shortages, service disruptions, and unmet need. For each relevant outcome, states should report both counts and denominators sufficient to calculate the ex parte verification rate, notice rate among people subject to verification, procedural denial and termination rate, reversal or reinstatement rate, and median time to reinstatement, disaggregated by verification pathway and relevant demographic category. Occupation and industry data should be obtained through secure linkage to wage, payroll, EVV, or other administrative records where feasible, with de-identified aggregate

reporting, and should not be required from applicants as a condition of eligibility. The rule should require public reporting and post-implementation third-party evaluation, with mandatory corrective action where implementation reduces coverage among working people or worsens LTSS workforce shortages.

Recommendations—CMS implementation: CMS should publish state data promptly and in comparable formats; act on corrective-action triggers rather than treating reporting as an archive; include direct care workforce and LTSS measures in its own evaluation; and provide resources to support states in meeting reporting requirements. CMS should also encourage states to publish public dashboards; track ex parte verification, notice, procedural termination, reversal or reinstatement, and time-to-reinstatement rates—not just raw disenrollment counts; and build occupation and industry data linkages into implementation from day one so that erroneous terminations and concentrated workforce effects are visible and corrected.

The Regulatory Impact Analysis Overstates Benefits and Ignores Costs. The IFC's regulatory impact analysis does not reflect the reasoned assessment of benefits and costs that federal rulemaking standards require. The high-impact scenario assumes that 4.4 million people will newly engage in work or community activities because of the rule and monetizes the resulting income and tax gains, resting on an accompanying analysis of a small set of welfare-to-work studies—studies of programs that included job search assistance, subsidized employment, childcare, and transportation supports that this rule completely lacks. Independent analysts have criticized the assumptions and evidentiary basis of that analysis, and the far more relevant evidence base—SNAP work requirements nationally and Medicaid work requirements in Arkansas—shows no significant employment effects.[57] Meanwhile, CMS projects Medicaid enrollment reductions of 3.1 to 3.3 million in subsequent years, while Congressional Budget Office (CBO) estimates that approximately 5.7 million people will lose Medicaid coverage by 2034 and that the uninsured population will increase by 5.3 million. CMS's own estimates also identify $551.7 million in annual beneficiary paperwork burden—$454.8 million at renewal and $96.9 million for applicants—before counting other state and beneficiary burdens estimated elsewhere in the IFC.[58]

The analysis also omits entire categories of cost: lost access to care among those disenrolled; estimated preventable higher-cost service use and avoidable mortality; the financial strain on safety-net providers; new provider

documentation burden associated with the medically frail rule; and the Marketplace subsidy lockout that converts Medicaid disenrollment into uninsurance.[59] And nowhere does the analysis consider the LTSS-specific consequences that are PHI's central concern: increased uninsurance among direct care workers, higher turnover and worsened recruitment in an already-strained workforce, deepening LTSS shortages and unmet need among older adults and people with disabilities, greater reliance on emergency departments and institutional care, and administrative burden on the employers, fiscal intermediaries, and community organizations that hold this system together.

Recommendations—revisions to the rule: CMS should withdraw and redo the regulatory impact analysis: replace the current welfare-to-work extrapolations with the directly relevant evidence base; adopt coverage-loss estimates consistent with CBO and the broader literature; and account for downstream costs to the health care system, the LTSS workforce, and state economies, including the effects of the Marketplace subsidy lockout.

Recommendations—CMS implementation: CMS should commit to publishing updated impact estimates as implementation data accrue, disaggregated by occupation and by procedural versus substantive disenrollment. CMS should also encourage states to assess the fiscal and LTSS-system impacts of coverage loss on their own budgets and delivery systems, where the costs this analysis omits will otherwise land unmeasured.

Conclusion. Direct care workers are already engaged in essential work—work that the Medicaid program itself depends on. The reality this IFC would create is direct care workers losing health coverage because of administrative barriers, definitional overreach, and premature implementation, not because they are failing to work or to contribute to their communities. And because individuals who lose Medicaid under this rule are locked out of Marketplace premium tax credits, and because states cannot simply waive the requirement, the guardrails CMS builds into this rule and its implementation are the only meaningful protection these workers will have.

We therefore urge CMS to withdraw or supersede the IFC and, at minimum, revise its discretionary provisions before any adverse action occurs. CMS should conform the caregiver and medically frail exclusions to the statute; require applicability-, exclusion-, and income-first verification; permanently accept reliable information where documentation is unavailable; require renewal-based

outreach before noncompliance notices; condition adverse actions on operational readiness; and require complete, disaggregated reporting with corrective-action triggers. If implementation proceeds, CMS should provide states with the data, guidance, model materials, and technical assistance necessary to protect coverage; approve good-faith-effort exemptions liberally; and direct states to maximize automatic determinations, minimize documentation demands, use trusted messengers, and monitor direct care workforce effects.

Without the protections described above, the rule will deepen workforce shortages, increase unmet need, and further destabilize already strained care systems. For the direct care workforce—and for the millions of older adults and people with disabilities who depend on it—CMS should use its full authority to prevent that outcome.

PHI appreciates the opportunity to provide these comments. If implementation proceeds despite these objections, PHI stands ready to help CMS and states protect coverage for direct care workers and preserve access to long-term services and supports.

Notes.

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