



July 31, 2026
Page 1 of 17

July 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)

Dear Administrator Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the [interim final rule](#) (IFR) with comment period published in the Federal Register on June 3, 2026, implementing a new statutory requirement for certain adults in Medicaid to meet an 80 hours per month work requirement (also referred to as community engagement) as a condition of eligibility, as required by the One Big Beautiful Bill Act (OBBBA). This IFR also proposes a number of interpretive, definitional, verification, and operational standards that are not expressly specified in statute. States must generally implement this requirement no later than January 1, 2027.

Medicaid is a cornerstone of the U.S. health care system, keeping more than 75 million Americans healthy by providing a stable pathway to affordable, continuous care, especially in underserved and rural communities. Family physicians are central to Medicaid access, serving as the primary point of entry for many enrollees and accepting new Medicaid patients at higher rates than most other specialties.^{i,ii} The AAFP is deeply concerned that CMS's rigid implementation of Medicaid work requirements in this IFR is inconsistent with both the program's core purpose and the statutory framework outlined in OBBBA. If finalized, this regulation risks undermining Medicaid's foundation by introducing avoidable coverage disruptions that hinder eligible individuals from accessing and maintaining care. When coverage is interrupted, access deteriorates, necessary care is delayed, and health needs often escalate into more complex and costly conditions. This instability also weakens physicians' ability to deliver continuous, high-quality care, erodes patient trust in the health system, and ultimately compromises the nation's health.

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July 31, 2026
Page 2 of 17

Further, the proposed implementation timeline of January 1, 2027, is not feasible given existing State capacity, system constraints, and resource limitations. Proceeding on this basis risks significant administrative disruption and coverage losses driven by implementation barriers rather than statutory eligibility criteria.

Accordingly, the AAFP strongly recommends that CMS revise and reissue this interim final rule to better align with the statutory framework for community engagement, existing State systems and administrative capacity, and to ensure that implementation is administrable in practice without diverting limited State resources from core Medicaid eligibility and enrollment functions. Any reissued rule should include an extended implementation timeline that reflects State operational realities and system readiness. If CMS elects to proceed without undertaking these revisions, it should, at a minimum, extend the full implementation deadline to January 1, 2028, across all provisions of the rule.

To further prevent eligible Medicaid enrollees from losing their health care coverage, the AAFP urges CMS to take the following actions in a revised final rule:

- Permit States to recognize additional, clinically comparable forms of medical frailty for specified exclusion where doing so is consistent with the statute and supported by objective, auditable standards;
- Extend and broaden self-attestation flexibility for medical frailty beyond 2027 when reliable information is unavailable or not reasonably compatible;
- Revise section II.E.5.b to eliminate the requirement for individuals to prove additional functional limitation beyond diagnosis of a serious or complex medical condition to qualify for exclusion under medical frailty;
- Eliminate the exclusion of individuals in recovery for more than five years from the medical frailty exclusion for substance use disorders (SUD);
- Make explicit that physicians and clinicians are responsible only for providing good-faith clinical documentation when requested for verification and are not responsible for making legal or programmatic determinations regarding an individual's compliance, exemption, or eligibility status;
- Limit repeated medical frailty reverification for chronic, progressive, or treatment-intensive conditions where clinical status is unlikely to improve materially over short intervals; and
- Narrow State data reporting expectations to elements most necessary to monitor program integrity and coverage impacts, particularly procedural disenrollment, medical frailty denials, reinstatements, and fair-hearing reversals, rather than imposing broad reporting requirements that require additional system buildout and staffing at a time of constrained State resources.

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July 31, 2026
Page 3 of 17

Applicable Individuals and Community Engagement Requirements

CMS identifies “applicable individuals” subject to the community engagement requirement primarily as members of the Medicaid expansion adult group (generally individuals ages 19 through 64 who are not pregnant and not enrolled in Medicare) or comparable populations covered through section 1115 demonstrations that provide minimum essential coverage.

Further, the rule implements the statutory categories under which an individual may demonstrate community engagement, including work, community service, participation in a work program, enrollment at least half-time in an educational program, or combinations of such activities totaling 80 hours per month, or satisfaction of a monthly income threshold equal to the federal minimum wage multiplied by 80 hours. In addition, CMS provides specification not expressly delineated in the statutory text regarding the scope and application of these categories. Notably, the IFR states that “work” is not limited to paid employment and explicitly includes unpaid roles such as internships or trial work, while “community service” follows the TANF framework as structured, nonpartisan, unpaid service through public or nonprofit entities, with States given further discretion to define qualifying activities. CMS also notes that Medicaid-funded employment supports (i.e., job coaching or vocational services) through Home and Community-Based Services (HCBS) waivers do not qualify as “work programs” for purposes of meeting the community engagement requirement.

The rule also establishes methodologies for implementing the income-based pathway, including the use of monthly MAGI-based household income, provisions for averaging income for seasonal workers to approximate community engagement, and the requirement that States apply the federal minimum wage rather than State-specific minimum wages when applying the statutory income threshold.

AAFP Comments on Applicable Individuals and Community Engagement

The AAFP appreciates CMS’s efforts to broaden the definitions of “work” and “community service” to include a wider range of meaningful activities, including unpaid roles such as internships and structured service opportunities. This flexibility is an important and constructive step toward recognizing the diverse ways individuals engage in and prepare for employment.

We also appreciate CMS’s use of MAGI-based household income for the income-based compliance pathway. This approach is consistent with longstanding Medicaid eligibility methodologies and more accurately reflects the financial realities of low-income individuals and families. Many Medicaid enrollees live in households where income is shared, fluctuates

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July 31, 2026
Page 4 of 17

across members, or is episodic in nature.ⁱⁱⁱ Thus, a household-based measure better captures overall economic capacity and avoids penalizing individuals whose individual earnings may not fully reflect their access to resources or their participation in work-related activities.

That said, we are concerned by this rule's exclusion of Medicaid-funded employment supports, such as job coaching and vocational services provided through HCBS, from qualifying as "work programs." These services are specifically designed to support employment readiness and retention, particularly for individuals with disabilities or complex health needs. Excluding these services creates an inconsistency in the framework set by CMS for qualifying activities, in which less structured unpaid activities may qualify while clinically supported, employment-focused services do not, potentially discouraging participation in evidence-based workforce programs. **Thus, we recommend CMS revise this provision to include Medicaid-funded employment supports as "work programs."**

Mandatory Exceptions and Specific Exclusions to Community Engagement Requirements

Mandatory Exceptions: CMS notes that States must deem an applicable individual compliant for a month if the individual meets the mandatory exception criteria including if for one month prior, an individual was: under age 19; entitled to or enrolled in Medicare; fell within certain mandatory Medicaid coverage groups under the Medicaid State plan; convicted; or at any point during a 3-month lookback period ending on the first day of that month, an inmate of a public institution.

Specified Exclusions: In addition to mandatory exceptions, the IFR codifies a separate category of "specified excluded individuals," which includes nine subcategories: former foster youth under age 26 under standardized SUPPORT Act criteria; American Indians; pregnant and postpartum individuals; participants in qualifying drug or alcohol treatment programs; inmates of public institutions (separate from the mandatory exception above for recently incarcerated individuals); individuals subject to SNAP or TANF work requirements; veterans with a 100 percent disability rating; parents, guardians, and caregivers of disabled individuals or children age 14 or younger; and individuals who are medically frail or have special medical needs.

Specified Exclusion: Medical Frailty

The rule specifically codifies the exclusion for "medical frailty," including the five eligible subcategories in section 1902(xx)(9)(A)(ii)(V) of the OBBA through which an individual may qualify. Under the statute, these five categories include individuals with "blindness, substance use disorders (SUD), disabling mental disorders, physical, intellectual, or developmental

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July 31, 2026
Page 5 of 17

disabilities that significantly impair their ability to perform 1 or more activities of daily living, and serious or complex medical conditions.”

CMS does not add additional categories under medical frailty in this rule and prohibits States from adding additional categories beyond the five groups mentioned. Further, CMS provides additional prescriptive guidance for each category of medical frailty:

- A. ***Serious or complex medical conditions:*** CMS uses the Institute of Medicine’s [definition](#) from 1999 to define this category as any condition that “*is life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments.*” Further, CMS explicitly claims that “an individual with a well-managed serious or complex medical condition that does not significantly impair their ability to meet the community engagement requirement should not be determined medically frail” and directs States to enforce this functional test when determining eligibility for the specified exclusion. *State verification of medical frailty is discussed on page 9 of this comment letter.*
- B. ***Substance Use Disorders:*** CMS states this exemption must exclude individuals in more than five years of recovery. In the IFR, CMS claims that at the five-year mark, “the risk of SUD recurrence for an individual in stable recovery is approximately the same as the general population.”
- C. ***Physical, intellectual, or developmental disabilities:*** CMS claims that this exemption only applies to individuals with disabilities that significantly impair activities of daily living (ADLs), including bathing, dressing, and eating. CMS explicitly excludes instrumental activities of daily living (IADLs) which often include grocery shopping, cooking, etc.

AAFP Comments on Mandatory Exceptions and Specific Exclusions

The mandatory exceptions and specified exclusions for community engagement requirements in OBBBA are the statute’s primary safeguards for individuals with significant clinical, functional, caregiving, or programmatic barriers to compliance. This protection is

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July 31, 2026
Page 6 of 17

critical given the magnitude of the projected coverage losses from OBBBA implementation. The Congressional Budget Office estimates that 11.8 million people will lose Medicaid coverage due to the OBBBA in the next 10 years, and 4.8 million of those individuals will be losing their coverage due to the implementation of work requirements.^{iv,v} Further, Urban Institute modeling projects that, when work requirements are implemented together with the statute's six-month redeterminations, average monthly Medicaid expansion enrollment in 2028 will decline by 4.9 million people, representing an enrollment reduction of up to 55 percent among the population subject to the work requirements.^{vi} In light of these already substantial coverage losses, mandatory exceptions and specified exclusions must operate as a floor for protection, not a ceiling to be further narrowed through implementation.

Congress directed CMS to implement section 1902(xx) effectuating Medicaid work reporting requirements as required by OBBBA, and CMS must ensure that their interpretation and guidance is consistent with the statutory text, supported by a reasoned explanation, and administrable in practice. Mandatory exceptions and specified exclusions can function as meaningful protections only if they are defined and administered in a manner that eligible individuals can realistically access. Recent studies found that most Medicaid adults already work or would likely qualify for an exemption, yet Arkansas still experienced the loss of approximately 18,000 beneficiaries, or one in four of those subject to the requirement in the State, after implementing a work requirement.^{vii} Further, the Brookings Institution and the Center on Budget and Policy Priorities both found that many of these coverage losses in Arkansas were attributable to reporting and documentation barriers rather than to true noncompliance, and neither study found evidence that the policy produced a measurable increase in employment.^{viii, ix} Thus, the design and implementation of the primary safeguards of exceptions and exclusions will materially affect whether statutorily eligible individuals retain or lose their coverage.

The AAFP recognizes health as a basic human right for every person and has strongly advocated to maintain and expand federal health care coverage programs to ensure that all Americans, regardless of social, economic status, race, religion, gender or sexual orientation have the right to universal access to timely, high quality, and affordable essential health care services. **Thus, we are deeply concerned that multiple regulations in this IFR regarding the specified exclusions of medical frailty are narrower than necessary to implement the statute, insufficiently justified under the Administrative Procedure Act, and do not adequately protect eligible beneficiaries from avoidable coverage loss.**

AAFP Comments on Specified Exclusion: Medical Frailty

We are particularly concerned that the IFR prohibits States from recognizing additional clinical categories beyond the five statutory categories identified under the medical frailty

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July 31, 2026
Page 7 of 17

exclusion. This approach represents a departure from longstanding Medicaid regulations governing medical frailty. Under 42 C.F.R. § 440.315(f), the Medicaid regulation governing medically frail and special-needs populations for Alternative Benefit Plans provides that a State's definition "must *at least* include "specified categories, including disabling mental disorders, chronic substance use disorders, serious and complex medical conditions, and physical, intellectual, or developmental disabilities that significantly impair activities of daily living." That language establishes a federal minimum floor, as opposed to a categorical ceiling. We believe CMS does not adequately explain why States may not recognize additional categories of medical frailty to ensure coverage for eligible individuals who are similarly positioned but not captured by the IFR's narrow interpretation of the listed categories. In a cooperative federal-state program, a restriction of this magnitude should rest on a clearer statutory basis and explanation than the IFR currently provides.

Accordingly, AAFP strongly recommends CMS revise the IFR to clarify that the five statutory medical-frailty categories establish a federal minimum, not an exclusive ceiling, and to permit States to recognize additional, clinically comparable forms of medical frailty where doing so is consistent with the statute and supported by objective, auditable standards. Such an approach would be more consistent with existing Medicaid regulations, more faithful to the cooperative federal-state structure of the Medicaid program, and more likely to ensure that medically vulnerable individuals are not inappropriately denied the coverage protections Congress intended.

Further, the AAFP opposes the additional, non-statutory restrictions across the following medical frailty subcategories, which may leave otherwise eligible patients without the coverage necessary to access and maintain ongoing care:

- A. ***Serious or complex medical conditions:*** The statutory text set forth by Congress exempted individuals with serious or complex medical conditions. However, the IFR effectively narrows this protection by requiring that such conditions also significantly impair an individual's ability to meet the community engagement requirement. This additional criterion transforms a condition-based statutory exclusion into a functional compliance test that is not reflected in the statutory text. If CMS intends to adopt this interpretation, the agency must provide a clear and reasoned explanation for why the statute supports imposing a separate impairment standard and why such a requirement is necessary for program administration. Absent such justification, this approach risks being inconsistent with the statutory framework in OBBA and vulnerable under the Administrative Procedure Act.

We are also concerned with CMS's reliance on the 1999 Institute of Medicine definition of "serious or complex medical condition" without adequate explanation of

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July 31, 2026
Page 8 of 17

its continued relevance. Contemporary clinical practice reflects substantial advances in chronic disease management, behavioral health treatment, and community-based care. Many serious or complex medical conditions are frequently episodic, treatment-dependent, and variable in functional impact. Patients with these conditions may not experience uniform, continuous impairment, yet still require ongoing care and clinical monitoring to remain stable. **By conditioning eligibility for the medical frailty exclusion on demonstrating functional impairment during specific review periods, CMS risks excluding individuals whose conditions are well-controlled only because they maintain continuous access to care.** This creates a structural paradox with patients losing coverage precisely when they are clinically stable, thereby undermining continuity of care. Ample evidence demonstrates that coverage disruptions are associated with delayed treatment, unmet medical needs, increased emergency care utilization, and worsening health outcomes, particularly for patients with chronic or complex conditions.^{x,xi,xii} Even short interruptions in coverage due to patients falling through the cracks of this specified exclusion may delay access to diagnostics, specialist care, medications, and ongoing treatment, potentially resulting in disease exacerbation, avoidable hospitalizations, and long-term clinical harm.

Accordingly, the AAFP urges CMS to revise section II.E.5.b of the IFR on serious or complex medical conditions to align more closely with statutory intent by:

- i. Codifying a condition-based standard, consistent with the statute, that recognizes serious or complex medical conditions as sufficient to qualify for the medical frailty exclusion without requiring individuals to prove additional functional limitation; and
 - ii. Reevaluating the IFR's proposed definitional foundation of "serious or complex medical conditions" to ensure it reflects current clinical practice.
- B. ***Substance Use Disorders:*** We are likewise concerned by CMS restricting the medical frailty exclusion from individuals in more than five years of recovery from substance use disorders. The statute identifies SUD as a qualifying category, and does not distinguish among active use disorder, recent recovery, and longer-term recovery, nor does it establish a temporal cutoff after which the exclusion is categorically unavailable. Yet, the IFR states that individuals in recovery for more than five years are ineligible for the medical frailty exclusion, and CMS does not provide additional information on when they deem "recovery" to begin.

This classification stands in tension with the clinical realities of recovery and the definitions of SUD recovery across the federal government, all of which expressly do not assign specific temporal thresholds in their definitions. For example, SAMHSA [states](#) that *"the process of recovery is highly personal and occurs via many pathways..."*

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July 31, 2026
Page 9 of 17

[and] is characterized by continual growth and improvement in one's health and wellness and managing setbacks." Similarly, the National Institute on Drug Abuse (NIDA) [states](#) that *"even people with severe and chronic substance use disorders can, with help, overcome their illness and regain health and social function. This is called remission. Being in recovery is when those positive changes and values become part of a voluntarily adopted lifestyle."* We agree. Recovery is not a binary clinical state, and a fixed five-year threshold does not necessarily reflect relapse risk, medication-assisted treatment needs, co-occurring behavioral health conditions, or ongoing functional instability.

Accordingly, AAFP respectfully urges CMS to eliminate the exclusion of individuals in recovery for more than five years from the medical frailty exclusion for SUD, as it is not supported by the statutory text and does not reflect established clinical definitions of recovery. If CMS intends to adopt a blanket temporal limitation that is not grounded in individualized clinical assessment, they must provide a substantially more robust explanation of why that limitation is clinically supportable, administrable, and consistent with the statute's protective purpose.

- C. ***Physical, intellectual, and developmental disabilities:*** The IFR limits this exclusion to impairments in basic ADLs such as bathing, dressing, and eating, while expressly excluding IADLs, including tasks such as shopping, meal preparation, and other activities necessary for independent community functioning. CMS does not adequately explain why that distinction is appropriate for compliance with community engagement requirements. In practice, limitations in IADLs may directly affect an individual's ability to work, travel, pursue education, care for others, maintain documentation, and otherwise comply with community engagement requirements. If CMS is defining ADLs narrowly for medical frailty, it must explain why comparable functional limitations are not recognized elsewhere in the specified exclusion framework when they materially impair an individual's ability to comply. A standard that is defined too narrowly may also create unnecessary risk under Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act (ADA), both of which prohibit exclusion from federally funded programs or public services through eligibility criteria that fail to reasonably account for disability-related limitations. **Thus, the AAFP urges CMS to revise the definition of qualifying impairments to include limitations in both ADLs and IADLs, recognizing that both types of limitations may materially affect an individual's ability to comply with community engagement requirements.**

July 31, 2026
Page 10 of 17

State Implementation of Medicaid Community Engagement Requirements

Verification of Specified Exclusion: Medical Frailty

The IFR establishes detailed requirements for how States must verify medical frailty and special medical needs determinations, including evidentiary standards and ongoing reassessment obligations. States must ensure that “an individual's physical, mental, or other behavioral health condition significantly impair their ability to comply with the community engagement requirement, when determining if an individual has a serious or complex medical condition for purposes of the community engagement exclusion.” Further, States will be required to use auditable condition lists (e.g., ICD-10 codes) to identify potentially eligible individuals for this exemption, regularly update these lists based on implementation experience, and maintain case-by-case review pathways for individuals not captured on these lists. CMS also notes that any lists of diseases, diagnoses, disorders, or health conditions or other processes that States use to identify medically frail individuals must be shared with CMS upon request as part of their oversight and data monitoring activities. Further, through the end of 2027, States are permitted to accept self-attestation or a statement under penalty of perjury when verifying medical frailty if reliable information is unavailable or not reasonably compatible with the individual's account. After Jan 1, 2028, States may accept self-attestation for purposes of the medical frailty exclusion only once, after which documentation must be required at the next scheduled renewal. This additional, one-time self-attestation applies only to the medical frailty exclusion and does not extend to other specified exclusion categories.

CMS notes that verification may include documentation from a broad range of licensed practitioners, including physicians, nurse practitioners, physician assistants, psychologists, counselors, social workers, and other credentialed providers permitted under State law. States must conduct verification ex parte to the extent possible, relying first on available administrative data before requesting additional information from the individual. Information used for verification must generally be no more than 12 months old, and States must reverify medical frailty at least annually, or more frequently at State discretion.

CMS further encourages States to use plain-language screening questions at application and renewal to assess eligibility for exceptions, and to evaluate medical frailty using multiple domains, such as diagnoses, utilization, and level of functional impairment. Notably, CMS directs that the absence of claims data may not be used to deny medical frailty, particularly where data may be incomplete or delayed.

General Work Requirement Verification and Compliance Determination

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July 31, 2026
Page 11 of 17

As with medical frailty, CMS is requiring States to perform verification *ex parte* where possible, using available data sources before requesting information from the individual.

The rule also prescribes how States must structure review periods for both applicants and enrolled beneficiaries. For applicants, States must require demonstration of community engagement for at least one and no more than three consecutive months immediately preceding the month of application, with the exact period defined in the State plan. Applicants are considered compliant only if they meet the requirement for all months within the selected review period. For enrolled beneficiaries, States must specify how many months of community engagement must be demonstrated during the applicable review period, whether between renewals or between more frequent verifications if elected. States must require at least one month of compliance (and may require more) but may not require consecutive months and may not designate specific months within the review period.

CMS also notes that community engagement determinations must operate within the longstanding Medicaid procedural framework for notice and appeals. Under 42 C.F.R. part 431, States must provide timely and adequate written notice of eligibility determinations, including approvals, denials, and terminations, and must generally provide at least 10 days' advance notice prior to termination unless an exception applies. Individuals must be informed of their right to request a fair hearing and the procedures for doing so. The rule also notes that State notices of eligibility must specify whether the individual qualifies as a specified excluded individual and, if not, whether the individual demonstrated community engagement or met an exception.

Further, CMS is requiring States to conduct targeted outreach to affected populations beginning four to six months before implementation and continuing at key eligibility touchpoints. Outreach and notices must clearly communicate program requirements and beneficiary responsibilities. Specifically, States must inform individuals of the months under review, the methods for demonstrating compliance, how to qualify for exceptions or exclusions, applicable deadlines and submission methods, and the consequences of noncompliance, including implications for Medicaid eligibility and potential effects on Exchange subsidies. Notices must also explain how to reapply following denial or termination and provide information on short-term hardship exceptions, if applicable.

If an applicant or beneficiary fails to make a satisfactory showing, States must deny the application or disenroll the beneficiary, as applicable. Disenrollment must occur no later than the end of the month following a 30-day response period, and only after required notice and fair hearing rights are provided. CMS also prohibits States from imposing lock-out or waiting periods following denial or disenrollment. Individuals must be permitted to reapply immediately if otherwise eligible.

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July 31, 2026
Page 12 of 17

CMS acknowledges that implementing community engagement requirements will require significant eligibility system modifications and indicates that further guidance will address systems functionality, testing, and performance metrics. States undertaking system upgrades may qualify for enhanced federal funding, including 90 percent federal financial participation (FFP) for approved design, development, and installation activities and 75 percent FFP for ongoing operations, provided federal requirements are met. Existing systems do not generally require reapproval solely due to community engagement enhancements but remain subject to CMS oversight.

Finally, CMS establishes comprehensive data reporting requirements to support federal monitoring of implementation and program impact. States must submit timely, complete, and accurate data across multiple domains, including enrollment totals, application and renewal processing (including timeliness and backlogs), determination and redetermination outcomes, and the populations subject to the requirement and their compliance status, as well as any additional data specified by CMS to assess implementation and impact.

AAFP Comments on State and Physician Responsibility in Assessing Compliance

The AAFP recognizes that the OBBBA directs CMS to implement community engagement requirements and provide guidance for State verification processes, beneficiary communications, and ongoing compliance determinations. However, the operational requirements outlined in the rule raise significant concerns regarding State implementation feasibility, administrative burden, and impacts on patient care continuity, particularly as they relate to State capacity and the role of physicians and other clinicians. CMS itself acknowledges that implementation of the new community engagement requirements will require major system, policy, and operational changes by States, while the IFR further expects States to enact new systems functionality, testing, performance metrics, notice workflows, data reporting, and recurring verification processes. If finalized as written, the implementation requirements in this IFR will impose substantial operational and fiscal burdens on States and significant administrative burdens on physicians and other clinicians, with a corresponding risk of procedural coverage loss for eligible beneficiaries.

AAFP Comments on State Verification of Specified Exclusion: Medical Frailty

We are particularly concerned about the medical frailty verification framework, which requires States to evaluate whether an individual's physical, mental, or behavioral health condition significantly impairs their ability to comply; use auditable condition lists; maintain case-by-case review pathways; and to reverify medical frailty at least annually, or more frequently at State option. Although CMS permits self-attestation or statements under penalty of perjury through the end of 2027 when reliable information is unavailable or not

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July 31, 2026
Page 13 of 17

reasonably compatible, that flexibility narrows substantially beginning in 2028, when documentation must be obtained at the next renewal if reliable information remains unavailable. In practice, these requirements are likely to require repeated documentation and individualized adjudication for many patients whose clinical conditions are chronic, treatment-intensive, or unlikely to change materially over short periods.

Because the rule expressly permits verification through documentation from physicians, nurse practitioners, physician assistants, psychologists, counselors, social workers, and other licensed practitioners per State law, **the IFR's implementation requirements will predictably shift a meaningful share of the administrative burden onto physicians and clinicians.** In practice, physicians and care teams are likely to be asked by States to complete forms, certify conditions, document functional limitations, respond to follow-up requests, and support recurring reverification for patients whose eligibility depends on medical frailty or special medical needs. This will be particularly burdensome in primary care settings serving large Medicaid populations, where staff already manage substantial prior authorization, documentation, care coordination, and eligibility-related demands. Repeated requests for clinical documentation are likely to divert time and resources from direct patient care, while lapses in coverage are likely to increase uncompensated care, disrupt continuity of treatment, and strain safety-net practices and health systems.

As a result, we are deeply concerned that, absent clearer federal guardrails, the IFR will place physicians and other clinicians in the untenable position of making de facto eligibility judgments, rather than clinical assessments, regarding whether a patient is sufficiently impaired to qualify for a medical frailty exclusion. Where State forms or workflows effectively require clinicians to attest, explicitly or implicitly, that a patient is "able to work," "not sufficiently impaired," or otherwise ineligible for an exclusion, physicians may feel pressured to render legal or programmatic conclusions outside the scope of clinical judgment in order to avoid patient disenrollment, follow-up requests, or potential scrutiny by State agencies, plans, or CMS. This is particularly concerning from the perspective of physician liability given that Medicaid eligibility regulation at 42 C.F.R. § 431.10(b) places responsibility for adverse eligibility actions on the single State Medicaid agency, not on treating clinicians, and 28 C.F.R. § 35.130(b)(8) in the ADA Title II prohibits eligibility criteria that screen out individuals with disabilities without appropriate justification and reasonable modification. Accordingly, the AAFP urges CMS to state clearly in the final rule that **treating physicians and clinicians are responsible only for providing good-faith clinical documentation and are not responsible for making legal determinations as to whether an individual is subject to, exempt from, or compliant with the community engagement requirement.**

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July 31, 2026
Page 14 of 17

To reduce avoidable coverage disruptions and unnecessary burden on both States and clinicians, the AAFP respectfully urges CMS to adopt the following targeted changes:

- **Clarify the role of physicians and protect against inappropriate liability exposure.** CMS should explicitly state that treating physicians and clinicians are responsible only for providing good-faith clinical documentation and are not responsible for making legal or programmatic determinations regarding an individual's compliance, exemption, or eligibility status. CMS should require States to use documentation that request only objective clinical information and prohibit provider-facing requirements that ask clinicians to weigh in on employability or legal eligibility.
- **Extend and broaden attestation flexibility for medical frailty.** CMS should allow continued use of self-attestation or statements under penalty of perjury for medical frailty beyond 2027 when reliable information is unavailable or not reasonably compatible. Limiting attestation will increase administrative burden on States and clinicians and heighten the risk of procedural disenrollment without improving program accuracy.
- **Limit repeated reverification for chronic or persistent conditions.** CMS should clarify that States need not repeatedly reverify medical frailty for chronic, progressive, or treatment-intensive conditions where clinical status is unlikely to improve materially over short intervals. Longer verification intervals would conserve State resources, reduce clinician paperwork, and reduce the risk of wrongful disenrollment.
- **Right-size data reporting requirements to State capacity.** CMS should narrow reporting expectations to those data elements most necessary to monitor program integrity and coverage impacts—particularly procedural disenrollment, medical frailty denials, reinstatements, and fair-hearing reversals—rather than imposing broad reporting requirements that require additional system buildout and staffing at a time of constrained State resources.

AAFP Comments on Financial Impact of Implementing Community Engagement Requirements on States

This IFR will also impose significant financial costs on States, particularly in the context of broader proposed and codified Medicaid funding changes under the OBBBA that are already constraining State resources. POLITICO reports that estimated upfront costs for expansion States range from \$4 million to more than \$30 million, with significant recurring annual expenses; North Carolina, for example, received approximately \$1.9 million in federal support but projects \$31.2 million annually to administer the requirements, while Virginia has projected implementation costs exceeding \$60 million.^{xiii} These costs reflect the scope of the IFR's requirements, including redesigning eligibility systems, building new verification infrastructure, integrating cross-program data, implementing outreach and notice processes, and complying with extensive reporting obligations. Although CMS is offering enhanced

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July 31, 2026
Page 15 of 17

federal matching (90 percent FFP for system development and 75 percent for operations), those funds do not offset the magnitude of ongoing administrative costs that States must absorb. At a time when States are already responding to coverage losses, increased redetermination frequency, and other OBBBA-driven policy changes, these additional requirements risk diverting limited State resources away from core coverage and access functions and toward complex compliance infrastructure.

We also appreciate CMS's emphasis on notice and outreach, including requirements for advance communication and clear explanation of beneficiary responsibilities. However, clarity in notices cannot substitute for strong procedural protections embedded in system design. Where eligibility depends on complex, recurring verification processes, particularly where State systems are still being built or refined, due process protections will require sufficient time to respond, meaningful opportunity to address deficiencies, continued coverage pending fair adjudication, and safeguards against termination based on incomplete or delayed data. Without those protections, even well-designed outreach will not prevent avoidable coverage loss driven by administrative limitations rather than substantive ineligibility. Moreover, States will be forced to rely on imperfect systems and compressed timelines to make high-stakes eligibility determinations, effectively placing them in a position where they must either assume additional administrative burden to prevent wrongful terminations or risk increased procedural coverage losses among otherwise eligible individuals. Given existing fiscal and operational constraints, many States will struggle to absorb that burden fully, heightening the likelihood that beneficiaries lose coverage not because they fail to meet the statutory standard, but because State systems and processes cannot reliably execute the required verification. Thus, we believe that **CMS should not structure implementation in a manner that makes compliance with Medicaid's due process requirements operationally infeasible. The agency should therefore revise the IFR to ensure that States are not forced—due to system limitations, fiscal constraints, or compressed timelines—to choose between administrative compliance and the preservation of coverage for eligible beneficiaries.**

Short-term Hardship Exceptions

The IFR also permits States to elect short-term hardship exceptions in their State plans. As described by CMS, these optional exceptions can apply for all or part of a month in circumstances such as serious medical or institutional care, residence in an area affected by a federally declared disaster or emergency, residence in an area with elevated unemployment, or travel outside the community to obtain medically necessary care that is not available locally. Additionally, CMS requires States that choose to elect the short-term hardship exception to adopt all statutory categories listed above, without the ability to tailor the exception to State capacity.

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July 31, 2026
Page 16 of 17

AAFP Comments on Short-term Hardship Exceptions

The AAFP appreciates CMS's inclusion of short-term hardship exceptions as an important safeguard for individuals whose ability to meet community engagement requirements is disrupted by acute, involuntary circumstances such as serious medical needs, disasters, or lack of access to care. However, we oppose the requirement under which States that elect the hardship option must apply it to *all* statutory categories and may not tailor the exception to specific circumstances, even where certain categories (e.g., unemployment-based exceptions requiring separate CMS approval) are operationally complex. This approach may discourage State uptake of the hardship exemptions at a time when administrative systems are already strained, thereby limiting the availability of a key protection intended to prevent coverage loss during periods of acute vulnerability. To preserve both operational feasibility and beneficiary protections, **we urge CMS to allow States to adopt hardship categories individually and to simplify pathways for activation**, particularly where credible data demonstrates need, so that hardship exceptions can function as a practical safeguard against procedural disenrollment.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravarti, Regulatory Strategist, at schakravarti@aaafp.org.

Sincerely,

A handwritten signature in black ink that reads "J Brull, MD". The signature is fluid and cursive, with the first name "Jen" and last name "Brull" clearly legible, followed by "MD".

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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July 31, 2026
Page 17 of 17

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