Howard Brown Health

July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals 2026-11094 (91 FR 33348)

Howard Brown Health is one of the largest community health centers in the Midwest, serving more than 40,000 patients across seven clinic locations in Chicago. Howard Brown serves adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, dental health, research, HIV/STI prevention, youth services, and elder services. As a federally qualified health center (FQHC), Howard Brown provides services regardless of a patient's ability to pay or insurance status. Almost 30% of Howard Brown's patients are enrolled in Medicaid.

The Centers for Medicaid and Medicare Services (CMS) Interim Final Rule (IFR) implements the Medicaid community engagement requirements established by H.R. 1, which require Medicaid expansion adults ages 19–64 to document at least 80 hours per month of work to be eligible for Medicaid coverage. As currently written, the IFR is vague, unworkable for many state Medicaid programs, and is contrary to the language of H.R. 1 that was passed by Congress and signed by the President. Approximately 18.5 million adults across 42 states will be subject to the new work requirements, and this IFR will ensure that a significant share of them, who are legally entitled to exemptions, will lose their health coverage. **As such, we strongly urge CMS to delay this IFR and redraft it with a lawful and workable definition of "serious or complex medical condition" that covers people living with HIV, cancer, and other serious chronic illnesses.**

The IFR creates an unworkable system that extends beyond statutory intent.

Although the IFR is intended to implement the work requirements enacted through H.R. 1, the IFR adopts more restrictive standards than what is included in the law, which defies Congressional intent. H.R. 1 offers a blanket exemption from work requirements for any individual who is "medically frail or otherwise has special medical needs." The statute outlines five specific subcategories for this classification: blindness or disability under Social Security guidelines, a substance use disorder, a disabling

4025 N Sheridan Road
Chicago, IL 60613

TELEPHONE 773.388.1600
ADMIN FAX 773.388.1602
MEDICAL FAX 773.388.8936

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mental disorder, a physical/intellectual/developmental disability impacting daily activities, or a serious or complex medical condition. However, the IFR imposes a separate regulatory requirement that individuals who have serious or complex medical conditions must additionally demonstrate that the condition "significantly impairs the individual's ability to comply with the community engagement requirement."

The IFR is also unclear about how clinicians and state Medicaid programs should determine what constitutes a "significant impairment" as the phrase itself is not defined by the IFR. Determining whether an individual is "too sick to work" under the IFR is subjective because there is no universally accepted medical diagnosis, billing code, or standardized clinical assessment that measures a person's capacity to meet an 80-hour monthly work requirement. While clinicians routinely diagnose and treat medical conditions, they are not trained to evaluate employment eligibility, and there is no objective threshold that defines when a health condition renders someone unable to work. As a result, determinations of medical frailty or incapacity often depend on individual clinical judgment rather than clear, consistent standards. This lack of clear criteria creates significant implementation challenges. Two physicians evaluating the same individual with a chronic condition, such as severe back pain, depression, or an autoimmune disease, may reach different conclusions about whether the condition limits the person's ability to perform part-time or light-duty work. Howard Brown is concerned that providers may be asked to make complex functional assessments that are not routinely part of primary care practice, and as a result, beneficiaries may face delays or barriers in obtaining appropriate exemptions. This will increase the risk that medically vulnerable individuals lose coverage because of uncertainty in the verification process rather than an accurate assessment of their health status and eligibility for an exception. Mechanisms need to be in place to ensure such determinations are applied consistently across clinicians, CHCs, and states.

Additionally, determining "significant impairment" becomes an unfunded mandate and detracts from valuable time providing clinical care. Time spent preparing and documenting eligibility attestations cannot be devoted to seeing patients, managing chronic conditions, or coordinating care. In a safety net institution, where clinician capacity and bandwidth are already overloaded due to continued workforce shortages and staffing challenges, new administrative requirements may further strain limited capacity, complicate efforts to meet quality and performance goals, and contribute to provider burnout. Furthermore, diverting clinical time to eligibility certification and absorbing the coverage losses that follow when eligible patients cannot navigate the documentation threatens both appointment access and health center financial viability.

4025 N Sheridan Road
Chicago, IL 60613

TELEPHONE 773.388.1600
ADMIN FAX 773.388.1602
MEDICAL FAX 773.388.8936

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Lastly, any sort of required functional assessment must take into account the relationship between healthcare coverage and employment status. When patients can manage their health needs, it also supports their ability to maintain employment, volunteer or go to school. Medicaid coverage helps many of our patients to manage chronic and complex conditions. Assessments of functional capacity should thus consider the extent to which continued access to coverage contributes to an individual's ability to remain healthy and engaged. Failure to account for this relationship could result in coverage losses that ultimately undermine an individual's health status and reduce their capacity to participate in work or other community engagement activities. We are concerned that the way that the IFR is written may incentivize patients to allow chronic conditions to worsen in order to sufficiently demonstrate that they are unable to work in order to maintain necessary heath coverage. For example, current Medicaid patients who have HIV that is well managed may be forced to allow their condition to worsen in order to demonstrate that they cannot work to keep the health insurance that they need to stay health. This is not only dangerous and costly, it also would ultimately impair the patient's ability to engage in work or community service long-term, which is the exact opposite of the stated intent of these requirements.

The effects of the IFR's ambiguity are substantial. Physicians face growing administrative responsibilities that extend beyond clinical care, requiring them to make employment-related determinations for which they have little guidance. States are left to interpret broad federal standards independently, increasing the likelihood of inconsistent eligibility decisions and unequal access to exemptions and treatment based on where an individual lives. Most importantly, those with medically serious and complex medical conditions, particularly those with fluctuating, periodic, or difficult-to-document conditions, face an increased risk of losing health coverage. These patients may be unable to satisfy subjective documentation requirements, even when they legitimately qualify for an exemption. Without clearer federal standards and more accessible verification pathways, the IFR creates avoidable and unnecessary administrative barriers that undermine continuity of care and disproportionately affect individuals with the greatest health care needs.

The IFR must allow for self-attestation.

CMS allows states to permit individuals to self-attest that they meet the serious conditions criteria when eligibility cannot be verified through existing Medicaid claims or other administrative data. However, the IFR places significant limits on this pathway. Beneficiaries may rely on self-attestation only through January 2028 and, in most cases, only once during a continuous enrollment period. At their next renewal, they must provide supporting documentation, such as a provider certification or medical records, to maintain their exemptions.

4025 N Sheridan Road
Chicago, IL 60613

TELEPHONE 773.388.1600
ADMIN FAX 773.388.1602
MEDICAL FAX 773.388.8936

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While CMS presents these limitations as a way to balance beneficiary access with program integrity, the proposal clearly favors objective verification over beneficiary self-reporting. Restricting self-attestation to a single use and requiring documentation at renewal ultimately creates unnecessary administrative barriers for individuals with complex health needs, particularly those who face challenges obtaining timely medical records or provider certifications. For many medically serious condition beneficiaries, these documentation requirements could delay or disrupt access to critical services and protections.

People living with HIV will be disproportionately harmed by the IFR.

New work requirements for adults could produce consequences particularly severe for people living with HIV (PLWH). Medicaid is the nation's largest source of health insurance for this population, covering 40% of non-elderly adults living with HIV in the United States.[1] The IFR does not give an automatic exemption to someone with an HIV diagnosis even though H.R.1 specifically carves out a category that would exempt PLWH from the work requirement because HIV is a serious or complex medical condition. As mentioned above, the additional need for determination that a person living with HIV is "too sick to work" will only serve to delay access to necessary care, especially to manage a chronic disease like HIV. These disruptions and delays in care can have serious health consequences. Even a temporary interruption in access to HIV treatment as little as 30 days can reduce the effectiveness of future antiretroviral therapy and jeopardize long-term viral suppression.[2]

Medicaid work requirements do not work for patients.

The challenges associated with Medicaid work requirements are well established. Arkansas became the first state to implement Medicaid work requirements in 2018, but instead of increasing employment, the policy resulted in more than 18,000 people losing

[1] kfflindseyd. "Medicaid and People with HIV | KFF." *KFF*, 27 Mar. 2023, https://www.kff.org/hiv-aids/medicaid-and-people-with-hiv/. Accessed 17 July 2026.
[2] Jiamsakul, A., Kerr, S.J., Ng, O.T., Lee, M.P., Chaiwarith, R., Yunihastuti, E., Van Nguyen, K., Pham, T.T., Kiertiburanakul, S., Ditangco, R., Saphonn, V., Sim, B.L.H., Merati, T.P., Wong, W., Kantipong, P., Zhang, F., Choi, J.Y., Pujari, S., Kamarulzaman, A., Oka, S., Mustafa, M., Ratanasuwan, W., Petersen, B., Law, M., Kumarasamy, N. and the TREAT Asia HIV Observational Database (TAHOD) (2016), Effects of unplanned treatment interruptions on HIV treatment failure – results from TAHOD. Trop Med Int Health, 21: 662-674. https://doi.org/10.1111/tmi.12690

4025 N Sheridan Road
Chicago, IL 60613
TELEPHONE 773.388.1600
ADMIN FAX 773.388.1602
MEDICAL FAX 773.388.8936
howardbrown.org

health coverage while employment rates remained unchanged.[3] Most beneficiaries did not lose coverage because they refused to work; they lost it because they could not navigate complex reporting systems, burdensome paperwork, and confusing eligibility requirements. Georgia's Pathways to Coverage program has produced similar results. Although more than 110,000 people initially expressed interest, only about 5,500 individuals were enrolled by November 2024 due to extensive documentation requirements, application backlogs, and burdensome reporting obligations. The program has also proven costly, with administrative spending exceeding medical expenditures and per-enrollee costs far surpassing the state's original projections. As of 2026, only about 16,782 Georgians are actively enrolled in Pathways to Coverage.

These experiences demonstrate that work requirements create administrative barriers that often prevent eligible individuals from maintaining health coverage. Many low-income workers have fluctuating schedules that make it difficult to consistently meet monthly reporting thresholds, while family responsibilities, temporary illness, transportation challenges, and difficulties obtaining medical documentation can further impede compliance. Individuals with disabilities and chronic health conditions face additional obstacles in documenting their eligibility, increasing the risk of losing coverage despite remaining otherwise eligible for Medicaid. Rather than promoting employment, these policies have consistently resulted in eligible beneficiaries losing access to essential health care because of procedural hurdles, underscoring the need for eligibility systems that prioritize continuous coverage over burdensome administrative requirements.

Conclusion

The IFR that CMS published creates an invasive, subjective, and unworkable system for work reporting requirements. The rule also narrows the intent of H.R. 1 by restricting exemption criteria and imposing complex capacity-to-work determinations that make implementation more difficult, costly, and inefficient. As a result, more people with serious and complex conditions will become ineligible for Medicaid coverage, ultimately resulting in worse health outcomes. We urge CMS to delay this IFR and redraft a lawful and workable definition of “serious and complex medical condition” that ensures coverage for people living with HIV and other serious, chronic medical conditions.

[3] Abudaram, Jacob. “Medicaid Work Requirements Don’t Work — They Harm People with Disabilities | ACLU.” *American Civil Liberties Union*, 28 Apr. 2025, https://www.aclu.org/news/disability-rights/medicaid-work-requirements-dont-work-they-harm-people-with-disabilities. Accessed 17 July 2026.

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We appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Timothy Wang, Director of Policy and Advocacy at timothyw@howardbrown.org

Sincerely,
Travis Gayles, MD, PhD
CEO and President, Howard Brown Health

4025 N Sheridan Road
Chicago, IL 60613

TELEPHONE 773.388.1600
ADMIN FAX 773.388.1602
MEDICAL FAX 773.388.8936

howardbrown.org