MASSACHUSETTS Health & Hospital ASSOCIATION

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July 31, 2026

Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2449–P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-2454-IFC, Medicaid Program; Community Engagement Requirement for Certain Individuals. RIN: 0938-AV98

Dear Secretary Kennedy and Dr. Oz:

The Massachusetts Health & Hospital Association (MHA), on behalf of our member hospitals, health systems, physician organizations, and allied healthcare providers, appreciates the opportunity to offer our perspective regarding the interim final rule (IFR) implementing new community engagement requirements as condition for Medicaid eligibility.

MHA serves as the unified voice for Massachusetts hospitals in public advocacy with both state and federal government. Our members include 76 licensed hospitals, many of which are organized in healthcare systems. Massachusetts hospitals provide medically necessary care to all community members regardless of income or background. MHA members represent the full spectrum of hospitals in Massachusetts, including safety net hospitals, disproportionate share hospitals, academic medical centers, specialty hospitals, community hospitals, critical access hospitals, and long-term care hospitals. All participate in the MassHealth program, which serves approximately 1.9 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

We are concerned that the IFR rule would harm the health and welfare of the communities our members serve and destabilize the commonwealth's healthcare system. Further, at a time when HHS and CMS are actively seeking to identify and eliminate duplicative, outdated, and unnecessarily burdensome requirements to reduce healthcare costs and enable providers to focus on patient care, the IFR, as drafted, runs counter to these efforts by imposing significant new compliance, documentation, reporting, and operational obligations that will increase administrative costs and divert limited resources away from the delivery of care.

We respectfully urge CMS to withdraw or substantially revise the IFR and work with states and stakeholders to develop an approach that preserves continuous access to healthcare, minimizes unnecessary administrative burdens, and provides states with the flexibility needed to implement any community engagement requirements in a manner that minimizes administrative burden and protects eligible individuals and the healthcare systems that serve them.

Consequences to Healthcare Access, Costs and Delivery

The proposed requirements would impose significant administrative burdens on states, beneficiaries, healthcare providers, and managed care organizations. In Massachusetts, these burdens are likely to increase program costs, disrupt health coverage for eligible individuals, and shift costs throughout the healthcare system without sufficient evidence that the requirements will improve health outcomes, employment, or program integrity.

Massachusetts has long been recognized as a national leader in expanding health insurance coverage and designing efficient Medicaid administration. Through MassHealth, the commonwealth has invested heavily in streamlining eligibility, coordinated care, enrollment and renewal processes, and policies intended to minimize unnecessary administrative barriers to coverage. The IFR moves in the opposite direction by requiring states to establish new eligibility verification systems, monitor ongoing compliance with community engagement requirements, process exemptions and hardship requests, conduct extensive beneficiary outreach, maintain new documentation systems, issue additional notices, manage appeals, and submit expanded reporting to CMS within short timeframes and multiple times a year.

New Requirements Increase Administrative Burden and Disrupt Access to Care

Implementing these requirements would require healthcare providers to devote substantial administrative resources to activities that do not directly improve access to healthcare and, instead, take more dedicated time away from caring for patients and their families. Modifying information technology systems; training financial counselors; expanding capacity to support information-sharing, enrollment, and verification processes; increasing member support; and collecting, monitoring, and reporting data to CMS on an ongoing basis requires significant investments in staff time, technology, and financial resources.

The Kaiser Family Foundation (KFF) reported that implementation of Medicaid work and community engagement requirements requires "complex changes to eligibility and enrollment systems and processes." KFF further explains that states must build new verification systems, conduct extensive beneficiary and provider outreach, develop compliance monitoring procedures, revise notices, coordinate with managed care organizations, and manage ongoing reporting obligations. KFF also notes that states face limited administrative capacity, staffing constraints, and significant operational challenges associated with implementing these requirements. These findings underscore that the primary impact of the rule is not simply a policy change, but the creation of a substantial new administrative infrastructure.

These concerns are particularly important in Massachusetts, where MassHealth provides coverage to approximately one-quarter of the state's residents. The commonwealth serves a diverse population that includes individuals working multiple part-time jobs, seasonal workers, caregivers, people with

chronic medical conditions, individuals receiving behavioral health services, and residents whose employment or housing circumstances fluctuate throughout the year. Many of these individuals may ultimately satisfy community engagement requirements or qualify for exemptions, yet they would still be required to navigate new reporting and documentation requirements on a frequent basis.

Experience from previous Medicaid work requirement demonstrations suggests that administrative complexity itself becomes a barrier to maintaining coverage. Individuals may lose health insurance not because they fail to meet community engagement expectations, but because they misunderstand reporting requirements, miss deadlines, experience technical difficulties, fail to receive notices, cannot obtain required documentation, or encounter delays in state processing. In these circumstances, coverage losses are procedural rather than substantive, yet the consequences for beneficiaries are significant.

The administrative burden the IFR imposes is therefore likely to increase the number of uninsured and underinsured individuals in Massachusetts. Even relatively small increases in procedural disenrollment could result in thousands of residents experiencing interruptions in coverage. While some individuals may later regain eligibility, gaps in insurance coverage frequently disrupt access to primary care, prescription medications, behavioral health treatment, preventive services, and management of chronic conditions. Many individuals instead become uninsured or enroll in plans with significantly higher deductibles and out-of-pocket costs that leave them effectively underinsured. Both outcomes increase financial barriers to healthcare and reduce access to timely medical treatment.

Exemption Process for Determining Medical Frailty Strays from Congressional Intent, and Will Lead to Inconsistent Application and Undue Administrative Burden

While we appreciate the inclusion of exemptions for certain vulnerable populations, we are concerned that the process to determine whether someone is medically frail or has special medical needs that significantly impair their ability to comply with the requirement places significant and undue burdens on providers and does not function the way Congress intended.

Medical frailty is not a marginal category in this population. It encompasses patients actively undergoing cancer treatment, individuals managing progressive neurocognitive conditions such as Alzheimer's disease, beneficiaries with serious or complex chronic illness, and others whose health status makes the community engagement requirements clinically inappropriate or not attainable regardless of employment status. Congress recognized this reality and built a statutory exemption within H.R. 1 to match it. Our member hospitals' central concern with the IFR is that, as implemented, the medical frailty exemption will fail to function as Congress designed it – placing seriously ill patients at risk of losing coverage not because they fall outside the statutory exemption, but because CMS has layered a documentation and eligibility standard on top of it that the statute does not require and that will be applied unevenly across providers and states.

Section 71119 of H.R. 1, which amends section 1902 of the Social Security Act to establish the community engagement requirement, exempts from that requirement veterans with a disability rated as total under 38 U.S.C. §1155 and individuals who are medically frail or otherwise have special medical needs as defined by the Health and Human Services Secretary, including individuals who are blind or disabled (as defined in the Social Security Act §1614) or who have a substance use disorder; a disabling mental disorder; a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or a serious or complex medical

condition. The statutory text does not condition these exemptions on a separate showing that the qualifying condition impairs the individual's ability to work. Yet the IFR superimposes that requirement, directing states to determine not merely whether an individual is medically frail or has a serious or complex medical condition, but whether that condition "significantly impairs" their capacity to satisfy the 80-hour monthly community engagement requirement.

This is a material narrowing of the statutory exemption. Congress, in Section 71119, drew the eligibility line at diagnosis and condition – not at work capacity. A beneficiary undergoing active cancer treatment or living with a progressive condition such as Alzheimer's disease should qualify for exemption based on that diagnosis alone, a determination states could make efficiently and reliably using existing insurance claims data. Instead, the rule requires an additional, functional determination that places undue administrative burden on providers and goes far beyond their clinical role.

Although H.R. 1 directs states to use existing data sources to determine whether an individual complies with or is exempted from Medicaid's community engagement requirements, the complexity of the IFR's medically frail definition complicates states' ability to use standardized processes, and raises the likelihood that Medicaid enrollees, providers, and other stakeholders will need to rely on paperwork and other manual verification processes to carry out the elements of the community engagement requirements. In the absence of a reliable and administratively efficient verification system, providers will be burdened with the task of providing documentation attesting to a patient's medical condition and associated functional limitations; that is, they will be asked, on an ongoing basis, to translate clinical diagnoses into work-capacity determinations for which there is no established clinical methodology. The result will be inconsistent exemption determinations across providers, across hospitals, and across states, with eligibility for the same underlying condition varying based on the completion of documentation rather than on the beneficiary's actual medical status. We respectfully request that CMS maintain a broad definition of medical frailty and allow for states to determine how best to implement this exemption.

Downstream Effects of Disrupted Access to Care

Just as with other states around the nation, these coverage disruptions have broader implications for Massachusetts' healthcare system. Individuals without comprehensive insurance are more likely to delay preventive care and treatment until health conditions worsen, increasing reliance on hospital emergency departments for conditions that could have been managed in outpatient settings. Emergency departments serve as an essential safety net, but increased utilization for preventable conditions places additional strain on hospitals, contributes to overcrowding, and increases healthcare costs for *everyone*, including exacerbating uncompensated care, medical debt, and rising insurance costs. Patients who lose Medicaid coverage may face substantial medical bills they cannot afford, particularly if they require emergency treatment or hospitalization during a period without insurance. Hospitals, community health centers, and other safety-net providers consequently experience higher levels of uncompensated care and bad debt, placing financial pressure on institutions that already serve a disproportionate share of low-income patients and challenging their ability to maintain services. These costs are ultimately borne by healthcare systems and providers but also increase costs and raise commercial health insurance premiums across the entire system at a time when we should be focused on addressing healthcare affordability.

For Massachusetts, these consequences are especially concerning because the commonwealth has spent decades building a healthcare system focused on maintaining continuous coverage and reducing unnecessary barriers to care. Policies that increase administrative complexity risk reversing

progress toward those goals by creating avoidable coverage disruptions while increasing administrative expenditures and preventable emergency care utilization.

If CMS proceeds with implementation, it should modify the components of the IFR that would significantly increase administrative burden and drive-up healthcare costs. Specifically, CMS should allow flexibility, so that state Medicaid programs can maximize the use of existing electronic data sources for automatic verification, minimize documentation requirements, and expand automatic exemptions wherever legally permissible. Reducing reporting frequency and providing states with maximum flexibility to automate compliance determinations will help reduce administrative costs while helping preserve continuity of coverage for eligible individuals.

Concluding Comments

In conclusion, MHA respectfully requests that CMS carefully take into consideration the significant operational and undue administrative challenges burdens on healthcare this IFR will create for states, providers, and beneficiaries, particularly those with serious or complex medical conditions who may qualify for exemption but could still face barriers in navigating new documentation and reporting processes.

While we recognize CMS has a statutory obligation to implement the requirements of H.R. 1, we are concerned that the rule as written may impose costs and complexity that outweigh any demonstrated improvements in employment or community engagement, health outcomes, or program integrity. Moreover, at a time when the Administration, HHS, and CMS have emphasized reducing regulatory burden, lowering healthcare costs, and eliminating unnecessary administrative requirements that divert resources from patient care, the IFR would create significant new operational, reporting, verification, and compliance obligations for states, providers, and beneficiaries. Without additional safeguards, flexibility, and reliance on existing electronic data sources, the IFR will increase the number of uninsured and underinsured individuals, contribute to medical debt and uncompensated care, increase reliance on emergency departments, and divert limited state and provider resources away from efforts to improve healthcare access, affordability, and care delivery.

For these reasons, MHA respectfully urges CMS to withdraw or substantially revise the IFR and work with states and stakeholders to develop an approach that preserves continuous access to healthcare, minimizes unnecessary administrative and cost burdens, and provides states with the flexibility needed to implement any community engagement requirements in a manner that protects eligible individuals and the healthcare systems that serve them.

We appreciate your consideration of our comments and would welcome the opportunity to further engage with CMS on this issue.

Sincerely,

Steve Walsh
President & CEO
Massachusetts Health & Hospital Association