Congress of the United States

Washington, DC 20510

July 16, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

We urge the Centers for Medicare & Medicaid Services' (CMS) to withdraw its Interim Final Rule (IFR) implementing Medicaid "community engagement" requirements under H.R. 1, particularly the medical frailty exemption. These work reporting requirements passed by Congressional Republicans and signed by President Donald Trump last year will not increase employment, but instead risk causing thousands of Rhode Islanders and millions of Americans to lose their health coverage during an affordability crisis. CMS must delay implementation and reconsider the rule before vulnerable and medically fragile individuals needlessly lose access to essential health care.

The experience of Medicaid work requirements in Arkansas demonstrated that these policies do not meaningfully increase employment but do result in significant coverage losses among eligible individuals.[1] During Arkansas's work requirement program, approximately 18,000 beneficiaries lost coverage within months, largely because of reporting obligations and administrative barriers rather than failure to work. The Congressional Budget Office (CBO) projects that Medicaid work requirements will increase the number of uninsured Americans by approximately 5.3 million people by 2034.[2] In Rhode Island, approximately 90,000 Medicaid expansion enrollees could be subject to the new requirements, with an estimated 24,000 at risk of losing coverage. [3]

H.R. 1 established categories of individuals eligible for protection under the medical frailty exemption. However, the IFR narrows those protections by requiring that a medical condition significantly impairs an individual's ability to comply with "community engagement" requirements. As a result, individuals receiving treatment for cancer, serious mental illness, substance use disorder, developmental disabilities, and other complex medical conditions may no longer qualify for protection despite having conditions that states reasonably expected would be exempt.[4]

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[1] CBO's Estimate of the Budgetary Effects of Medicaid Work Requirements Under H.R. 2811, the Limit, Save, Grow Act of 2023

CMS Issues Interim Final Rule Imposing Medicaid Work Requirements for Expansion Populations | Foley Hoag LLP - JDSupra

Federal Compliance Advisory Group Report_vFinal_10302025.pdf

[4] Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement | Center on Budget and Policy Priorities

The IFR also creates a fundamental implementation problem. CMS directs states to rely on existing electronic data systems and automated verification processes, yet Medicaid claims, encounter records, and eligibility systems generally do not capture an individual's illness severity or functional ability to complete work requirements. States may therefore be forced to create new clinical review processes, provider attestation requirements, and manual case reviews to determine eligibility for exemptions.

This CMS guidance comes after states like Rhode Island have already spent months developing eligibility systems, exemption processes, beneficiary notices, outreach materials, and verification procedures in anticipation of implementation. CMS's revised interpretation risks forcing states to redesign major components of those systems while increasing administrative burdens for beneficiaries, providers, managed care organizations, and state agencies alike.

We are worried that the IFR could increase coverage losses among medically vulnerable individuals while imposing significant new costs and operational burdens on states. Given these fears, we respectfully request responses to the following questions by August 3, 2026:

1. What statutory authority does CMS rely upon to require that a medical condition significantly impair an individual's ability to comply with community engagement requirements when Congress expressly identified categories of medically frail individuals eligible for protection?
2. Did CMS conduct an analysis estimating how many fewer individuals would qualify for the medical frailty exemption under the IFR compared to a diagnosis-based interpretation consistent with the statutory categories identified in H.R. 1?
3. Did CMS estimate the number of beneficiaries expected to lose Medicaid coverage specifically because of the IFR's requirement that a medical condition significantly impair an individual's ability to comply with community engagement requirements?
4. Did CMS assess the potential impact of the IFR on continuity of care and treatment for individuals with serious or complex medical conditions who may no longer qualify for the exemption?
5. How does CMS expect states to electronically verify an individual's inability to comply with community engagement requirements when existing claims, encounter, and eligibility data generally do not capture functional work capacity?
6. How many individuals does CMS estimate will require manual review, provider attestation, clinical assessment, or case-by-case evaluation because existing electronic data sources are insufficient to determine whether their condition impairs compliance with community engagement requirements?
7. Did CMS estimate the administrative costs that states, providers, managed care organizations, and beneficiaries will incur to implement the IFR's requirements? If so, please provide that analysis.
8. Why did CMS choose to implement these requirements through an interim final rule, and does CMS intend to provide additional implementation flexibility or timeline adjustments to states that must substantially redesign systems and procedures as a result?

Medicaid work requirements have repeatedly demonstrated that administrative complexity is what causes eligible individuals to lose coverage. We urge CMS not to implement a medical

frailty framework that creates new barriers for medically vulnerable beneficiaries while imposing substantial new costs and operational burdens on states. Further, we ask CMS to reconsider its interpretation of medical frailty and work with states to ensure eligible individuals do not lose access to care because of bureaucratic obstacles rather than changes in their health status or eligibility.

Sincerely,

Gabe Amo
Member of Congress

Jack Reed
United States Senator

Sheldon Whitehouse
United States Senator

Seth Magaziner
Member of Congress