FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

July 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MC 21244-1850
Attention: CMS-2454-IFC

Submitted electronically via Medicaid.gov

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals; CMS-2454-IFC

Dear Administrator Oz,

On behalf of Families USA, thank you for the opportunity to comment on the Interim Final Rule (IFR) implementing Public Law 119-21 § 71119, which establishes community engagement requirements for certain adults who access Medicaid through the Affordable Care Act's (ACA's) Medicaid expansion or through similar coverage under a state Section 1115 waiver.

Families USA serves as the longtime national, non-partisan health care consumer advocacy organization, dedicated to achieving high-quality, affordable health care and improved health for all. Representing low-income Medicaid consumers, **we strongly oppose numerous aspects of the Centers for Medicare and Medicaid Services' (CMS') approach to implementing § 71119, including the IFR's definition of "medically frail" and the limitations it sets on states' abilities to conduct verifications using auditable self-attestations.** This letter details how these elements of the IFR go against the unambiguous text of the statute, are costly and unworkable to administer in any time frame, and place massive burdens on patients and providers. **We respectfully ask CMS to redraft the IFR in a way that appropriately and thoughtfully designs a work reporting requirement program that meets statutory obligations and helps keep eligible people on coverage.** Until CMS can draft an IFR that complies with the statute and maintains access for the communities Medicaid was designed to serve, it must delay § 71119 implementation.

A substantial body of research documents the harm that work reporting or community engagement requirements cause to vulnerable populations and the waste of taxpayer dollars these requirements are to states and the federal government, as they require intensive resources to implement and yet do not yield higher employment rates, reduce poverty or lower health care costs.[1] Furthermore, these programs push eligible people off of Medicaid by setting eligibility hurdles so high that many hard-working, eligible Americans cannot overcome bureaucratic barriers and red tape to repeatedly prove their eligibility and access, in order to enroll or maintain Medicaid coverage. When Congress passed Public Law 119-21 (referred to by several different names but referred to as "H.R. 1" throughout this comment letter), the Congressional Budget Office estimated that 5.3 million Americans would lose access to Medicaid.[2] This is likely a low estimate, as other independent research estimates up to 10.1 million Americans will lose coverage—over half of the approximately 20 million low-income Americans who access health insurance through the ACA Medicaid expansion.[3]

That said, we recognize that H.R. 1 is now law, despite our opposition to work reporting requirements in any form. However, this interim final rule goes impermissibly beyond the law and violates the spirit and

letter of what Congressional and Administration champions of this policy stated was their intention, which was an easy and quick process that would allow eligible Americans to keep their coverage and would not impact vulnerable populations, including people with disabilities and serious medical conditions. In that vein, we support efforts to implement the statute in ways that: ensure the maximum number of eligible people remain covered; treat vulnerable populations fairly with respect to their needs and circumstances; ensure health care providers continue to participate in Medicaid networks; and give states the flexibility they need to design programs that function within their administrative capacity. The IFR fails in all these respects. A July 2026 analysis by Manatt estimates that CMS' policies in this IFR are likely to substantially increase coverage loss beyond what would have occurred under a plain-language reading of the statute, causing at least **1.8 million *more* people losing Medicaid coverage each year**.[4]

While the IFR offers an implementation framework for many aspects of work reporting requirements, our comments focus on two specific CMS policy choices that will impose unrealistic paperwork burdens on states, providers, and Medicaid patients alike, leading to even greater coverage losses:

> A definition of "medically frail" that is impermissibly beyond the statutory framework. CMS' problematic definition of an individual who is "*medically frail or otherwise has special medical needs*" goes far beyond the text of the statute to require people who have the most need for medical care – including people with substance use disorder, disabling mental disorders, physical, intellectual or developmental disabilities, or other "serious or complex" medical conditions – to not only prove their health condition, but also to take extra steps to prove that, because of their condition, they lack capacity to work. Not only does CMS fail in its obligation to implement the statute by defining this key term differently and substantially beyond the statutory text, but CMS also fails the very communities Medicaid is designed to protect and that H.R. 1 specifically exempts from such bureaucratic barriers. The definition sets up exponentially more cumbersome paperwork burdens that Medicaid systems are not equipped to collect and process, and that our health care system is not equipped to provide. All of this will leave the most vulnerable people with significant health needs without ability to prove their medical frailty and at great risk of losing coverage.
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> Unrealistic limitations on self-attestation that do not respect the realities of individual conditions and circumstances. Many Medicaid-eligible people may have difficulty proving their health conditions, work capacity or other life circumstances without the ability to self-attest to this information. H.R. 1 sets an expectation for states to reduce paperwork burdens and expressly gives states the ability to conduct verifications using auditable self-attestations. However, the IFR significantly limits self-attestation starting in 2028. With limited ability to self-attest, Medicaid enrollees will have to submit *more* paperwork than required under the statute and are at risk of losing coverage if they do not have access to health care providers who can support them in medical frailty documentation every 12 months.

We respectfully request CMS to redraft the IFR to define "medically frail" as required by the statute—removing all references to work capacity—and allow states to conduct verifications using auditable self-attestations, as required by the law.

Our comments examine these issues in full, in three parts:

- An examination of the statutory text and discussion of how the definition of "medically frail" and limitations on self-attestations impermissibly stray from unambiguous statutory requirements;

- An assessment of how the IFR's definition of "medically frail," coupled with limitations on self-attestation and a data lookback period restricted to 12 months, creates an unworkable framework that will not be feasible for states to implement; and
- A discussion of the unnecessary strain new medical frailty requirements and inflexibilities in self-attestation will create for providers and their patients who have legitimate medical frailties and, if not for the IFR, would be eligible for the exceptions guaranteed to them under the statute.

I. CMS must redraft its definition of "medically frail" as the IFR's additional requirement linking medical frailty to ability to work is not supported by the unambiguous statutory text. CMS must also remove its regulatory limitations on states' abilities to conduct verifications using auditable self-attestations, as H.R. 1 explicitly preserves this flexibility for the states.

Where Congress has unambiguously spoken—when the statutory text is clear and unequivocal—an agency regulation that contradicts the statute is unlawful, full stop.

While Congress has delegated authority to CMS to conduct rulemaking to interpret certain statutory provisions governing H.R. 1's Medicaid work reporting requirements, under the Administrative Procedures Act (APA), CMS has no discretion to depart from the plain meaning of unambiguous statutory terms defined by Congress.[5] The APA instructs courts to hold unlawful and set aside agency action that is "not in accordance with law" or "in excess of statutory jurisdiction, authority, or limitations."[6]

The IFR impermissibly departs from clear statutory language on two major occasions: (i) CMS' definition of the "medically frail" exclusion which adds stringent restrictions and requirements that are not contained anywhere in the plain language of H.R. 1; and (ii) CMS' significant limitations on self-attestation that constrain states' ability to verify statutory requirements, exceptions and exclusions and remove verification flexibilities expressly preserved for states under H.R. 1. These clear departures from the statute render these new definitions, requirements and limitations unlawful under the APA.

Further, the eleventh-hour regulatory changes forced by Trump Administration officials on these issues and effectuated in the IFR are blatant arbitrary and capricious actions that are not allowable under § 706(2)(A) of the APA.

i. CMS does not have authority under Public Law 119-21 § 71119 to define "medically frail" as requiring an individual to prove they lack capacity to work; the statutory text defining "medically frail" is unambiguous and does not permit CMS' interpretation.

The term "medically frail" is unambiguously defined. Congress defined the categories of individuals who must be "specifi[cally] excluded" from H.R. 1's new work requirements based on the existence of a demographic characteristic or medical condition, without any additional reference to the individual's ability to work. In the case of an individual who is "medically frail or otherwise has special medical needs," the exclusion from the work requirement is specifically defined by reference to a medical condition *only.* Under 42 U.S.C. § 1396a (xx)(9)(A)(ii)(V) "medically frail or otherwise has special medical needs" is defined by the statute to include an individual who falls under one of five categories:

> *(aa) who is blind or disabled; (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition*.

Nowhere in the statute does Congress state that individuals are excluded from the community engagement requirement as medically frail only if they also establish that their condition impairs their ability to work. **The IFR adds stringent new requirements to the "medically frail" exclusion that are not contained anywhere in the plain language of H.R. 1 rendering these additions unlawful under the APA.**

Where Congress wants to link a medical diagnosis to ability to work, it does so without ambiguity. For example:

- Social Security Disability Insurance is authorized under the *Social Security Act*, setting a requirement in statute connecting a medical condition with ability to work (referred to in the statute as "substantial gainful activity").[7] Under 42 U.S.C. § 423(d), the term "disability" means an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." In further defining disability, the statute states: "An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy."[8]
- The *Family Medical Leave Act of 1993* gives employees the right to 12 weeks of leave from work for several reasons, including, "a serious health condition that makes the employee unable to perform the functions of the position of such employee."[9]

In these two examples, Congress left no ambiguity that it was connecting a medical condition to an individual's ability to work, and administrative bodies implementing these statutory requirements have been lawful in setting requirements that ask individuals to demonstrate their inability to work to gain benefits. H.R. 1, by contrast, contains no similar language defining medical frailty as requiring an inability to work. Rather, the statute unambiguously defines an individual who is "medically frail or otherwise has special medical needs" as someone who has a condition falling under one of the five enumerated statutory categories of medical conditions. Linking medical frailty to ability to work is clearly outside of the bounds of H.R. 1 and impermissible under the APA.

ii. CMS does not have authority under Public Law 119-21 § 71119 to limit self-attestations for individuals who are medically frail. H.R. 1 explicitly gives states flexibility to conduct verifications using auditable self-attestations and the IFR impermissibly limits this verification method.

Despite instituting new paperwork burdens designed to kick eligible people off coverage, Congress did offer important protections for Medicaid applicants and enrollees by requiring *ex parte* verifications for determining individuals' compliance with work requirements at application and redetermination and whether an individual is "specifi[cally] excluded" from those requirements.[10] H.R. 1's *ex parte* verification provision requires that states "establish processes and use reliable information available to the State […] without requiring, where possible, the applicable individual to submit additional information."[11] In other words, where possible, states must make decisions about eligibility without demanding more information from the Medicaid member or applicant.

While states are required to verify through data-based sources, such as medical history or health services claims, in some cases such data may not be available to the state—for example, when an individual is newly applying for Medicaid and does not yet have access to health care providers that can help them build a medical claims history, or when appropriate treatment for a condition happens

outside the health care system and does not produce a medical claim (as in the case of community-based treatment for substance use disorder). Congress addressed this issue by allowing states to "elect to not require an individual to verify information" through documentation, thereby establishing an option for states to accept self-attestation under penalty of perjury to determine compliance and exclusions, including the medical frailty exclusion.[12]

Because H.R. 1 explicitly gives states' the ability to conduct verifications using auditable self-attestations, it is against the plain language of the statute for CMS to limit the use of self-attestations. The words of the statute have no meaning if they are to be interpreted as disallowing self-attestation on the basis of medical frailty, and the limitation set in the IFR is unlawful under the APA.

iii. Administrative actions in defining "medically frail" and limiting self-attestation were conducted arbitrarily, capriciously and in bad faith; CMS issued a policy succumbing to last-minute political whims of the Administration, rather than a reasoned and thorough approach to developing policy and guidance for states.

As the work that state Medicaid agencies need to do to implement H.R. 1's work reporting requirement is complex, expensive, and takes extensive time and attention to perform correctly, states did not have the luxury of waiting for the IFR's release before beginning implementation. Prior to the IFR, in reliance on the plain language of the statute and CMS' prior guidance and communications to them, states made substantial investments in and modifications to enrollment and other systems to capture information necessary to determine work/community engagement status and exceptions and exclusions required under the statute.[13]

- None of CMS' prior communications with states indicated that the Agency would define an individual who is "medically frail or otherwise has special medical needs" in relation to that individual's ability to engage in work or other qualifying activities.[14] States did not have any inkling that CMS would define medical frailty in this manner: after all, the plain language of the statute would not allow for such a definition.
- While CMS previously described self-attestations as something that should be used infrequently, it never indicated to states that it would limit states' ability to rely on self-attestation when other data sources are unavailable.[15] Because the statutory text gives states express ability to conduct verifications using auditable self-attestation, states did not have reason to think CMS would curtail the use of self-attestation going forward.

However, last-minute political maneuvering forced extensive changes to the IFR,[16] leaving states to implement regulations that differ substantially both from the pre-IFR guidance issued by CMS and from the statute itself. Setting aside the wisdom of these new approaches, the lack of consistency between CMS' prior guidance and its eventual IFR represents a marked change in course, one that sends state planning into a tailspin. States now must interpret new compliance regimes in mere months to meet the August 31, 2026, statutory member notice date, and only four months thereafter to design and operationalize their systems in time to comply with the January 1, 2027, implementation date. States must engage vendors to re-design electronic systems and processes to ascertain whether a particular health condition significantly impairs one's ability to comply with the work requirements, whether and how an enrollee can use self-attestation and the appropriate age of the data for claim consideration, among other major issues (as discussed in further detail below).

These change orders add administrative expense to an already costly endeavor (see discussion below), but more to the point here, the fact that CMS has demanded these changes after months of guidance and communications that stated otherwise undermines the legitimacy of CMS' policymaking. While agencies are allowed to change their policy positions, when they ignore or fail to grapple with the reliance interests generated by their own prior statements, courts find that agencies are acting in an arbitrary and capricious manner in violation of the standards required of them under the APA.[17] As Justice Scalia explained in *FCC v. Fox Television Stations, Inc.*: "when [an agency's] prior policy has engendered serious reliance interests that must be taken into account… It would be arbitrary or capricious to ignore such matters… a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[18]

Here, states had reason to rely on CMS' prior statements and earlier guidance—indeed, states had *no choice* but to rely on CMS' prior statements given the statute's compressed implementation timeline and the urgency of designing an operable work reporting requirement system to meet statutory deadlines. Although states understood that agency guidance ahead of the IFR was preliminary and could be subject to change, these wild shifts in policy were not foreseeable given that they are not permissible under the statute. Finally, CMS does not provide a reasoned explanation in the IFR for these last-minute changes or acknowledge the reliance interest states had in following their previous guidance. Indeed, CMS does not even acknowledge that it has changed position at all. Arbitrary and capricious agency actions such as these are the very types of erratic agency behavior that the APA is in place to stop.

II. Families USA strongly urges CMS to redraft its definition of "medically frail." Coupled with limitations on self-attestation and data lookback restricted to 12 months, the definition is unworkable and infeasible for states to implement.

H.R. 1 does not delegate authority to CMS to define "medically frail" as requiring an individual to prove they lack capacity to work. Even if the statute would allow for this extra-statutory requirement under the medically frail exception, Families USA would strongly urge CMS to remove this requirement given the extraordinary impact determinations regarding an individual's ability to work will have on state Medicaid programs, particularly without self-attestation.

CMS' definition of "medically frail" and limitations on self-attestation add billions in costs and create unnecessary administrative waste.

By linking medical frailty to capacity to work, CMS has chosen a pathway for states that will require states to make individual-level assessments of the medical frailty exception, applicant-by-applicant, enrollee-by-enrollee. It is already enormously expensive for states to implement the Medicaid work reporting requirements mandated under H.R. 1:[19]

- Prior to the IFR being released, and the burdensome new extra-statutory requirements therein, states estimated upfront administrative costs to be between $4 million and more than $30 million per state.[20]
- For example, Ohio and New Mexico estimate $28 million and $24 million, respectively, to make tech upgrades, hire new staff and conduct outreach to consumers.[21]
- States project considerable ongoing costs going forward: North Carolina estimates $31.2 million *annually* to enforce the work requirement and to conduct required biannual eligibility checks.[22]

While these cost estimates greatly surpass the $200 million in national implementation funding offered under H.R. 1, they are in alignment with prior state history. According to the Government Accountability

Office (GAO), Georgia—the only state with an active work requirement in place ahead of H.R. 1—has incurred over $54.2 in administrative costs for new technology and paperwork processing.[23] Arkansas, a state that previously implemented such requirements, estimated more than $42 million to reboot their program.[24]

These state administrative costs and cost estimates, however, reflect programs based on the statutory text and prior CMS guidance, with two key program functions and flexibilities:

(1) That the medically frail exception refers to medical condition(s) *only* and not connected to one's ability to work; and
(2) That states can allow individuals to self-attest, under penalty of perjury, to their condition where documentation is not available.

Instead of designing a program with these definitions and flexibilities as required by the statute, CMS has designed a program akin to determinations made by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI). SSI disability determinations require a complex administrative system to determine whether a specific individual's disabilities are severe enough in relation to job opportunities to substantially impair the disabled individual's ability to work. These individualized determinations come at a substantial cost: $4.6 billion in 2024 in administrative costs alone for 7.4 million recipients.[25] That price tag is for a program that's already up and running, one where decades of federal regulation and expense have built a system of local Social Security Administration field offices and state agencies that specialize in disability determinations. Medicaid has no remotely comparable system in place and states must start all of this from scratch, hiring and training staff to become specialists in medical frailty assessments. To set such structures up will come with extensive upfront costs, in addition to the costs already projected.

Furthermore, to assess medical frailty within the statutory framework—where states must reverify medical frailty status at least every 12 months and as often as every six months at Medicaid renewal—CMS will arguably need to invest more resources toward these assessments to avoid the administrative backlog that has plagued SSI disability determinations where applicants wait, on average, seven months for a decision because there are not enough adjudicators to handle millions of complex applications.[26] In addition, unlike the annual medical frailty verification requirements, the SSI determination system includes measures to reduce administrative burden: the Social Security Administration does not require yearly verifications and there are many categories of conditions for which disability determinations last between three and seven years.[27]

While it is likely an underassessment of the costs state will incur, we can use SSI fiscal history as a conservative marker to get a sense of the immense additional administrative costs that come with a system that tries to assess individual capacity to work:

- Historically, administrative costs for SSI have consistently been between 5.8 and 7.4% of the program's federal spending, with an average of 6.7%.[28] Applying that to the spending for the Medicaid expansion program ($180 billion in federal and state spending in fiscal year 2024[29]), and assuming, conservatively, that 40% of adult Medicaid expansion enrollees face serious health limitations which may qualify them as medically frail,[30] that's **over $4.8 billion in *annual* administrative costs to make medical frailty assessments as designed by the IFR – expenses on top of those already faced by states and the federal government to implement the work reporting requirement program.**

- Much of these administrative costs will fall on the federal government: In GAO's 2019 analysis across five state work requirement programs, the federal government paid (or would have paid) between 55 and 87% of program administrative costs.[31] In Georgia, 87.6% of administrative spending ($47.4 million) for the current program has been financed with federal dollars.[32]

H.R. 1's Medicaid work requirements have already placed a considerable financial burden on strained state budgets. CMS' added requirements increase administrative waste, in direct opposition to the Administration's goal of tackling waste in the health care system and reducing federal spending.[33]

Medical frailty assessments as specified by the IFR are not feasible for states to implement, especially when accompanied by limits on self-attestation and other data restrictions.

Even if Congress and state policymakers devote substantial resources to support medical frailty determinations, taxpayer dollars cannot overcome the fact that the IFR requires a system of medical frailty assessments that is unworkable. Medicaid agencies are not disability determination agencies: they do not employ occupational medicine experts with the expertise and training necessary to ascertain medical severity in relation to ability to work. But even if such experts were readily available, CMS has not provided states with any regulatory framework to make medical frailty determinations.

In the context of SSI determinations, the Social Security Administration has amassed, overtime, a large national network of adjudicators who specialize in making determinations about disability benefits eligibility, including whether physical or mental impairment(s) are of such severity that they render someone unable to engage in any "substantial gainful activity." A comprehensive statutory framework supports this process, along with expansive federal guidance that includes specific details about what constitutes a disability and relevant factors for adjudicators to consider, including functional limitations and residual functional abilities, relative to prior job experience.[34] The IFR provides nothing comparable, giving state Medicaid agencies very little to go on to develop the processes required to properly pull this off.

Certainly, CMS could theoretically design and deploy a full regulatory framework to fill these gaps. However, it cannot simply adopt the SSI determination framework and apply it to Medicaid. As Congress envisioned, H.R. 1's expansive medical frailty definition and the inclusion of qualifying activities beyond gainful employment are far more substantial than the SSI framework. Under H.R. 1, state eligibility systems do not just have to determine capacity to work, but also capacity to volunteer or attend school or engage in other qualifying activities. And, unlike for SSI determinations which involve narrow criteria for what constitutes disability for purposes of that program, the statute and the IFR envision "medically frail" as encompassing many more conditions and individual circumstances. CMS is wading into new territory here and simply will not have the required regulatory framework in place by January 2027. This leaves state Medicaid programs in the dark as they begin to make medical frailty assessments, yet on the hook for any errors in eligibility determination.

CMS only makes matters worse by including additional restrictions in the IFR that make the system even more complicated and less feasible for states to implement:

- **Data look-back of only 12 months puts unreasonable limitations on states' use of claims data to verify medically frail individuals.** H.R. 1 requires state Medicaid agencies to use "reliable information" to make automatic determinations where possible to verify compliance with or exclusion from community engagement requirements.[35] The IFR defines "reliable information" to

include medical claims data, but arbitrarily limits the lookback period to claims adjudicated in the preceding 12 months.[36] This limitation ignores the realities of Medicaid claims processing, where there is often a significant lag between the time a given service is provided to a patient, the time when a provider submits a claim for payment, and the time a state Medicaid agency processes and pays a claim for that service.[37] For this reason, CMS' own databases that include claims data rely on a 24-month lookback period to ensure accuracy.[38] CMS acknowledges this issue in the IFR ("*When beneficiaries access covered services, their receipt of services will appear (with some degree of lag) in adjudicated claims or encounter data…*"),[39] but assumes that individuals will figure out how to obtain the correct services from the correct providers at the correct cadence to prove their condition and continued medical frailty status within the 12-month lookback constraint. This assumption wholly ignores the realities of health care system capacity and Medicaid patient access to care (both discussed in detail below). Furthermore, some individuals may have permanent disabling conditions (such as organ loss or paralysis) that do not require ongoing treatment after the patient has reached stability, meaning claims data for the preceding 12 months may not reflect their current condition. (The Social Security Administration does not require ongoing medical treatment to approve disability benefits where conditions are permanent, and it specifically allows for the submission of older medical records as these records may demonstrate disease progression and long-term impact[40]). **Limiting the review period for medical frailty to claims data in the previous 12 months renders this category of data substantially less effective as it does not give states the full picture of reliable information that would guide accurate medical frailty verification.**

- **Self-attestation limitations make it harder for states to reverify eligibility and create unnecessary and expensive program churn.** Beginning on January 1, 2028, states may accept "a statement or other information provided under penalty of perjury" (in other words, self-attestation) only once during a member's period of enrollment for purposes of the medical frailty exception. This means that states cannot allow individuals to self-report their health status or capacity to work when there is no documentation available. Setting aside the fact that the statute expressly gives states the flexibility to use self-attestation (as described above), limits on self-attestation add to the state's administrative burden. Self-attestation is an important element of Medicaid enrollment today, as states frequently use auditable self-attestation to verify Medicaid eligibility, including using screening questions that allow for self-attestation of household members and caretaker status, age, pregnancy and postpartum status, status as a former foster youth, and identification as American Indian or Alaska Native.[41] As CMS states in the IFR, self-attestation in the form of "screening questions and tools" is important to "reduce administrative barriers and speed identification and processing for applicants and beneficiaries who may be specified excluded individuals."[42] In limiting self-attestation in the context of medical frailty determinations, the IFR creates new administrative burdens for states to track down documentation, including for people that it may know (given prior data) remain eligible for the exception (for example, an individual who has a permanent medical condition).

  Furthermore, limits on self-attestation create an arbitrary loophole for enrollees seeking a "medically frail" exclusion. If an individual lacks documentation, they lose all ability to self-attest to their continuing condition after their first time and may be disenrolled. However, if they are disenrolled, H.R. 1 allows them to immediately reapply and the IFR would allow them to self-attest anew (at the start of a new period of enrollment). This may create an incentive for some people to disenroll and immediately reapply as a means of regaining benefits when health or life circumstances make obtaining documentation challenging. **Frequent disenrollments and**

reenrollments not only disrupt an eligible individual's continuity of care, but they generate unnecessary churn in the Medicaid population, which greatly increases administrative costs and burdens on state systems.[43]

By limiting the lookback window to those claims adjudicated in the last 12 months and phasing out self-attestation, the IFR puts state Medicaid programs in an untenable position: they must verify medical frailty accurately, but with an incomplete accounting of recent medical care and an inadequate picture of enrollee health conditions. Couple these challenges with the added requirement for state Medicaid agencies to ascertain capacity to work without any regulatory framework to guide this process, and what CMS has designed is a system that will utterly fail people with legitimate medical frailties who are eligible for the exceptions provided to them under the statute. **We emphatically urge CMS to redraft their IFR to construct a system that is feasible for states to implement, one that abides by the statute's medically frail definition and permits states the full use of data available to them and as allowed for their use under the statute.**

III. Families USA strongly urges CMS to redraft the IFR as the definition of "medically frail" and the limitations on self-attestation put unnecessary strain on health care providers and create an unfair burden on eligible applicants and enrollees.

H.R. 1 explicitly allows for self-attestation, and it does not allow for CMS to define "medically frail" as requiring an individual to prove they lack capacity to work. Even if the statute would allow for these definitions and limitations, Families USA would strongly urge CMS to rethink their approach given the extraordinary impact these definitions and limitations will have on health care providers and the vulnerable Americans the Medicaid program is intended to serve.

The IFR places an unreasonable burden on Medicaid providers and the health care system to assess capacity to work. These paperwork burdens will discourage provider participation in Medicaid and compound existing provider shortages.

Assuming states can overcome substantial challenges to implement systems to assess medical frailty, states will need to rely heavily on the availability of trained health care providers who can document medical frailty in the medical record, along with their patients' capacity to work or engage in other qualifying activities.

One major obstacle here is that many clinicians lack training in occupational medicine and, thus, the skills and knowledge needed to formally evaluate whether their patient might have a health condition sufficiently serious or complex to prevent work and community engagement.[44] In addition, the health care system lacks valid clinical assessment tools to help providers make these types of determinations.[45]

Assessing condition severity becomes more challenging when a patient has co-occurring conditions that, in combination, may severely impact capacity for community engagement. Social Security disability regulations offer a framework for assessing the combined impact of multiple impairments,[46] but providers struggle with the challenge of these assessments when individual clinicians do not treat patients for all relevant conditions, lack clinical training in areas required to make a full assessment or must base findings on incomplete or older medical records from other providers.[47]

Additionally, assessing condition severity may require providers to understand how personal circumstances and the particulars of health care access in a patient's community impact ability to obtain

appropriate care.[48] After all, conditions that can be well managed with regular care (for example, asthma or diabetes) can quickly turn serious without reliable access to specialists, case management services, therapies or medications, and other necessary services. Furthermore, medical conditions, alone or in combination, do not impact every individual the same way, with patients experiencing variability in symptom presentation or oscillating between periods of relative health and periods of greater symptom severity.[49] Even with specialized training, assessing the severity of medical conditions is not a simple task, as working ability can vary at any given time, even if the underlying condition remains unchanged.[50]

Perhaps Congress understood these significant challenges when it defined medical frailty to turn on clinical indicators *alone* without regard to the separate and immensely difficult questions of working capacity.

If CMS moves forward with the IFR as written, many unanswered and important questions must be addressed about how medical frailty documentation will function, practically, within the health care system:

- ***Do communities have enough providers available to support additional patients who need medical frailty documentation?*** New documentation requirements and strict limits on self-attestation will mean patients with serious or complex medical conditions will have to schedule frequent doctor's visits to generate medical claims and obtain the additional documentation they need to stay on Medicaid. But recurring medical documentation depends on the availability of appointments, an unrealistic scenario for many Medicaid patients who already struggle to access care: Compared to patients with other health insurance types, Medicaid patients have far greater difficulty accessing needed primary and specialty care[51] due to widespread Medicaid provider shortages, lack of available appointments and refusal of health care providers to accept new Medicaid patients.[52] Rural areas consistently have fewer Medicaid-participating primary care providers per capita compared to urban counties and have severe shortages of specialty providers willing to see Medicaid patients.[53] Medicaid patients in urban areas are not guaranteed access either: a recent survey of 15 major metro areas found that just over half (53%) of providers accepted Medicaid as a form of payment.[54] In addition, Medicaid participation on paper does equate patient access, as a 2026 study found that more than one-fourth of Medicaid-enrolled physicians do not see any Medicaid patients.[55]

- ***Are providers willing to take on additional medical frailty paperwork for Medicaid patients?*** Providers already face multiple administrative hurdles to Medicaid participation, including the complexity of health care billing, frustrations related to claims denials and resubmissions, and haggling with insurers over prior authorization and other documentation requirements.[56] These bureaucratic burdens are key contributors to physician burnout and attrition.[57] Recurring medical frailty certifications add another layer of non-clinical work, consuming scarce physician and staff capacity, and taking time away from diagnosis, treatment and care coordination. Providers may feel unwilling or unable to take on this additional paperwork, and the ongoing burden of documenting medical frailty may further disincentivize provider participation in Medicaid networks.[58]

- ***Will Medicaid or managed care organizations pay providers for the additional clinic and office time required to make these assessments?*** Medicaid historically reimburses providers at significantly lower rates than Medicare and commercial payers.[59] This lower reimbursement is a major reason providers turn Medicaid beneficiaries away, particularly in specialty care settings.[60] If providers are not paid for the additional time it takes to conduct medical frailty assessments, they may refuse patients that need them. In addition, where the quest to obtain medical frailty

documentation every 12 months leads patients to visit health care facilities without clinical need, health insurers may deny reimbursement under "medical necessity" rules.[61]

- ***Are providers willing to submit documentation of medical frailty if they do not have clinical guidelines or standards that provide cover for their assessments?*** If a clinician submits paperwork attesting that their patient is medically frail and lacks capacity to work or otherwise engage in qualifying activities, they may worry their judgment will be second-guessed by state or federal reviewers. In addition, providers may be worried they will face significant professional consequences if government auditors disagree with their assessments. These concerns may be especially likely to arise in cases where providers lack clear objective findings that indicate work capacity and have had to rely on patient-reported outcomes or their own clinical judgement in making a medical frailty determination.[62] Further, if a health care practice predominantly serves a high percentage of Medicaid-enrolled patients with significant health care needs and, subsequently, documents a large number of medically frail patients, they may worry about standing out to auditors in comparison to other practices with a different patient mix. These concerns may influence fewer cases of medical frailty documentation, even where they are warranted.

Although inconvenient, perhaps, to the Administration's work reporting requirement agenda, providers may simply be unwilling to participate in this process or to the degree required to provide states with the level of documentation needed to determine medical frailty for millions of Medicaid beneficiaries. **Removing requirements to assess capacity to work as part of medical frailty assessments, allowing for patient self-attestation and enabling states to use older medical claims data as evidence of health conditions (particularly for health conditions that are not likely to change) would alleviate many of these burdens. We urge CMS to redraft the IFR to make these important adjustments and ensure providers remain willing to participate in Medicaid and support patients with complex and serious health care conditions.**

CMS' definition of "medically frail" and inflexibility in self-attestation places an unreasonable burden on Medicaid beneficiaries.

Many people access Medicaid through the ACA Medicaid expansion while awaiting an SSI disability determination or as an alternative to applying for SSI, given the length and uncertainty of that application process.[63] Research from KFF estimates that in 2019, almost 60% of people with a disability on Medicaid did not have SSI.[64] The medically frail exception under H.R. 1 recognizes this fact and the reality that many people on Medicaid have a disability or have serious and complex health conditions that impact their ability to meet community engagement obligations. Even if CMS can look past the millions in wasted administrative dollars caused by its policy choices in the IFR and ignore the burdens this new regime will have on state Medicaid systems and Medicaid-participating providers, CMS should not overlook the impact on the most vulnerable among us.

It is Medicaid beneficiaries that will have to navigate new eligibility systems and requirements that their states are still designing and updating mere months from launch. It is Medicaid beneficiaries that will be left without access to health care when untrained state Medicaid staff do not have the expertise required to ascertain their medical severity and ability to work. And it is Medicaid beneficiaries who will be scrambling when wait times to see providers in their community are too long for them to secure necessary documentation within strict time limits.

This comment letter has already outlined the significant challenges Medicaid beneficiaries may face in finding providers willing and able to support them with needed documentation to support the IFR's new medical frailty definition. But there are other documentation and access challenges Medicaid beneficiaries will face in demonstrating medical frailty:

- **New cost-sharing requirements imposed under H.R. 1 make accessing care more difficult.** Considering how frequently people who are medically frail may have to obtain medical documentation, any cost barriers to care can derail documentation within the IFR's time constraints. Even relatively small levels of cost sharing in the range of $1 to $5 can cause people to delay or forgo doctor visits.[65] However, effective October 1, 2028, H.R. 1 requires states to impose cost sharing of up to $35 per service (with certain exceptions) for Medicaid expansion enrollees with incomes over 100% of the federal poverty line. This places additional burden on a subset of the population who may not have the spare income to afford the additional doctor's visits required to support their continued medical frailty exception.
- **Common insurance practices can act as a barrier to documenting medical frailty for people enrolled in Medicaid managed care**. In addition to restrictive provider networks that make it difficult to secure appointments with Medicaid-participating providers, managed care plans may also have strict limits on what can be covered in a basic visit and payment policies may not permit clinical time to be spent on medical frailty/capacity to work assessments. "Medical necessity" rules may prevent a visit to a health care facility when there is no clinical need, leaving patients without options if they need to visit a doctor to obtain documentation of their condition.[66]
- **Pulling together paperwork and scheduling unnecessary doctor's visits just for the purposes of medical frailty documentation is a challenge for anyone, but especially for those with the most serious health care needs.** CMS does not have any provisions in place to reduce documentation hurdles for people in health crisis. Social Security disability guidance, while imperfect, takes steps to reduce enrollment barriers for people with the most serious health conditions. The agency maintains an extensive medical guide that outlines specific medical tests and criteria; if one's medical records match the criteria, then the individual is presumed disabled without needing an evaluation of capacity to work.[67] In addition, Social Security has "compassionate allowances" to further reduce enrollment barriers for people with the most serious conditions, including cancer.[68] Furthermore, the Social Security Administration does not require annual documentation when conditions are unlikely to change, allowing disability determinations to remain in place for up to seven years.[69]
- **Individuals who seek appropriate care outside of health care settings may have difficulty generating medical claims that document their conditions.** For example, substance use disorder (SUD) is specifically listed as a medically frail condition, but care for SUD may appropriately happen in community-based settings outside of the traditional health care system; this treatment may not result in medical claims that would support a medically frail exception.[70] SUD may be referenced in medical records as part of a patient's history or as a secondary diagnosis to other treatment, but it is unclear if these types of records will be enough evidence to show medical frailty.
- **Individuals may be reluctant to disclose personal health information to the state if they fear it may lead to discrimination and other harmful consequences.** The stigma associated with HIV, mental health or SUD may discourage individuals from disclosing their condition and how it impacts their life.[71] Disclosing the severity of their patients' conditions and the impact on capacity to work may also raise ethical concerns for providers if reporting this information is not supported by clinical practice guidelines.[72]

These many documentation hurdles may leave people with the most significant health needs, and the greatest urgency for accessing Medicaid coverage, without the ability to document their medical frailty.

This puts individuals in a difficult position: to maintain Medicaid coverage without medical frailty documentation, they will have to demonstrate community engagement; but working 80 hours per month could interfere with treatment needs (and likelihood of success with pending SSI applications). Further, any temporary period of joblessness that occurs when someone needs to stop working to seek necessary treatment can mean losing coverage. **Removing requirements for individuals to prove capacity to work and allowing individuals to self-attest to their circumstances would give vulnerable Medicaid enrollees the ability to stay on Medicaid when the realities of the U.S. health care system make medical documentation all but impossible.**

Conclusion

By adding "capacity to work" to the definition of medically frail, limiting the lookback window to those claims adjudicated in the last 12 months and phasing out self-attestation, the IFR has handed states and the health care system a totally unworkable program that is against the unambiguous language of the statute. And yet the stakes are so high for states and providers to get this right: CMS has explicitly threatened states with significant financial penalties for any noncompliance with the IFR if they are later found to have determined individuals to be "medically frail in a manner inconsistent" with the IFR's new, unlawful definition.[73] Providers increasingly fear they will be accused of Medicaid fraud even if they are acting in the best interests of their patients.[74]

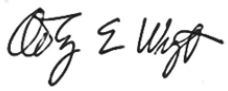
For these reasons, a *delay* in the start of work requirements alone would not solve the problem—CMS must redraft the IFR. This is not just a matter of states needing time to play administrative catch-up to absorb the IFR's new requirements or of providers and their patients learning the ropes of a new process. The IFR implements a wholly new system with inadequate regulatory and monetary support behind it, no federal- or state-level expertise to guide it, no clinical guidelines to support provider participation, and overly complex and confusing requirements for Medicaid-enrolled individuals with legitimate medical frailties who may not be able to document their health condition given the realities of the U.S. health care system.

We urge CMS to redraft the IFR in a way that appropriately and thoughtfully designs a work reporting requirement program that meets statutory obligations and keeps eligible people on coverage. Until CMS drafts an IFR that complies with the statute and maintains access for the communities Medicaid was designed to serve, it must delay § 71119 implementation either outright or through the good faith waiver authority permitted by the statute.

We thank you for the opportunity to comment on CMS' implementation of Medicaid work reporting requirements. For questions or comments regarding the recommendations in this letter, please contact Mary-Beth Malcarney, Senior Advisor on Medicaid Policy, Families USA at mmalcarney@familiesusa.org.

Thank you for your time and consideration.

Sincerely,



Anthony Wright
Executive Director

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