July 27, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period (CMS-2454-IFC)

Dear Administrator Oz:

On behalf of the Academy of Medicine of Cleveland & Northern Ohio, representing physicians across Northeast Ohio who care for hundreds of thousands of patients each year, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule regarding Medicaid work and community engagement requirements.

Our physicians support policies that improve health outcomes, encourage employment when appropriate, and strengthen the long-term sustainability of the Medicaid program. However, we are deeply concerned that the proposed rule, as drafted, will create significant administrative burdens while ultimately reducing access to medically necessary care for vulnerable Ohioans. Indeed, Manatt Health estimates that the IFR implementation approach would increase average annual Medicaid coverage losses by 1.8 million people, from 6.4 million to 8.2 million between FFY 2027–2034—nearly 1 in 10 Medicaid enrollees nationwide. The estimate assumes a 40% coverage-loss rate among those subject to work requirements, informed largely by New Hampshire's prior experience implementing work requirements.

Administrative Complexity Will Divert Resources from Patient Care

Physicians and hospitals already face unprecedented administrative requirements related to insurance verification, prior authorization, quality reporting, and documentation. The proposed work requirement adds another layer of bureaucracy requiring providers to:

- Complete additional medical exemption documentation;
- Respond to eligibility verification requests;
- Assist patients in navigating complex reporting requirements;
- Manage interruptions in coverage resulting from procedural rather than clinical issues.

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These activities consume valuable physician and staff time without improving patient care. Instead, they shift limited healthcare resources away from direct patient services toward administrative compliance.

For many independent physician practices—particularly those serving Medicaid populations—these additional responsibilities may require hiring additional administrative personnel or reducing clinical capacity. At a time when physician burnout remains a significant concern, CMS should avoid policies that increase non-clinical workload. Administrative requirements are already recognized as a major contributor to healthcare costs and clinician burnout across the healthcare system.

Coverage Interruptions Lead to Worse Health Outcomes

Experience has demonstrated that work reporting requirements frequently result in eligible individuals losing coverage because of paperwork or reporting challenges rather than ineligibility. Patients with chronic illnesses, behavioral health conditions, disabilities, limited English proficiency, unstable housing, or inconsistent internet access are particularly vulnerable to these procedural barriers. Concerns have also been raised that eliminating or restricting self-attestation increases paperwork burdens for both patients and clinicians.

When patients lose coverage—even temporarily—they often delay preventive care, discontinue medications, postpone treatment for chronic diseases, and ultimately seek care only when conditions become acute. These interruptions frequently result in increased emergency department utilization, avoidable hospitalizations, and higher overall healthcare expenditures. This is particularly true of those with primary mental health or substance abuse diagnosis. Of the 778,000 Ohioans currently enrolled in the Group 8 Medicaid Expansion population, 40% fall into this category—leaving vulnerable Ohioans at risk.

Rural and Safety-Net Providers Will Bear a Disproportionate Burden

Safety-net providers, federally qualified health centers, teaching hospitals, and rural health systems care for large numbers of Medicaid beneficiaries. These organizations often operate with limited administrative capacity while managing patients with complex medical and social needs.

Additional documentation and eligibility verification responsibilities will disproportionately affect these providers, increasing uncompensated administrative work without corresponding reimbursement.

Physician Time Should Be Reserved for Clinical Care

Every hour physicians spend completing eligibility documentation is an hour unavailable for diagnosing illness, managing chronic disease, counseling patients, or improving access through additional appointments.

CMS has appropriately recognized in numerous initiatives that reducing unnecessary administrative burden improves healthcare delivery. The Academy strongly encourages CMS to ensure that any eligibility policies align with that same objective by minimizing documentation requirements, maximizing automation through existing state and federal databases, and preserving physician time for direct patient care. CMS itself has recently emphasized reducing administrative burden in other regulatory initiatives.

Recommendations

The Academy respectfully recommends that CMS:

1. Simplify verification processes by maximizing automated data matching and minimizing physician documentation requirements.
2. Preserve broad medical exemptions and maintain flexible self-attestation processes where appropriate.
3. Conduct a comprehensive analysis of the administrative costs imposed on physician practices, hospitals, and health systems before implementation, as well as county and state governments facing this unfunded mandate.
4. Delay implementation until CMS demonstrates that the proposed requirements will not reduce access to care for eligible beneficiaries.
5. Monitor and publicly report the effects of the rule on coverage continuity, provider administrative burden, appointment availability, and patient health outcomes.
6. Reconsider removing self-attestation: as proposed to phased out by 2028, as this put documentation burden on sickest, hardest-to-reach enrollees.
7. Revise the proposed timeline of Jan 1, 2027 as this deadline is too compressed, and county and state systems are not ready for implementation.

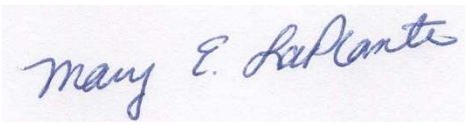
Conclusion

The Academy of Medicine of Cleveland & Northern Ohio shares CMS's commitment to improving healthcare quality, promoting healthy communities, and ensuring responsible stewardship of public resources. We believe these goals are best achieved through policies that expand—not restrict—timely access to care while reducing unnecessary administrative burden on healthcare providers.

We respectfully urge CMS to revise the proposed rule to ensure that administrative requirements do not unintentionally create barriers to care, increase healthcare costs, or further strain an already challenged physician workforce.

Thank you for considering our comments. We appreciate the opportunity to participate in the rulemaking process and welcome continued dialogue with CMS.

Sincerely,



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