HEALTHY MOMS. STRONG BABIES.
MARCH OF DIMES

OFFICE OF GOVERNMENT AFFAIRS

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

July 31, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov

RE: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Interim Final Rule titled, "Medicaid Program; Community Engagement Requirement for Certain Individuals," RIN number 0938-AV98, file code CMS-2454-IFC, 42 CFR Parts 431, 435, 438, 457, and 600 (June 3, 2026)

Dear Administrator Oz:

March of Dimes, the nation's leading nonprofit organization fighting for the health of all moms and babies, appreciates the opportunity to comment on the Interim Final Rule titled, "Medicaid Program; Community Engagement Requirement for Certain Individuals."

Introduction

In March, it was estimated that between three and seven million people would lose Medicaid coverage in 2028 due to the work reporting requirement established under the One Big Beautiful Bill Act (P.L. 119-21).[1] Such losses pose a great threat to families across the country, at a time when the United States is already among the most dangerous developed nations for childbirth.

Medicaid covers over 71 million people with an additional 7 million enrolled in the Children's Health Insurance Program (CHIP).[2] The program plays a critical role in ensuring access to healthcare and improving health outcomes for women and children in every state, covering 41% of all births in the U.S., including many high-risk pregnancies, and providing health coverage for 39% of all children.[3,4] Uninsured women have a more difficult time getting the healthcare they need before, during, and after pregnancy compared to insured women. In the U.S., 1 in 9 women is uninsured and the lack of coverage can negatively impact both their health as well as the health of their babies.[5]

Medicaid is particularly important for rural areas, covering 23% of rural women of childbearing age and 47% of rural births, and is vital for ensuring the viability of the healthcare systems that care for these moms and babies.[6] Nearly two-thirds of rural counties are already considered maternity care deserts, areas with no access to obstetric clinicians or birthing facilities, a fragile baseline that is likely to be adversely impacted by reductions in coverage.[7] Any changes to Medicaid should be made with the intention of improving, not limiting, access to vital healthcare services to families.

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

Work requirement definitions and exemptions

The Government Accountability Office has estimated that the cost to implement work requirements could be as high as $270 million depending on a state's implementation.[8] We fear instituting work requirements nationally will draw significant funds from state budgets, potentially requiring cuts to essential programs to retain their balanced budget. Beyond the risk of potential cuts to healthcare to offset these increased costs, these are taxpayer dollars that could better used to improve the efficiency of the state's health system and efficacy of critical care delivered to citizens, including millions of moms and babies.

During past work reporting requirement implementations, states suffered from communication failures with enrollees, and the P.L. 119-21 policies on data and sworn affidavits were designed to mitigate that.[9,10,11] Any requirements on individuals must be designed to prevent a repeat of Arkansas' experience, where 18,000 individuals — a quarter of those subject to the requirement — lost coverage.[12]

Today, 92% of adults on Medicaid are either working or would qualify for an exemption, such as being pregnant, while the other 8% include retirees, caregivers, those enrolled in school, persons with disabilities and others unable to find work.[13] We are pleased pregnant women and children are exempt from work requirements and reverification during their pregnancy and postpartum that could cause them to lose coverage. (§ 435.553/§ 435.554(a)-(c)). While pregnant women, postpartum mothers, babies, and their caregivers are exempt, confusing and complex paperwork requirements would still unnecessarily burden women and caregivers with administrative red tape to accessing life-sustaining healthcare. Administrative errors, or late or missing documentation, could lead to gaps in coverage that could cause them to miss important appointments or be unable to receive services critical to their health and pregnancy. This could be a particular risk given the short timeline that states must implement the IFR (§ 435.559). During the Medicaid unwinding, 58% of those re-enrolling experienced at least one problem doing so, and more than half of those said they found it difficult to renew coverage.[14] Delayed or foregone care elevates the risk of maternal and pediatric complications, ultimately resulting in greater reliance on emergency services and higher overall healthcare expenditures — or worse, the loss of mother or child.

Given the short implementation timeline there is a need for help to prevent administrative delays and errors. CMS should provide additional resources, model documentation, guidance on how to operate an appeals process, and best practices to help states communicate clearly about new requirements, available exceptions, and the steps needed to maintain coverage. CMS should also encourage and support state coordination with organizations and individuals engaged in assisting individuals with documentation and the submission of eligibility information (§ 435.559).

Like many in the healthcare and nonprofit service community, we are also concerned about the exemption process proposed by CMS for people with complex medical conditions or who are medically frail (§ 435.554).[15] P.L. 119-21 created a broad exclusion to work reporting

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

requirements for the medically frail, however, CMS has redefined medically frail by adding an enrollee's identified health condition "significantly impairs the individual's ability to comply with the community engagement requirement."

By significantly restricting states' ability to define and exempt populations, we will see significant numbers of otherwise eligible Medicaid recipients cut from the program. With the new requirements and definitions provided in the IFR, populations without access to providers who cannot provide medical claims or other documentation acceptable to their state will be more at risk for loss of coverage. This includes some of the more than 5.5 million women of childbearing age living in a maternity care desert or counties with low access to obstetric clinicians.[16] To illustrate the harm caused by unwarranted disenrollment due to lack of flexibility, complex requirements and paperwork, during the Medicaid unwinding nearly a quarter of those disenrolled during 2023 remained uninsured.[17] With many women on Medicaid prior to pregnancy, this is highly concerning for the health of any subsequent pregnancy and baby.[18]

States should continue to have the unfettered ability to determine acceptable definitions and methods for documentation, including self-attestation following January 1, 2028, to help those with limited access to acceptable sources of documentation comply with these new requirements. This is particularly vital until state verification data and processes function reliably. Additionally, for those residing in maternity care deserts, states should have the ability to adopt standards that promote consistency and auditability without imposing excessive paperwork on enrollees, clinicians, or the healthcare system. Self-attestation, which occurs under penalty of perjury, remains the best way to verify eligibility for the caregiver, illness, and disability exclusions, and is consistent with several preexisting processes for both Medicaid and the Supplemental Nutrition Assistance Program (SNAP) (§ 435.557(f)/ § 435.557(f)).

Administrative and financial burdens placed on states, volunteer organizations, and practitioners

While March of Dimes appreciates that the rule directs states to use reliable existing income and eligibility data to verify status on an ex parte basis before requesting information from individuals, we encourage CMS to expand the reliable data sources available to states through the Federal Data Services Hub and other available data sources (§ 435.557). This will help reduce reliance on enrollee-supplied paperwork for both six-month renewals and community engagement verification, as well as help prevent complications due to procedural, not ineligibility, causes.

March of Dimes is also concerned that states are being presented with an unexpectedly complicated, compressed, and overlapping set of obligations, and are not being given appropriate time to hire and train additional qualified staff to make the determinations required by the IFR that could lead to errors and delays impacting the ability of Americans to get the care they need (§ 435.560).

This is even more important as approximately three-quarters of those on Medicaid rely on the U.S. Postal Service to receive critical notices about their coverage, rather than electronically.

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

Reported mounting mail delivery difficulties could complicate the ability of many individuals to meet reporting requirements, particularly in rural areas, which are experiencing the worst problems (§ 435.561).[19]

CMS' definition of medical frailty places an unreasonable administrative burden on healthcare providers to determine, and then document, their patient's ability to work an unfamiliar job (§ 435.554(c)). Providers may not have training to, be familiar with, or otherwise be able to attest to their patient's ability to work "any" eligible paid or volunteer employment without putting themselves in unnecessary legal jeopardy. Many healthcare providers lack the necessary training in occupational medicine, and other skills and knowledge needed to formally evaluate whether a patient's health condition qualifies.

Alongside our concerns about requiring practitioners to attest to the ability of a patient to work, we are also concerned about the lack of clarity for managed care organizations' role (§ 435.561/§ 438.58). The IFR does not provide states and MCOs the necessary specificity on which support activities may be delegated to managed care organizations, so that plans' frequent, direct contact with members can be used to help identify potentially affected individuals, explain requirements and exemptions, and connect members to resources without crossing into the verification, exemption determination, or reporting functions that remain the state's responsibility. Additionally, if MCOs are required to take on the roles required by the IFR to support outreach, member education, and navigation, clarification is necessary regarding how the costs of this service will be sustainably supported, given that these activities cannot be included in capitation rates.

March of Dimes also is concerned that many community service organizations that may not have historically been a part of the Medicaid eligibility and compliance process, particularly in rural and low-income regions, are not currently prepared to, or lack the capability to, manage the volunteer inflow, data tracking, and reporting burden required by the IFR because of limited funding, staff, and infrastructure (§ 435.552). We recommend that CMS issue further guidance on resources, such as financial, templates, and legal advisories, that should be provided to these organizations to assist in alleviating the burdens placed upon them.

If CMS is unable to reduce this unreasonable burden on organizations and clinicians, March of Dimes suggests that CMS strongly consider providing model documentation standards that states can adopt to promote smooth facilitation, consistency, and auditability without imposing excessive paperwork on enrollees, caregivers, organizations, or clinicians.

Conclusion

The work requirements and resulting red tape set by the IFR could be especially devastating for rural communities, where the demand for care is already greater due to limited access to medical care resulting from hospital and practice closures, and an overall decrease in clinicians. With 41% of all births in the U.S. and health coverage for 39% of all children being provided by Medicaid, any changes to the program should be made with the intention of improving, not

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

limiting, access to vital healthcare services. Thank you for considering these comments. Please contact KJ Hertz (khertz@marchofdimes.org) for more information.

Sincerely,

Stacey Y. Brayboy
Sr. Vice President, Public Policy & Government Affairs

---

[1] Buettgens, M., Karpman, M., Haley, J., Carter, J., & Kenney, G. (2026, March 25). Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations | Urban Institute. Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work

[2] Medicaid.gov. (2025, January 15). October 2024 Medicaid & CHIP Enrollment Data Highlights. Retrieved January 28, 2025, from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.

[3] March of Dimes Peristats (December 2022). Health Insurance/Income – Medicaid coverage of births: United States 2023. Retrieved February 14, 2025. https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=154&lev=1&slev=1&obj=18

[4] Burns, A., Hinton, E., Rudowitz, R., & Mohamed, M. (2025, February 18). *10 Things to Know About Medicaid*. KFF. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/

[5] Births Financed by Medicaid. KFF. (2023). https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Percent+of+Births+Financed+by+Medicaid%22%2C%22sort%22%3A%22desc%22%7D

[6] Georgetown University Center For Children and Families. (n.d.). Medicaid Plays A Key Role for Maternal and Infant Health in Rural Communities. https://ccf.georgetown.edu/2025/05/15/medicaid-plays-a-key-role-for-maternal-and-infant-health-in-rural-communities/

[7] March of Dimes. (2024). (rep.). Nowhere to Go: Maternity Care Deserts Across the US. Washington, D.C. https://www.marchofdimes.org/maternity-care-deserts-report

[8] Ibid

[9] MaryBeth Musumeci, et al., "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees" (Kaiser Family Foundation, December 2018), available at https://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees.

[10] Concord Monitor, "New Hampshire Medicaid work requirement faces crucial test," July 6, 2019, https://www.concordmonitor.com/New-Hampshire-Medicaid-work-requirement-faces-crucial-test-26791579.

[11] Ian Hill et al., "New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results," Urban Institute, February 10, 2020, https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results.

[12] Harker, L. (2023, August 8). Pain but no gain: Arkansas' failed Medicaid work-reporting requirements should not be a model. Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model. https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

[13] Hinton, E., & Rudowitz, R. (2025, February 18). 5 Key Facts About Medicaid Work Requirements. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/

[14] Lopez, L., Sparks, G., Presiado, M., Tolbert, J., Rudowitz, R., Diana, A., & Kirzinger, A. (2024, April 12). KFF survey of Medicaid unwinding | KFF. KFF Survey of Medicaid Unwinding. https://www.kff.org/medicaid/kff-survey-of-medicaid-unwinding/

[15] American Lung Association. (2026, June 2). 48 patient organizations warn of massive coverage losses under Final Work Reporting Requirement Rule | American Lung Association. 48 Patient Organizations Warn of Massive Coverage Losses under Final Work Reporting Requirement Rule. https://www.lung.org/media/press-releases/fy26-work-requirements-coalition-statement

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

[16] March of Dimes. (2024). (rep.). Nowhere to Go: Maternity Care Deserts Across the US. Washington, D.C. https://www.marchofdimes.org/maternity-care-deserts-report
[17] Lopez, L., Sparks, G., Presiado, M., Tolbert, J., Rudowitz, R., Diana, A., & Kirzinger, A. (2024, April 12). KFF survey of Medicaid unwinding | KFF. KFF Survey of Medicaid Unwinding. https://www.kff.org/medicaid/kff-survey-of-medicaid-unwinding/
[18] Ranji, U., Salganicoff, A., Tolbert, J., Frederiksen, B., & Gomez, I. (2025, May 29). 5 key facts about Medicaid and pregnancy | KFF. 5 Key Facts About Medicaid and Pregnancy. https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-pregnancy/
[19] Searing, A. (6AD). Post Office Rural Service and proposed Medicaid work reporting requirements on Collision course – center for children and families. Post Office Rural Service and Proposed Medicaid Work Reporting Requirements on Collision Course. https://ccf.georgetown.edu/2026/07/06/post-office-rural-service-and-proposed-medicaid-work-reporting-requirements