Niskanen Center

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

July 31, 2026

Re: RIN 0938-AV98, Medicaid Program; Community Engagement Requirement for Certain Individuals [Docket ID: CMS-2454-IFC]

Dear Administrator Oz,

On behalf of the Niskanen Center, we are pleased to share comments on the Centers for Medicare & Medicaid Services' (CMS) interim final rule (IFR), "Medicaid Program; Community Engagement Requirement for Certain Individuals," published on June 3, 2026 in the Federal Register.

Background and Summary

The Niskanen Center is a nonprofit public policy organization that advocates for a government that provides social insurance and essential public goods, fosters market competition and innovation, and invests in state capacity.

We believe that **policy design** and **policy implementation** go hand-in-hand: without due attention paid to the dependency between both, bad choices made about either can imperil the other. As a result, we have long advocated for social insurance programs that both protect and uplift those hurt by economic shocks, and proceed with due attention to program integrity and effective delivery. Our commitment to the provision of a robust social safety net demands an equal commitment to maximize access by legally-eligible beneficiaries, ensuring that it does not come at the excessive administrative burden to applicants, states, or the federal government.

With all these values in mind, we take a keen interest in CMS' approach to both Medicaid policy *and* how CMS and state operationalize that policy. We have previously written on Medicaid eligibility administration and on the state IT governance and procurement systems through which federal requirements like this one must actually be implemented.[1] We argued at the time that, as CMS develops and issues its guidance to states, the agency has an opportunity to

[1] Gabe Menchaca and Lawson Mansell, "Don't Let Work Requirements Become the Next Expensive Government Tech Meltdown," Niskanen Center, September 30, 2025.

improve the accuracy of state Medicaid offices' verification work while shrinking the price tag of a mammoth national work reporting process. We encouraged CMS to do this in two ways:

- Permitting states to use existing data sources to verify income and work history, which reduces reliance on expensive and incomplete data from commercial brokers as well as administrative spending on call centers and outreach; and
- Streamlining its guidance to states by cutting CMS's own red tape, which makes it easier for states to seek out new, innovative vendors and shared platforms, quickly prototype and iterate on solutions, invest in their internal capacity to manage contractors, and ultimately serve as better stewards of taxpayer resources.

We are encouraged to see several of our recommendations reflected in the IFR. Two verification-related choices deserve particular credit:

- CMS makes clear to states that quarterly wage data can be used to derive the number of hours worked, consistent with the recommendation we made last year.[2] This should help states avoid leaning on expensive commercial data brokers to verify who is meeting the requirement.
- CMS plans to make National Student Clearinghouse data available to states through an accessible federal data hub. If completed, this would reduce the manual reporting of school documents and transcripts that would otherwise require manual review by Medicaid caseworkers.

We expect that both of these decisions will likely reduce unnecessary expenditures and bureaucracy, by allowing states to maximize *ex parte* (i.e., automatically, without manual reporting from beneficiaries, based on data the state obtains through other means) verification and we are supportive of the parts of the IFR that makes this clear. In fact, we continue to recommend that CMS provide states with as much flexibility and clarity as possible to use data they already have on hand or could obtain through other means to automatically verify compliance with community engagement requirements as a means of preventing inadvertent, administrative disenrollment.

However, other choices CMS has made in the IFR leave us ambivalent about the rule. In particular, CMS has introduced unexpected changes to how it asks states to define “medical frailty” that are burden-enhancing for both beneficiaries and administrators. By requiring states to assess whether a qualifying condition significantly impairs an individual's ability to work, rather than simply whether the condition is present, CMS has converted a determination states could at least, in part, automate into one requiring clinician documentation and case-by-case

[2] Ibid.

review. In addition to the likelihood that CMS' new approach will result in legally-eligible beneficiaries being disenrolled due to paperwork requirements, the unexpected nature of these changes poses significant administrative challenges to states. Both of these together increase the likelihood that states will fail to implement CMS guidance without significant disruption to state operations and the beneficiary population that relies on Medicaid. Furthermore, they make it more likely that states will be forced into costly bridge contracts with incumbent software vendors that, as we discussed in our prior writing, will inflate CMS's costs and degrade service quality.

In particular, because of both the tight statutory timeline for H.R. 1 and the long lead time associated with software development, communications, training, and other aspects of implementation, any mismatch between state expectations and CMS policy creates significant issues. The result, we predicted in September, would be that states will reach for expensive, sub-optimal solutions: "In H.R. 1, Congress gave CMS until June 2026 to issue an interim rule that governs how states approach implementation, leaving six months for states to change course if that guidance doesn't match their plans. Given the length of procurement timelines, states will have little choice but to funnel more money to existing vendors for implementation support."

Unfortunately, this fear has come to pass: most, if not all, states have already begun building (and in some cases implementing)[3] these verification processes. Forcing them back to the drawing board with six months to go introduces costly uncertainty into an already very complex program. 25 states and D.C. have already sued to block this change[4] and, while courts will surely have to sort out the legal merits of their claims, our work on policy implementation success (and, frequently, failure) makes us sympathetic to their point.

Litigation notwithstanding, CMS needs to take these implementation challenges seriously lest it create precisely the conditions for a large technology meltdown that it should seek to avoid: unclear and shifting requirements, management to arbitrary deadlines, no room for iteration, and reliance on incumbent vendors.

There is still time for CMS to avoid the worst-case scenarios, though the window narrows every day. To minimize the chance of a meltdown, CMS should swiftly update its IFR to focus on two key goals:

[3] Office of Governor Jim Pillen, "Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements," December 17, 2025.
[4] Jennifer Tolbert, "States Sue CMS Over Medicaid Work Requirements Rule, Citing Departure from Earlier Guidance on Medical Frailty," KFF Quick Takes, June 30, 2026.

- **Continue to maximize data source flexibility so that states can complete as much *ex parte* verification as possible and economize on the data they purchase**; and
- **Adjust its approach to medical frailty so that states can rely on claims-based automatic classification wherever possible,** given how little runway remains to select vendors, bring them up to speed, and build a new severity evaluation process from scratch.

In addition, we also urge CMS to clearly and credibly communicate a commitment to offer good faith extensions to states *regardless* of whether it adopts our recommendations, to account for the uncertainty this IFR has introduced. To be successful in implementing a policy change as administratively complex as this one, states need certainty: about the timeline, about the requirements, about how CMS will govern them, etc. By changing course on medical frailty via IFR with just a few months left to go, CMS has put both itself and states in a bind. On the one hand, given the rapidly-approaching January 1st deadline, CMS has put itself on a tight timeline to rectify any issues identified in public comment on this IFR. On the other hand, that same tight timeline means that states would be remiss if they did not recalibrate based on this IFR in its current form, disrupting plans based on CMS' prior guidance. Neither option is likely to help CMS realize Congressional intent, its own goals, or general goals of quality public administration. The more prudent choice would be to delay implementation while these issues are resolved and we strongly urge CMS to do so.

We discuss these views in more detail below.

Allowing quarterly wage and student enrollment data reduces manual reporting for beneficiaries and caseworkers alike

Much of the public debate over this rule has focused on who is subject to the requirement and who is exempt. But provisions governing data sources warrant equal if not more attention. Whether a state can verify compliance automatically, using data it already holds, determines how many eligible people keep their coverage, how much caseworkers will be asked to absorb, and what implementation ultimately costs.

The more compliance a state can verify *ex parte* , the fewer eligible people lose coverage over paperwork. We are glad to see CMS make clear throughout the rule that states should focus on *ex parte* verification using "reliable information" first. In this regard, the IFR gets two important things right that will make it easier for states to accomplish this kind of automatic, more seamless verification.

First, CMS makes clear to states that quarterly wage data "can be used to derive the number of hours worked." Quarterly wage records are the most robust, comprehensive, and timely source of income data that states already have, but before this rule, neither their timing nor their structure aligned neatly with the statute's reporting framework, raising doubts about whether they could be used at all. This uncertainty was shaping state plans, as survey data showed that as of April 2026, 18 of the 43 implementing states were not planning to use quarterly wage data, while 25 states planned to purchase wage data from Equifax's Work Number.[5] CMS' clarification in the IFR gives states another powerful source of data for verification besides these commercial options.

Commercial wage databases carry two serious problems: first their employer coverage is incomplete and skewed toward larger companies. This means that they are incomplete and do not capture many of the people employed in small businesses that are *more likely* to be eligible for Medicaid despite continued employment. Workers at small firms are more likely to be Medicaid-eligible while employed, since only 59 percent of firms with fewer than 200 workers offer health benefits, compared with 97 percent of larger firms.[6] Such a gap does not exist in the quarterly wage data file because nearly all employers (regardless of size) have a legal obligation to report.

Second, these databases are expensive on an ongoing basis for states to use. For example, North Carolina's Work Number spending nearly doubled between 2022 and 2026, to $22.5 million, and South Dakota's costs rose nearly 400 percent over the same period.[7] CMS is not insulated either, since its own income verification contract with Equifax has grown so fast that it now requires states to cover a share of the costs.[8] Furthermore, because the federal government matches a large share of state spending on state administration and data collection, reliance on Equifax's work number or other data brokers comes at significant federal cost as states pass along these price hikes to CMS.

As we argued in September, states should use the data they already have rather than create new systems to purchase data, and private data brokers should be a last resort for verifying income. Because the Work Number is priced per query, every beneficiary verified through the quarterly wage file is a query the state never has to buy. In this way, this one sentence in the IFR could potentially save states millions of dollars.

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[5] Jennifer Tolbert, Amaya Diana, Anna Mudumala, Tricia Brooks, Yuliya Yafimenka, and Antony Lin, "An Early Look at Policy Decisions as States Get Ready to Implement Work Requirements," KFF, April 30, 2026.
[6] KFF, "2025 Employer Health Benefits Survey," October 22, 2025.
[7] Sarah Kliff, Margot Sanger-Katz, and Asmaa Elkeurti, "Senators Accuse Equifax of 'Price-Gouging' Medicaid Programs," The New York Times, February 4, 2026.
[8] Jordan Atwood, "Senators Probe Equifax Over Plans to Profit From Medicaid and SNAP Work Requirements," NationofChange, February 5, 2026.

CMS also made plans to make National Student Clearinghouse data available to states through an accessible federal data hub. The administration should follow through on this offer. For beneficiaries who meet the requirement through education, the alternative is manual reporting of school documents and transcripts, which in turn requires manual review by Medicaid caseworkers. A survey of state leaders shows how far states were from this solution on their own: only 10 of 43 states planned to use Clearinghouse data as of April 2026, with most of the rest still deciding whether they had the capacity to establish these kinds of new data linkages at all.[9] A federally provided pathway would make the data available to every state without dozens of separate procurements and data sharing agreements.

Furthermore, CMS has done a good job in its IFR giving states direction to use these types of data sources *first*, writing that

> (i) The agency must attempt to verify the individual's specified excluded individual status or that the individual demonstrated community engagement or was deemed to have demonstrated community engagement using all reliable information available to the State for all relevant months **before requesting additional information from the individual.**
>
> (A) **Only** after checking all reliable information available to the State without successfully verifying compliance, deemed compliance, or specified excluded individual status may the agency request additional information from the individual and initiate the noncompliance procedures under § 435.558, as appropriate.
>
> (B) An individual **must not be required to provide documentation or other additional information unless information needed by the agency could not be verified using reliable information available to the State**, including when there is no reliable information available to the State or the reliable information is not reasonably compatible with the information provided by or on behalf of the individual.

CMS deserves significant credit for this: this approach that centers *ex parte* verification is likely to reduce the administrative burden of verification for many applicants, shifting the onus instead onto states.

But unfortunately, many states designed and procured their verification systems without awareness of these policies, due to the truncated implementation timeline. In the same survey,

[9] Jennifer Tolbert, Amaya Diana, Anna Mudumala, Tricia Brooks, Yuliya Yafimenka, and Antony Lin, "An Early Look at Policy Decisions as States Get Ready to Implement Work Requirements," KFF, April 30, 2026.

29 states cited insufficient time as a major barrier to adding new data sources, and roughly half cited the costs of establishing and maintaining new data linkages.[10] Because this guidance was issued at the statutory deadline, roughly six months before implementation, states have little runway to rebuild their approaches around these better sources. More time, or earlier guidance, would have allowed states to capture the full value of these changes.

CMS's approach to medical frailty undercuts the rule's administrability and adds unnecessary administrative burden

Beyond those who satisfy the work or education requirements, a large share of beneficiaries will qualify for exemption through other categories. Those include caregivers, pregnant women, foster youth, and people recently released from incarceration. Each of these statuses can be verified reliably and automatically on an *ex parte* basis using Medicaid eligibility and claims data the state already holds, with no additional reporting from the beneficiary. The rule also designates a broader set of "specified excluded" individuals, which sweeps in categories such as people who are "medically frail," those with "special medical needs," SNAP recipients, former foster youth under age 26, and veterans with a 100 percent disability rating.

Among the IFR's most consequential choices is its treatment of “medically frail” individuals, which, contrary to what states had been building toward, will require manual reporting by some beneficiaries to secure a medically frail exemption.

The statute defines the medically frail exemption through several categories of qualifying conditions, limited to individuals who are blind, disabled, or have any of the following:

- a substance use disorder (SUD)
- a disabling mental disorder
- a physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living
- a serious or complex medical condition.

As many read it, meeting any one of these categories qualifies an individual for the exemption. As a result, states have been anticipating a process where they can identify the qualifying conditions in claims and eligibility data, exempt the people who have them, and reserve all manual review for the cases that this data cannot resolve.

But the IFR added a new determining factor not anticipated in the law itself, requiring that *any* condition "significantly impair” the individual's ability to comply with the community

[10] Ibid.

engagement requirement. This sets up a future where individuals *with* a qualifying condition can still be required to work 80 hours per month to keep their Medicaid coverage if it doesn't meet this new standard.

CMS communicated concerns that allowing "automatic classification" of medical frailty would risk "sweeping in" individuals whose conditions do not "significantly impair their capacity…to perform 80 hours per month of qualifying activities." In practice, this means a qualifying diagnosis is no longer enough to establish an exemption, as CMS interpreted the statute "to require consideration of the severity" of one's condition. In this case, those seeking an exemption of medical frailty will need to instead *prove* that the severity of their condition significantly impairs their ability to work, likely requiring either a clinician form or medical records. The state Medicaid offices will then be tasked with determining if the medical records or provider form proof are enough to grant the exemption. Rather than an easier-to-administer binary (i.e., that an applicant either has a covered condition or not), suddenly states are thrust into the role of having to make *judgement calls* about the relative severity of a condition.

This will substantially increase the complexity of administering the program and add significant burden to both applicants and states in having to sort through this new conditional requirement.

States are not necessarily equipped to make these conditional decisions today. CMS clearly envisions this difficulty in the IFR, evidenced by its attempts to delineate, among each category of qualifying conditions, which diagnoses within the category actually count. For example, CMS stipulates that an individual with a substance use disorder who has been in recovery for 5 or more years, does not qualify for an exemption. As a result, someone with a SUD will need to prove through their medical records or a clinician that they *have not* been in recovery for 5 or more years to receive an exemption. For the "serious or complex medical condition" category, the most subjective of them, CMS does list some qualifying conditions such as ESRD and HIV/AIDS, but clarifies that they should only be used to exempt an individual "when such conditions significantly impair" their ability to meet the work requirement. It is this *second* review that adds significant new burdens. States were already expecting to need to build a list of conditions that qualify for the exemption, likely using ICD-10 codes, but now this list will only serve as a first-stop to proving an exemption, as the vast majority of cases will still require meeting the higher standard of significant impairment.

Because states scarcely have the capacity to make these types of decisions themselves, we presume many will rely on findings by doctors. While this somewhat lowers the burden on states in administering the program, it has its own challenges. Relying on clinician forms will create a lot of variability depending on which doctor they see and the evidence on physician

exemption decisions is not reassuring. Studies show that physicians vary widely in their willingness to support exemption requests. In a survey experiment testing physician responses to Medicaid work requirement exemption requests from patients with depression, 54 percent of primary care physicians declined to assist a patient who qualified under their state's criteria, while 25 percent were willing to assist a patient who did not qualify.[11] Willingness varied with the state, the administrative effort involved, and the physician's own political affiliation. Further, this can be extremely burden-enhancing for applicants, as it requires yet another form.

Additionally, this will require a robust administrative review system in each state's Medicaid office to evaluate this paperwork (either medical records or provider forms) akin to state disability examiners who similarly review clinician reports and records to determine disability status. The disability determination process shows how this model performs in practice. Initial decisions now take 100 days longer than a decade ago, and in roughly 40 percent of cases the medical records providers submit are insufficient to make a determination at all, forcing examiners into a second round of evidence collection.[12] This is no one's idea of an efficient or effective system; CMS should not seek to replicate it for Medicaid.

To help states develop their list of codes/diagnoses that can be used for automatic classification, CMS has allowed individuals to self-attest about the severity of their condition at the point of initial eligibility determination during a transition period. This means that individuals will not *necessarily* need to provide additional evidence of the severity of their condition until 2028. Subsequent to 2028, states are allowed to accept such a self-attestation "only once during the period of enrollment" but must have "reliable information" to verify during their first-regularly scheduled redetermination.

This is a bandaid, however. Self-attestation merely pushes out the worst administrative burdens by a year (or shorter, depending on future redetermination cycles). In the meantime, states *still* have to build this capability into their Medicaid systems, train staff to manage yet another administrative process, and figure out how to explain a murky concept to applicants.

Most importantly, however, despite ample evidence that this provision is potentially burden-enhancing, CMS has not provided a complete estimate that fully accounts for this provision. Absent in CMS's discussion of burden is a discussion for example, of clinician hours potentially spent verifying condition severity, making it difficult to evaluate this rule on the merits.

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[11] Harald Schmidt, Andrew J. Spieker, Tianying Luo, Julia E. Szymczak, and David Grande, "Variability in Primary Care Physician Attitudes Toward Medicaid Work Requirement Exemption Requests Made by Patients With Depression," JAMA Health Forum 2, no. 10 (2021): e212932.
[12] Will Raderman and Lawson Mansell, "How to Improve the Social Security Administration's Efficiency," Niskanen Center, January 13, 2025.

CMS should reverse course and adopt a simpler definition of medical frailty that only requires states to adjudicate *the presence* of a condition (a binary yes/no) rather than the *relative severity* of the same. This would both faithfully capture the goals Congress had in statute while also avoiding needlessly complicating the process.

The compressed timeline already presented challenges for states; these changes magnify the risks of a costly technology meltdown

While we believe the burden-enhancing quality of these new requirements is enough of a reason for CMS to change course, CMS should also consider reversing course because of the negative impact they are likely to have on states' ability to technically implement H.R. 1 in the first place.

As we discussed in our prior work, the biggest risk to this entire enterprise is the calendar: because of the tight timeline, states have basically been forced to make some decisions well in advance of definitive guidance. Working backwards from January 2027, accounting for CMS APD approval timelines, state procurement lead time, beta testing, training for case workers, and the actual software development, states needed to make decisions about how to implement CMS guidance months ago. This meant that, for practical reasons, they had to make some educated guesses about the rules CMS would outline in this IFR — as if they were pilots forced to attempt a landing without being able to quite see the runway because the alternative was running out of gas.

This was risky. These are precisely the conditions that have historically led to major government technology meltdowns in the past: rigid statutory deadlines, unclear requirements, compressed timelines, and so on. We also pointed out that these conditions could force states to stick with incumbent vendors that had spotty track records of success in building systems — they could save some time by modifying existing contracts rather than awarding brand new ones, but that this both denied them the possibility of better service from non-incumbent vendors and inflated the cost due to lack of competition. This was precisely what had happened with both FAFSA modernization and Healthcare.gov and we were concerned that CMS was pushing states into that same failure mode inadvertently. Furthermore, because of cost sharing rules, this meant that CMS would ultimately bear much of both the fiscal burden for development and the eventual cost to clean up the failed implementation, a sum likely well in excess of the money Congress had appropriated for this purpose. All of this would be not just embarrassing and costly, but also increase the chaos for applicants and governors all over the country just trying to follow the law.

Some of this was unavoidable given the hand Congress dealt CMS and states. We previously argued, however, that there were several measures CMS could take to reduce this risk: for instance, we suggested that CMS could issue APD waivers to speed up its own part in the process, allowing states to proceed more quickly with competitive procurements for better solutions on the open market. More importantly, we also noted that "nothing prevents CMS from issuing interim guidance much sooner. Doing so would give states far more options—allowing them to initiate procurements and adjust their implementation strategies as conditions evolve. If CMS quickly signals that the approaches described above are allowable, it can substantially reduce costs and lower the risk of another high-profile IT failure–where vendors often escape accountability." We also suggested that CMS could take action to make more innovative vendors easier to access via federally-managed contract vehicles, among other changes.

CMS, to its credit, has done some of this: earlier this year, for example, CMS announced that it would help "fast-track" interested vendors on to the GSA schedules to support implementation.[13] Additionally, it is our understanding that CMS has been regularly and proactively coordinating with states about the requirements well in advance of the June deadline for more directive guidance.

However, the inclusion of the unexpected additional medical frailty requirements in this IFR undercuts all of these efforts. By introducing a major, unexpected system requirement this late into the game, CMS has thrown states exactly the type of curveball that we were concerned about last fall. **This late in the game, states will be left no choice but to pay whatever they are quoted by incumbent vendors, lest they risk noncompliance.** In cases where they've already done work to accommodate this requirement, states will also be forced to spend more of CMS' and their own money to re-do this work.

There are other worse dangers too, however. System development, particularly for highly complex, integrated enterprise software like that which states use to adjudicate benefits, does not proceed linearly: any new development is just as likely to introduce a solution-breaking bug today as it was six months ago and as it will be in six months. Changing requirements this late in the game will necessitate significant new development work by states, increasing the likelihood that something will break at a period when they desperately need stable technology to facilitate beta testing and training. While there are mitigation precautions responsible programs will take, CMS is making their job that much harder without a clear statutory reason to do so.

[13] Centers for Medicare & Medicaid Services, "Fact Sheet: Pledges from Medicaid Technology Companies to Support Community Engagement Implementation and Related Medicaid System Improvements," January 29, 2026.

CMS does not need to take our word for it: this additional work that the IFR has created for states is why 25 states and the District of Columbia have decided to pursue legal action against the administration, asking the court to set aside several provisions of the IFR, among them the medical frailty definition. The plaintiff states argue that the IFR's *new* medical frailty standard forces them to spend money they never budgeted.[14] Because the impairment requirement demands a system capable of evaluating an individual's ability to work, rather than simply identifying qualifying diagnoses in the data they already hold, states must now engage new vendors and build new verification systems.

While we do not express an opinion about the veracity of their claim, we *do* think it is plausible for all the foregoing reasons we discussed late last year. In any case, CMS should treat their arguments seriously as a sign that the worst case scenario we predicted might be coming to pass.

CMS can take actions inside and outside this IFR to reduce the risk of a meltdown and reduce burden in a win-win solution for states, applicants, and CMS' own budget

Ultimately, however, it is not too late for CMS to change course.

First, on its own merits, CMS should amend the "medical frailty" proposal contemplated in this IFR. Ideally, CMS would move entirely away from a requirement that states verify whether individual conditions prohibit individual applicants from working, preferring instead the model it had previously signaled: states determine a list of qualifying conditions and evaluate eligibility based on the incidence of those conditions alone. If, however, CMS is unwilling to go this far, it can also take steps to allow more automatic classification, reserving requirements for clinician evaluation for just the most ambiguous cases. This could be accomplished by bifurcating its approach: it could require states to maintain a list of conditions that would absolutely meet the definition of "medically frail" for which states could automatically enroll applicants and *then* a smaller list of other conditions where further evaluation is needed. That way, in cases where further review by a clinician and then a state evaluator would be effectively pro-forma can become, in fact, automatic while the burden and effort is concentrated just on marginal cases. While this change to the IFR may take additional, critical time, we believe it is worth the effort for CMS to update its approach in an effort to reduce unnecessary burden for states and applicants.

[14] Complaint, Commonwealth of Massachusetts et al. v. Oz et al., No. 1:26-cv-12962 (D. Mass. filed June 29, 2026).

Second, regardless of whether CMS changes its approach, it should offer a blanket good-faith extension of the compliance deadline for states beyond January 2027. In the IFR, CMS has outlined criteria by which it will evaluate "good faith effort exemption[s]" for states, including importantly this provision:

> (4) Any exigent circumstances, such as an administrative or other emergency beyond the agency's control, impacting the State's ability to implement the community engagement requirement consistent with § 435.559.

We believe that the structure of this IFR satisfies CMS' own criteria no matter what CMS chooses to do in response to public comment. In the case that CMS chooses to walk-back or adjust its approach, and extension would be obviously warranted: states would need more time to metabolize the finalized guideline, update their approach, and ensure that the systems are ready for a smooth rollout after being disrupted by surprise changes in this IFR that were out of their control. Our preference would be that CMS take this course. However, even in the case where CMS *does not* change its approach to medical frailty, we believe that this extension would be warranted: states need time to metabolize *this* guidance too.

Congress clearly envisioned that this would be a possibility when it authorized HHS to authorize good-faith extensions in the first place[15] and CMS should take full advantage of this authority—it would be better to get this right the first time than risk another costly meltdown that explodes the federal budget and leaves Americans with the lingering sense that their government cannot implement duly-enacted Congressional priorities. Notably, the plaintiff states suing CMS over this IFR have already requested a six-month good-faith delay of the January 1, 2027 deadline, using the extension process the statute and the IFC provide. CMS granting that request would address the immediate operational problem states are facing, but the legal questions at the heart of the lawsuit will still need to be settled in court.

States have a tremendously hard job this year. They are buffeted on all sides: by applicants who need healthcare, by advocates who need clarity, by challenging economic conditions, by shrinking budgets, lower federal spending, and all the rest. In November, 36 states will choose new governors, each of whom will just be starting their terms as these rules go into effect (absent an extension). Their to-do lists are long in the absolutely best case.

CMS has before it an opportunity to make it easier for them, their teams, and the people they serve to all comply with Congress' statutory intent and it should take it: we urge CMS to

[15]Pub. L. No. 119-21, 139 Stat. 72 (July 4, 2025) (An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, commonly known as the One Big Beautiful Bill Act), p. 243.

continue to support as much *ex parte*, automatic verification as absolutely possible while giving them as much time as possible to get it right.

Respectfully,

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