

July 31, 2026

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Comments on Medicaid Community Engagement Interim Final Rule (CMS-2454-IFC)

The undersigned North Carolina foundations jointly submit these comments on the interim final rule (IFR), “Medicaid Program; Community Engagement Requirements Under the Medicaid Program” published June 3, 2026. We are a coalition of philanthropic funders working across North Carolina to improve health, economic security, and quality of life for North Carolinians with low incomes. We write because this rule threatens the well-being of the communities we serve. Our specific concerns and recommendations are outlined below.

The IFR will Increase H.R. 1 Coverage Losses

Starting January 1, 2027, H.R. 1 (the federal budget bill passed in July 2025) will require Medicaid expansion adults to document 80 hours a month of work, volunteering, or schooling to keep their coverage, unless they qualify for an exemption (e.g., pregnancy, caring for a young child, medical frailty, or substance use treatment). Evidence from Arkansas' 2018 work-requirement experiment shows this kind of policy tends to strip coverage from people through paperwork burdens rather than through any real change in employment. ¹ CMS's rule implementing H.R. 1 goes further than the statute requires and Manatt Health's July 2026 analysis found the IFR alone accounts for a significant share of North Carolina's projected coverage losses. ²

Scenario	Avg. Annual Decline	% From Baseline
Scenario 1: H.R. 1 plain language	225,000	-7%
Scenario 2: CMS IFR implementation	289,000	-9%
Additional loss attributable to the IFR	64,000	+28% vs. Scenario 1

Of the roughly 289,000 North Carolinians projected to lose Medicaid coverage annually under the IFR, an estimated 64,000 (nearly one in four) would retain coverage under a plain-language reading of H.R. 1. That gap is entirely attributable to CMS's discretionary implementation choices.

CMS Failed to Limit How Much Additional Red Tape States Can Add

The IFR also left the door wide open for states to pile on additional requirements, with no upper limit. North Carolina has already shown just how far states will go without firm limits. NC House Bill 696,³ signed April 30, 2026, shifts NC Medicaid eligibility reviews from quarterly to monthly, on top of the required federal six-month redetermination cycle. H.B. 696 further bars North Carolina from accepting self-attestation (a beneficiary's own signed statement) as the sole evidence of eligibility for any Medicaid requirement, even though the IFR itself allows states to accept self-attestation through 2027. In practice, this leaves no margin for NC Medicaid members engaged in informal or cash-based work. For example, a farmworker paid in cash for a sweet potato harvest may work well over 80 hours a month, but because her word alone is insufficient, she must also produce a pay stub, employer letter, or formal time record that a cash arrangement is unlikely to generate, leaving her indistinguishable on paper from someone who did not work at all. Because H.B. 696 layers state-level burden on top of the IFR's federal floor, North Carolina's actual losses are likely to exceed the estimates provided by Manatt.

SNAP's Work-Requirement Rollout Is a Warning Sign

North Carolina doesn't need to speculate about how work-reporting rules affect enrollment — SNAP is already showing us. H.R. 1 expanded SNAP work requirements to groups that used to be exempt, including parents of teens 14 and older, adults up to age 64, veterans, and former foster youth. North Carolina rolled out these changes on December 1, 2025. Since then, 194,669 North Carolinians have lost food assistance, a 13% drop in enrollment.⁴ And because the rules only take full effect at renewal, with a 3-month grace period, most of that drop happened before enforcement was even fully underway, meaning further declines are still coming.

This decline isn't about people finding jobs. North Carolina's unemployment rate barely moved over the same period, which points to paperwork and red tape driving the drop, not people leaving the workforce.⁵ We fear that Medicaid work requirements will have similar consequences. CMS should treat North Carolina's SNAP experience (and similar patterns in other states) as real-world evidence of how this verification approach will actually play out.

Provider Shortages Make the Added Functional Impairment Test Unworkable

H.R. 1 exempts people who are medically frail or have special medical needs. The IFR adds something H.R. 1 doesn't require: proof that the condition "significantly impairs" the person's ability to do daily activities. That's a new hurdle, and North Carolina's ban on self-attestation makes it worse.

The medical frailty exemption works differently than the general work-reporting rule described above. Under the IFR, someone can self-attest to being medically frail in 2027 and only once starting in 2028. After that, they must provide documentation proving their conditions limit their ability to work. That's an additional layer of red tape. A doctor can easily confirm a cancer diagnosis or a serious mental illness. Confirming that the condition crosses a specific work-limiting threshold is a different, more specialized kind of evaluation.⁶ Because North Carolina doesn't allow self-attestation, NC beneficiaries will need this formal certification from day one. Patients who have never needed formal documentation of their limitations will be scrambling to seek verification from providers who have never been asked to do this. With 93 of North Carolina's 100 counties designated as primary care shortage areas,⁷ many beneficiaries simply won't have a nearby provider able to complete this certification.

The IFR's Burdens Will Fall Hardest on Rural Communities and Communities of Color

Rural North Carolina communities already face higher unemployment, more seasonal work, and limited broadband and transportation access. These conditions make monthly work-hour reporting and paperwork corrections structurally more challenging to navigate.⁸ Rural hospitals, which depend disproportionately on Medicaid revenue, are least equipped to absorb these coverage losses. In North Carolina, 5 rural hospitals have been identified as being at risk of closure due to H.R. 1 provisions.⁹ These hospitals are often among the largest employers in their counties, so a single closure would not only eliminate a critical source of care but also strip the local economy of jobs, wages, and tax revenue that surrounding businesses and services depend on.¹⁰

The same documentation burden compounds existing racial disparities. Nationally, during Medicaid's post-pandemic unwinding, Black and Hispanic adults who lost coverage were about twice as likely as White adults to report losing it because they could not complete the paperwork, not because they were ineligible.¹¹ Narrowing self-attestation and tightening the medical frailty exemption risks reproducing this pattern at even greater scale.

Philanthropy Cannot Fill Gaps at This Scale

As North Carolina funders, we want to be direct about the limits of what philanthropy can do here. North Carolina's roughly 1,800 foundations give about \$1.4 billion a year for every cause in the state combined.¹² Medicaid covers more than three million North Carolinians, spending \$41.6 billion a year to do it.¹³

North Carolina foundations are already being asked to help respond to community needs resulting from H.R. 1 and this IFR. NC DHHS and community-based organizations need additional funding to communicate about changes, help people navigate confusing new rules, and provide legal assistance for people who are likely to be terminated for procedural reasons. We already aren't able to fulfill these requests, and we know that the need will only increase. As hundreds of thousands of North Carolinians begin to lose Medicaid coverage, the need from free clinics and health centers for safety-net care will far exceed our collective resources.

Recommendations and Conclusion

Based on these concerns, we recommend CMS:

- Set firm limits on how much additional administrative burden states can impose;
- Remove the added functional-impairment test from the medical frailty exemption and align it with H.R. 1's statutory text;
- Give states flexibility to keep people covered, including letting medical frailty be established by diagnosis or self-attestation when it can't be verified automatically through existing records (ex-parte); and
- Require states to publicly report monthly procedural (non-eligibility-based) coverage terminations, disaggregated by race, ethnicity, and rurality.

These are examples, not a complete list, and fixing any one of them wouldn't solve the underlying problem: H.R. 1's work requirements will cause large-scale coverage loss among eligible North Carolinians, no matter how carefully CMS implements the rule. Even a version that matched H.R. 1's plain language exactly, with none of the IFR's added restrictions, would still lead to an estimated 225,000 people in our state losing their coverage each year. We're raising these concerns to show where and how this rule causes harm, not because fixing them would make it acceptable. We urge CMS to weigh all of this before finalizing the rule and assess its impact on the North Carolinians we serve.

Thank you for the opportunity to comment. Please contact Madison Allen at madison@kbr.org with questions.

Respectfully submitted,

Dr. Laura Gerald, President, Kate B. Reynolds Charitable Trust

Dr. Susan Mims, President & CEO, Dogwood Health Trust

Flozell Daniels, Jr., Chief Executive Officer, Mary Reynolds Babcock Foundation

Foundation for a Healthy High Point

The Health Foundation, Inc.

Highlands Cashiers Health Foundation

John Rex Endowment

¹ Laura Harker, *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model*, Ctr. on Budget & Policy Priorities (Aug. 8, 2023), <https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be>.

² Manatt Health, *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034*, Vital Signs: 50-State Tracking tbl.1 (N.C.) (July 2026), <https://www.manatt.com/Health>

³ Act of Apr. 30, 2026, ch. 2026-1, § 3C.7, 2026 N.C. Sess. Laws (codified at N.C. Gen. Stat. § 108A-55.6 (2026)) (eff. Oct. 1, 2026).

⁴ R. Butts & L. Perez Uribe Guinassi, *How Many People Are Losing Access to SNAP Because of the One Big Beautiful Bill?*, News & Observer, Under the Dome (July 17, 2026), <https://www.newsobserver.com/news/politics-government/politics-columns-blogs/under-the-dome/article316488600.html>

⁵ Bureau of Labor Statistics, *North Carolina Economy at a Glance*, U.S. Department of Labor, <https://www.bls.gov/eag/eag.nc.htm> (last visited July 25, 2026).

⁶ Sam Whitehead, *Doctors 'Cringe' at Possibility of Documenting Which Medicaid Enrollees Too Sick To Work*, KFF Health News (July 20, 2026), <https://kffhealthnews.org/medicaid/medicaid-work-requirements-medical-frailty-documentation-doctors/>.

⁷ N.C. Department of Health & Human Services, Office of Rural Health, *North Carolina Health Professional Shortage Area* (2024 Profile, data as of June 10, 2025), <https://www.ncdhhs.gov/nc-dhhs-orh-hpsa-one-pager/open>

⁸ J. Baxley & J. Fernandez, *Looming Medicaid Work Rules Bring Big Challenges to NC Counties*, N.C. Health News (Apr. 30, 2026), <https://www.northcarolinahealthnews.org/2026/04/30/medicaid-work-county-challenges/>

⁹ E. Moore, *These 5 Hospitals Across NC Could Close With House Republicans' Funding Cuts*, Charlotte Observer (June 20, 2025), <https://www.charlotteobserver.com/news/state/north-carolina/article308821350.html>; see also P. Shafer & C. Sloan, *Viewpoints: Looming Medicaid Cuts Will Hurt North Carolinians*, Chapelboro.com (July 21, 2026).

¹⁰ Chartis, *2026 Rural Health State of the State* (2026), <https://www.chartis.com/insights/2026-rural-health-state-state> (last visited July 28, 2026).

¹¹ KFF, *Medicaid Efforts to Address Racial Health Disparities* (Aug. 2025), <https://www.kff.org/medicaid/medicaid-efforts-to-address-racial-health-disparities/>

¹² Candid, *North Carolina Foundation Giving Data* (2023), <https://southeast.candid.org/dashboard/state/nc/>

¹³ N.C. Division of Health Benefits, *FY2026-27 Budget*, reported in Carolina Journal (July 2026), <https://www.carolinajournal.com/nc-medicaid-spending-nears-42b-after-93-growth-in-4-years/>