NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
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July 30, 2026

Via Federal Rulemaking Portal

The Honorable Dr. Mehmet Oz
Administrator
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

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC); Comments of the North Carolina Department of Health and Human Services, Division of Health Benefits

Dear Administrator Oz:

The North Carolina Department of Health and Human Services, Division of Health Benefits (NC Medicaid), submits these comments on the interim final rule (IFC) published by the Centers for Medicare & Medicaid Services (CMS) on June 3, 2026, implementing Medicaid work requirements under Section 71119 of H.R. 1.[1] North Carolina administers Medicaid eligibility through 100 county departments of social services (DSS) and 1 tribal health and human service office, and the IFC's verification, documentation, and notice obligations will fall directly on a county caseworker workforce.[2]

In addition to the implementation of H.R.1 for Medicaid, county DSSs are simultaneously undertaking new requirements for SNAP eligibility and new State statutory requirements that increase the

[1]See Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026) (to be codified at 42 C.F.R. 435), https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals.
[2]North Carolina's one hundred county staff, rather than state staff, determine Medicaid eligibility, process verifications, and respond to beneficiary inquiries under state supervision and county administration. See N.C. Gen. Stat. § 108A-25.

frequency of change in circumstance reviews from quarterly to monthly and eliminate NC Medicaid's flexibility to leverage CMS's allowable use of self-attestation to meet Medicaid eligibility requirements. The combination of these new requirements creates significant burden on county DSSs which will impact their ability to retain staff and continue to maintain the high levels of eligibility accuracy that NC Medicaid has maintained.

As we prepare to implement the requirements in the IFC, we have concerns with several aspects of the IFC that conflict with CMS's earlier guidance and the plain language of Section 71119 that further complicate NC Medicaid implementation of H.R.1. The rule narrows the definition of medical frailty beyond the statutory language, adds mandatory documentation requirements for medical frailty in 2028, and undermines the statute's short-term hardship exception framework. These elements of the IFC will cause many eligible individuals in North Carolina to lose coverage, will increase workload for county DSS staff, and conflict with CMS's earlier guidance on which North Carolina relied in designing its policies, eligibility systems, application and renewal forms, verification workflows, notice templates, and provider and eligibility worker training programs.[3]

North Carolina relied on the plain language of the statute and CMS's verbal and subregulatory guidance, both of which define medical frailty without limiting the exclusion to individuals whose medical condition "significantly impairs" their ability to work. North Carolina engaged CMS in good faith throughout implementation, reporting monthly against the Minimum Viable Product workplan, participating in weekly technical assistance calls, and meeting directly with CMS leadership, including during Deputy Administrator Brillman's May 2026 visit to Raleigh, to flag the operational consequences of both federal and state requirements as they have taken shape. That good-faith effort has not changed the operational reality: the IFC introduces extensive new requirements that will make it necessary for North Carolina to implement significant policy changes, IT systems reconfiguration, operational redesign, and form and notice revisions that were not contemplated based on CMS's earlier

[3]In December 2025, CMS shared with states a Minimum Viable Product template, "Preliminary Features and Requirements for Community Engagement Implementation," that outlined required features and functional requirements for states' IT systems. Based on the Minimum Viable Product template, states were required to develop a workplan and report monthly to CMS on progress made against expected timelines. In parallel, CMS set up weekly meetings with states where it provided verbal guidance on allowable approaches for implementing medical frailty and defining qualifying activities, specified excluded status, and mandatory and optional exceptions, among other topics. North Carolina Medicaid further engaged CMS directly on these and related implementation issues, including during CMS Deputy Administrator and Director of Medicaid and CHIP Dan Brillman's visit to Raleigh in May 2026.

guidance. Moreover, the State's funding request for implementation resources was developed based on that earlier guidance and did not account for the additional verification processes, systems development, staffing, and operational costs imposed by the IFC.

While we have and will continue to work expeditiously to implement the new policies, it is unlikely that North Carolina will be able to fully implement the IFC's new requirements by the January 1, 2027, deadline despite good faith efforts to do so. Moreover, the new requirements inject substantial ambiguity into the requirements that CMS intends to impose on states and beneficiaries.

North Carolina originally projected that approximately 30 percent of Medicaid expansion adults would lose coverage because of H.R. 1's work requirements and six-month renewals. Yet those estimates, as well as the Preamble and the research CMS cites, fail to adequately address the risk that a *greater* number of eligible individuals will lose coverage because of the IFC's new narrower medical frailty definition, administrative complexity, and operational barriers, compounded in North Carolina by a locally administered eligibility system and new state regulatory requirements. In short, the IFC is likely to result in an estimated 64,000 more people losing coverage.[4]

Those additional coverage losses will not eliminate the need for health care; rather, they will shift costs to the State and to hospitals, clinics, and other providers that will continue to furnish uncompensated care to individuals who remain eligible for Medicaid but lose coverage because they are unable to navigate or satisfy the IFC's new verification requirements. This cost shifting threatens to further strain North Carolina's health care safety net and reduces resources available to serve Medicaid beneficiaries who remain enrolled.

Considering these issues, NC Medicaid strongly recommends that CMS issue a final rule that adheres to the plain language of Section 71119. CMS should also provide states sufficient time to implement its new requirements. As states adapt to and implement CMS's new and still-evolving guidance, states and beneficiaries should be protected from unfair and arbitrary penalties. To accomplish this objective, CMS should suspend PERM enforcement and federal disallowances related to work requirements until

[4] P. Boozang et al, "CMS's Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034" Manatt Health, July 2026. Available at https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/23b961e2-a654-4fd1-9358-1e3d42205358/Vital%20Signs%2050-State%20Tracking_CMS%20Medicaid%20Work%20Requirements%20Rule.pdf.

such time as a state can align its policies and systems fully with the IFC. States that are acting in good faith to implement a complex new eligibility framework on a compressed timeline, through a county-administered system that is already stretched, should not face payment recovery risk for coverage that continues while CMS's policies were still being clarified, adopted, and implemented.

I. The IFC's Medical Frailty Definition Exceeds CMS's Statutory Authority and Is Operationally Unworkable by the January 1, 2027, Deadline.

Recommended Change: *CMS should revise the medical frailty definition at 42 C.F.R. § 435.554(c)(5) to align with the plain language of Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act (SSA). Specifically, CMS should strike the phrase "significantly impairs the individual's ability to comply with the community engagement requirements in this subpart" from the new 42 C.F.R. § 435.554(c)(5)(i), which improperly adds a functional limitation standard.*

The IFC significantly departs from the statutory language and CMS's prior guidance with respect to the exemption for "medically frail" individuals, narrowing the exclusion to those individuals whose medical condition "significantly impairs" their ability to work. The additional requirement both exceeds CMS's authority under the statute and fails to consider states' reliance on the prior, contrary guidance, making the new policy unworkable under the January 1, 2027, deadline.

SSA §1902(xx)(9)(A)(ii)(V) defines the term "specified excluded individual" to mean, among others, an individual "who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual" with one of five clinical conditions: (1) an individual "who is blind or disabled as defined in section 1614;" (2) "with a substance use disorder"; (3) "with a disabling mental disorder;" (4) "with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living;" or (5) an individual "with a serious or complex medical condition." The statute does not condition all the exclusions on a determination that the individual is functionally unable to work.

The IFC, however, imposes an additional requirement not found in the statute. The rule defines an individual who is a "specified excluded individual" due to medical frailty as only an individual whose qualifying condition "significantly impairs" their "ability to comply with the community engagement

requirement."[5] CMS's interpretive addition converts what, for those "with a substance use disorder," a "disabling mental disorder," or "a serious or complex medical condition," is a clinically defined exclusion into a functional capacity determination. That determination is a materially different standard that requires a different evidentiary foundation, a different verification infrastructure, and a different provider role than the standard the statute authorizes, and in North Carolina that different infrastructure and provider role does not currently exist at the scale the IFC demands.

Throughout 2025 and up until the rule was released, CMS provided guidance that states should use claims data and diagnosis-based code lists as the primary mechanism for verifying an individual's medical frailty. North Carolina relied on this framework when building its information technology systems and strategy for verifying eligibility and compliance. Diagnostic codes and claims data convey clinical condition and treatment history; they do not directly convey an individual's capacity to work.

By adding this requirement, the IFC undermines the data-driven verification approach CMS previously instructed states to develop for medical frailty determinations. In doing so, the rule does not address why CMS narrowed the definition from the earlier guidance, nor that states had relied on the prior guidance in implementing the statute over the past year. Nor does the rule consider, or address, any additional eligible individuals who will lose coverage as a result of the narrowed definition.

II. The IFC's 2028 Documentation Requirements for Medical Frailty Conflict with the Statutory Flexibility and Will Accelerate Coverage Loss of Eligible Individuals.

Recommended Change: *To be consistent with the statute, CMS should revise the new 42 C.F.R. § 435.557(b)(2) by removing the medical frailty carve-out, and revise the new 42 C.F.R. § 435.557(b)(2)(i) and (ii) by eliminating the tiered pre-2028 / post-2028 verification hierarchy entirely, replacing both provisions with a single uniform standard that reads: "When there is no reliable information available to the State, or the reliable information available to the State is not reasonably compatible with the information provided by or on behalf of the individual, the agency may require documentation or accept other information as provided in § 435.952(c)."*

[5]See 42 C.F.R. § 435.554(c)(5)(i).

While the IFC provides time-limited transitional flexibility for medical frailty attestation in 2027, it fails to provide states the ongoing flexibility that SSA § 1902(xx)(9)(A)(ii)(V) requires, imposing instead a verification framework that effectively eliminates attestation as a viable verification method beginning in 2028.

This framework conflicts with statutory flexibility in SSA § 1902(xx)(3)(A), which expressly permits states to elect not to require verification of information that results in an exemption from work or community engagement.[6]

Beginning in 2028, the verification framework tightens materially in ways that conflict with the statute. Under the IFC, where data are insufficient to verify excluded status or an exception, states must require documentation from the individual if documentation is reasonably available. Only where documentation does not exist or is not reasonably available must states accept other information, such as a reasonable explanation.[7] Even then, the burden falls on the individual to produce the requested information.

For medical frailty specifically, beginning in 2028, the IFC limits the ability of an individual to self-attest to only once during a period of enrollment, even though this limitation is not allowed under SSA § 1902(xx)(3)(A). After that single opportunity, states must require documentation where data are unavailable;[8] there is no state option to accept self-attestation for subsequent verification cycles. This framework is more restrictive than the statute and its operational consequences are compounded by the medical frailty definition problem described in Section I. Under prior CMS guidance, North Carolina anticipated that claims data identifying qualifying clinical conditions would resolve a significant share of medical frailty determinations without requiring additional action from beneficiaries or their health care providers. By redefining medical frailty to require an assessment of whether a condition significantly impairs an individual's ability to satisfy the work requirement, the IFC creates a

[6]SSA § 1902(xx)(3)(A) ("The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month, and may elect to not require an individual to verify information resulting in such deeming," if the individual, for part or all of a month, was a "specified excluded individual," or under the age of 19, pregnant or entitled to postpartum coverage, eligible for Medicare or another Medicaid eligibility group, or an inmate of a public institution). Under federal regulations, states may generally rely on attested information in an application when determining Medicaid eligibility unless federal law specifically requires a state to verify that information, such as for income, citizenship, or immigration status. See 42 C.F.R. § 435.945(a).

[7]42 C.F.R. § 435.557(b)(2).

[8]42 C.F.R. § 435.557(b)(2).

determination that claims data generally cannot answer. As a result, many beneficiaries will be required to obtain additional medical documentation or provider certifications to establish eligibility for the exclusion. This process will force eligible individuals—many of whom have serious physical or behavioral health conditions—to navigate additional administrative hurdles and schedule appointments solely to obtain eligibility documentation, while simultaneously imposing significant new paperwork and certification responsibilities on already overburdened health care providers.

Most clinicians are not trained to conduct this assessment, which places health care providers, including those in North Carolina's rural and underserved counties where specialist access is already constrained, in the position of making administrative determinations that could result in their patients losing health coverage. North Carolina's implementation funding request was developed based on CMS's earlier guidance and did not anticipate the need for providers to furnish individualized documentation or certifications regarding a beneficiary's ability to satisfy the work requirement. Nor is there dedicated funding to reimburse providers for the substantial time and administrative effort these assessments will require. For beneficiaries, the burden is equally significant. Individuals seeking an initial determination of medical frailty may be required to secure appointments solely to obtain eligibility documentation before they can enroll in coverage, creating a significant barrier for uninsured individuals who may already face financial, transportation, or provider access challenges.

The burden does not fall on providers alone. North Carolina's eligibility determinations are made by caseworkers in 100 county departments of social services, trained to apply objective eligibility criteria, not to evaluate the functional employment consequences of a clinical diagnosis.[1] Because these determinations cannot be automated, they will require labor-intensive, manual review of provider certifications, and other supporting documentation on a case-by-case basis. This additional workload will slow application processing and eligibility renewals, divert staff from core eligibility functions, and require significant additional administrative resources that were not contemplated in the State's implementation funding request. These new administrative requirements will increase costs for both the State and the federal government while delaying eligibility determinations for applicants and beneficiaries across the Medicaid program.

The populations most likely to qualify as medically frail, those with serious chronic conditions, behavioral health disorders, and complex disabilities, are also among those most likely to face barriers

to obtaining provider documentation on the timeline the rule requires. Where the patient cannot obtain and provide the necessary document, the patient will lose coverage even if they qualify for the exclusion, which, in turn, will make it difficult to gather the documentation from medical appointments needed to re-establish eligibility for Medicaid.

III. The Short-Term Hardship Exception Framework Is Undermined by the Lookback Requirement, a Problem North Carolina's State-Law Lookback Period Will Compound.

Recommended Change: *CMS should revise the new 42 C.F.R. § 435.555 by adding the following: (1) If an individual experiences a short-term hardship event described in this section during a month included in the review period under § 435.556, the state may deem the individual to have demonstrated community engagement requirements for that month; (2) If an individual experiences a short-term hardship event during the month of application, renewal, redetermination, or reconsideration, the state may deem the individual to have demonstrated compliance with community engagement requirements for that month, notwithstanding the individual's compliance status during any prior review month.*

Nothing in the statutory text requires a state to first determine that an individual satisfied work requirements during a prior lookback month before applying a short-term hardship exception. To the contrary, the statute authorizes states to deem an individual to have demonstrated community engagement "for such month," the month in which the hardship occurs. This language suggests that the exception operates on the individual's work requirement obligation for the month in which the hardship occurred, rather than exclusively within a retrospective compliance review.

Accordingly, the best reading is that a short-term hardship exception may satisfy an individual's work requirement obligation for the month of the hardship event, including where that month is the month of application or renewal, without requiring a separate showing of compliance during a prior review period.

The lookback problem the statute creates is acute in any state, but North Carolina's circumstances make the federal interpretation more consequential. House Bill 696 currently directs NC Medicaid to apply a 3-month compliance lookback at both initial application and redetermination, rather than the

1-month lookback that H.R. 1 permits states to elect and that 38 of the 41 states required to implement work requirements for Medicaid expansion intend to adopt.[9]

A 3-month lookback widens the same hardship-exception gap the statute already creates: an applicant who experiences a qualifying hardship event in the month of application is assessed against compliance in not one but 3 prior months, increasing the likelihood that an otherwise-eligible individual is found noncompliant before the hardship exception can be reached. The General Assembly had no way of knowing that CMS would impose this restrictive view, which is inconsistent with the statute, when they passed the law, but it is now the law nonetheless. NC Medicaid recommended that the General Assembly revise this provision to a 1-month lookback tied to the applicant's current eligibility period, and separately advised CMS of the lookback's estimated $2.6 million annual cost in additional verification checks alone.[10] Until and unless that state-law change occurs, CMS's resolution of the federal hardship-exception lookback question will determine how often North Carolina applicants and beneficiaries experience the gap described above, magnified across a 3-month rather than 1-month review window.

IV. Until States Can Fully Address Last-Minute Changes and New Requirements Included in the IFC, CMS Should Suspend PERM Enforcement and Disallowances, Particularly Where, as in North Carolina, County-Administered Systems Are Absorbing Concurrent State-Law Changes.

Recommendation: *CMS should suspend PERM error findings and disallowances arising from work requirement eligibility, including findings that individuals were enrolled at application or permitted to remain enrolled during renewal pending completion of systems builds. States that are acting in good faith to implement a complex new eligibility framework on a compressed timeline, a challenge exacerbated by sweeping, last-minute changes made by CMS, should not face payment recovery risk for coverage that continued while CMS's policies were still being clarified, adopted, and implemented.*

[9]National Association of Medicaid Directors, survey of state implementation approaches to Medicaid expansion work and community engagement lookback periods (2026).

[10]North Carolina Department of Health and Human Services, Division of Health Benefits, DHHS Recommended Adjustments to HB 696 (May 15, 2026) (estimating that lengthening the work requirement lookback period from one month to three months will require a second Equifax-based verification check for approximately one quarter of expansion enrollees every six months, at a cost of approximately $7 per check, totaling approximately $2.6 million annually).

For the same reasons, CMS should exercise its authority to approve temporary implementation extensions for any requesting state demonstrating a good faith effort toward compliance, beyond the two states that the IFC indicates CMS anticipates will receive good faith waiver approvals.

Considering the operational challenges with implementing the IFC by the January 1, 2027, deadline, CMS should suspend PERM enforcement and federal disallowances with respect to work requirement determinations until North Carolina can confirm its work requirement eligibility system logic, verification workflows, and notice suite comply with the IFC. States cannot be held to an error rate standard for a body of eligibility determinations that depend on system configurations and operational workflows that they have not had sufficient time to implement, and for which CMS still has not issued clear, practical guidance.

Along with the major departures from CMS's earlier guidance, the IFC contains a substantial number of new policy clarifications that collectively require North Carolina to reconfigure eligibility determination systems, redesign workflows, revise application and renewal forms and notices, and develop new training materials, all on a timeline that does not permit adequate design, testing, and deployment across 101 county DSSs and tribal eligibility office. The scope of these changes was not apparent from CMS's earlier guidance, and many were not signaled in the preliminary Minimum Viable Product framework that states had been reporting against for the last five months. For example:

- **Qualifying activity and specified excluded individual definitions do not map to North Carolina's existing system logic.** The qualifying activity definitions count in-kind and unpaid work, establish a credit-hour-to-hours conversion standard for part-time educational enrollment, and permit income-based hours proxies with household proration logic when actual hours cannot be verified. The specified excluded individual framework requires states to assess excluded status before evaluating compliance or exception status, enroll individuals promptly when sufficient information exists even if excluded status verification is incomplete, designate the exclusion category requiring the least frequent reverification as the basis of record when multiple bases are available, and track status transitions mid-eligibility-period that trigger advance notice obligations and fair hearing rights. None of these definitions map to data fields, form questions, or determination logic that North Carolina's eligibility system currently maintains, and county DSS caseworkers, not state staff, will be the ones applying this new logic case by case.

- **Community service verification infrastructure does not yet exist for the organizations North Carolina beneficiaries rely on.** The IFC's definition of community service effectively limits qualifying activities to organizations that can track, document, and verify participation. This approach excludes many informal volunteer activities that provide meaningful community benefit, and it creates significant implementation challenges in North Carolina's rural counties, where community-based organizations are less likely to have the staffing, processes, or technology needed to track hours and respond to verification requests. To make community service a viable compliance pathway, North Carolina will need to identify and work with community-based organizations capable of documenting participation in a manner that satisfies Medicaid requirements. Building that infrastructure will require considerable time and coordination and may ultimately limit the availability of community service opportunities for beneficiaries in the counties that most need an accessible compliance pathway.

- **The notice framework requires a redesign timeline for January 1, 2027, deadline does not accommodate.** The rule mandates three categories of notices with extensive content requirements: phased outreach notices tied to the implementation date and lookback period; notices of noncompliance specifying available compliance pathways and consequences for both Medicaid and Marketplace coverage; and updated eligibility determination notices for adverse actions. Revising, translating, integrating with eligibility system notice-generation logic, and testing notices across the full range of triggering events typically requires six to nine months under normal conditions. Notices are the primary mechanism through which members learn about a complex new set of obligations, understand how to demonstrate compliance, and avoid wrongful coverage loss. CMS should allow states to suspend disenrollment actions until notices have been finalized, translated, legally reviewed, and validated against eligibility system notice-generation logic.

- **CCIIO's decision not to build work requirement verification into the Marketplace before January 1, 2027, will shift volume directly onto North Carolina's counties.** North Carolina is a Federally Facilitated Marketplace state with delegated Medicaid eligibility determination authority (FFM-D), meaning NC Medicaid currently accepts Marketplace eligibility determinations and processes them without additional county DSS caseworker intervention. CMS has informed North Carolina that the Marketplace will not build system changes in advance of January 1, 2027, to support verification of community engagement compliance or exceptions, and will instead pend adult Medicaid applications and send them to states to make the determination. Because the information

> needed for both compliance determinations, such as monthly income, and exception determinations, such as American Indian/Alaska Native status, is already available to the Marketplace, this is a federal system design choice rather than a data availability problem. The practical consequence for North Carolina is a volume of pended Marketplace cases that will need to move through NC Medicaid's ex parte review and county-level adjudication, on top of the verification and documentation burdens the IFC itself imposes, and county caseworkers, again, will be the ones absorbing that volume.

These are substantive eligibility determination logic changes that go beyond the systems build North Carolina had anticipated based on earlier guidance and the December 2025 Minimum Viable Product.

Conclusion

NC Medicaid is committed to implementing work requirements in a manner that is legally compliant, operationally sound, and protective of the eligible individuals the exclusion and exception framework is designed to serve.

Nevertheless, we have serious concerns that certain portions of the IFC are contrary to the statute and will result in coverage loss for eligible individuals. Specifically, the medical frailty definition exceeds the statutory text and renders existing data infrastructure insufficient, and the 2028 documentation framework forecloses self-attestation for the population most likely to struggle with documentation burdens. To resolve these concerns, CMS should revise the rule to align with the plain language of the statute.

The additional policy changes in the rule will make it extraordinarily difficult for North Carolina to complete compliant implementation by January 1, 2027, a difficulty that is concretely worse in North Carolina, where one hundred county departments of social services, not a centralized state workforce, must absorb new federal verification and documentation logic, a redesigned notice suite, and a wave of Marketplace cases CCIIO has chosen not to resolve at the federal level, at the same time NC Medicaid is independently working to implement state-law changes that compound the same county DSS workload. CMS should, therefore, suspend PERM enforcement and federal disallowances with respect to work requirement determinations until each state has had the opportunity to fully implement the last-minute and expansive changes included in the IFC. Where CMS's final rule lands on the medical frailty definition, the 2028 documentation framework, and the hardship exception's interaction with

the lookback period will determine how much of this county-level burden North Carolina absorbs as a matter of federal law, separate from whatever the General Assembly ultimately decides with respect to House Bill 696.

Thank you for the opportunity to provide these comments. We look forward to continued engagement with CMS as implementation proceeds.

Respectfully submitted,

DocuSigned by:
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