AMERICA'S PHYSICIAN GROUPS

July 31, 2026

Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/docket/CMS-2026-2047

Re: Comments on the Interim Final Rule with Comment Period (IFC) – Medicaid Program; Community Engagement Requirement for Certain Individuals, CMS-2454-IFC

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) Interim Final Rule on the Community Engagement Requirement for Certain Individuals in Medicaid, as cited above.

Below, APG will first provide (section I.) a brief description of our organization and our interests in this proposed regulation, followed by a summary of our recommendations (section II), our fuller analysis, comments, and recommendations ni context (section III), and our conclusion (section IV). Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Medicaid beneficiaries have consistently accessible, high-quality, equitable, person-centered health care.

I. Introduction: About America's Physician Groups

APG is a national association representing more than 300 physician groups, whose more than 260,000 physicians and other clinicians provide care to nearly 90 million patients, including an estimated 1 in 4 Americans. APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based health care in which physician groups are accountable for both costs and quality.

APG's member organizations have successfully operated under such budget-responsible care models for decades, including in concert with Medicaid managed care plans operating in multiple states. Collectively, APG groups deliver care for millions of patients on Medicaid and have consistently supported and advocated for this vitally important form of publicly financed health care. APG member organizations also care for millions of severely ill patients who have serious and complex medical conditions, and who meet both commonly understood and previous statutory definitions of "medical frailty."

APG fully supports appropriate oversight of financing of all forms of health coverage, including Medicaid, and shares CMS's commitment to fiscal accountability. However, APG is concerned that multiple provisions of both the underlying statute, Public Law 119-21, and the Interim Final Rule (IFR), will be harmful to many Medicaid beneficiaries and – for those who become uninsured as a result – will preclude the benefits of value-based care.

Multiple analyses of the law, including those of the Congressional Budget Office, have concluded that at least several million individuals are likely to lose coverage because of the community engagement requirements, often for administrative reasons. APG is concerned that the Interim Final Rule will now make matters far worse.

APG members are long-standing proponents of, and advocates for, value-based care, the transition to which CMS has long been fully committed. As you know, value-based care entails proactive prevention, high-quality and cost-effective treatment, and care coordination for patients, among other interventions, all aimed at keeping them as healthy as possible and avoiding unnecessary hospitalization and low-value care. The provision of value-based care requires and necessitates insurance coverage, as value-based care arrangements must be arranged and negotiated with either public or private payers. To the extent that many Medicaid enrollees who are indisputably 'medically frail' will lose coverage due to new administrative requirements, the resulting coverage gaps will make participation in value-based care models impossible for these affected populations, as there will be no payer with which to negotiate these arrangements. The health of Medicaid enrollees who become uninsured will suffer; they will receive little if any preventive care; and to the extent that they can obtain health care at all, it is likely to be delivered episodically and reactively in hospital emergency departments, where it will drive up the costs of uncompensated care and further destabilize the delivery system. These pernicious results would be avoidable if CMS adopts our recommendations.

Practically, ethically, and morally, it is also impossible to care well for very sick patients if physicians must also sit as judge and jury on their ability to work, as the IFR implies that they will and as discussed further below. APG believes – along with multiple other likely respondents to this IFR – that its provisions would exceed Congressional direction as expressed in the underlying statute; introduce significant operational uncertainty; harm beneficiaries' access to care, including high quality and cost-effective care, and produce millions more uninsured individuals.

With respect to CMS's new definition of medical frailty, APG also believes that it is inevitable that physicians will be called upon, one way or another, to make assessments about the ability of their seriously ill patients to work. APG believes that the information that physicians and other clinicians record on medical records, claims, or other materials will also be used by others to make these determinations. Physicians will thus become unwilling partners in the calculation of whether individuals who are seriously ill must still meet work requirements; whether they can thus work and maintain their Medicaid coverage; whether they must lose their coverage if they do not work; and whether their resulting inability to obtain the regular health care that they require will contribute to their premature deaths. Placing physicians in such a position would violate nearly every core principle of medical ethics[1]: the obligation to act for benefit of the patient; the obligation to not to harm the patient; the obligation to respect the patient's autonomy; and the obligation to ensure the fair, equitable, and appropriate treatment of patients.

Below, in Section II, APG offers a summary of its recommendations. In Section III, items A-G, APG offers its further analysis of the proposed rule to provide context around its recommendations for CMS. APG is grateful for this opportunity to highlight these concerns and fervently hopes that CMS will overhaul the IFR to address APG's recommendations.

[1] Varkey B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30(1):17-28. doi: 10.1159/000509119. Epub 2020 Jun 4. PMID: 32498071; PMCID: PMC7923912.

II. Summary of Recommendations

APG's recommendations to CMS are as follows:

- **T**hat the IFR not exceed the provisions in the underlying law by requiring that a medically frail person also demonstrate inability to meet work requirements, so that a state-defined condition of medical frailty is a sufficient condition for exemption from these requirements.

- That CMS authorize states to allow for other categorical exclusions from community engagement requirements to mitigate the risk of loss of Medicaid coverage for the most vulnerable Americans.

- That states should be able to categorically exclude from work requirements under the law -- automatically and permanently – persons age 65 and older; those dually enrolled in Medicare and Medicaid; family caregivers; and those who meet the medical frailty definition.

- That CMS reconsider and remove the narrowing of this exemption disqualifying people who have been in stable recovery for five more years.

- That CMS reconsider the look-back period for the purposes of identifying medical frailty and revise it to 36 months.

- That CMS broaden the IFR's caregiver exemption to explicitly include family caregivers of older adults and that -- to minimize administrative hurdles – CMS accept self-attestation by a caregiver as sufficient verification that a person is in that role.

- That CMS restore for 2028 and beyond the ability of medically frail individuals to self-attest as to their condition and exemption from work requirements for up to 12 months upon initial enrollment.

- That states should be instructed to develop a process for new enrollees to obtain documentation of their condition by a health care provider within a year of enrollment, and to obtain ongoing revalidation of their condition from a provider have a provider annually thereafter.

- That CMS extend its implementation date for the IFR for at least one year from January 2027 to January 2028 to allow states sufficient time to update and test their systems and ensure that plans, providers, and enrollees and new beneficiaries are fully apprised of the new eligibility requirements. Alternatively, APG respectfully requests that CMS consider granting extensions to states on a case-by-case basis to help mitigate the adverse effects of complex and medically frail enrollees losing health care coverage when they need it the most.

- That CMS not go beyond provisions of the underlying statute -- and therefore eliminate the requirement that the "medically frail" exemption by definition must include inability to work -- because of the high degree of likelihood that these and other provisions of the IFR will be found to violate the Title II of the Americans With Disabilities Act in their disparate treatment of persons with disabilities.

III. APG's Analysis

The IFR would implement section 71119 of Public Law 119-21, which added section 1902(xx) to the Social Security Act and requires certain adults applying for or enrolled in Medicaid to demonstrate "community engagement" as a condition of eligibility (herein, the 'statute' or the 'law'). According to CMS, this requirement applies in states covering the Affordable Care Act (ACA) adult expansion group and may apply in states with section 1115 demonstrations providing minimum essential coverage to similar adult populations.

The IFR provides additional definitions and guidelines for implementing community engagement requirements to those spelled out in the underlying law. APG is concerned that the IFR would impose restrictions not included in law that would limit potentially millions of individuals' ability to access an exemption to the requirements. Furthermore, many elements of the IFR would create administrative and other barriers that would lead to improper terminations and loss of coverage, and disrupted access to health care for the most vulnerable Americans. The regulation would do so in the following ways:

A. The IFR improperly narrows the definition of "medical frailty."

The underlying statute broadly defines the medically frail to include, but not be limited to, those who are blind or disabled, have substance use or disabling mental disorders, possess disabilities impacting daily living activities (ADLs), or have complex medical conditions. Although Congress delegated to the Secretary of Health and Human Services the responsibility to define medical frailty further, it did not authorize the Secretary to impose non-statutory criteria on the terms of exemption from the community engagement requirements.

Nonetheless, the IFR would add a non-statutory requirement that, for a given medical or other condition to constitute "medical frailty," it must significantly impair "the individual's ability to comply with the community engagement requirement." The IFR further states that, for this determination to be made requires "consideration of the severity of an individual's condition as relevant to whether that individual is capable of meeting the community engagement requirement," such that "an individual who lacks the capacity to meet the community engagement requirement may properly be determined to be medically frail or otherwise to have special medical needs." But the IFR is silent as to how the severity of an individual's condition is to be assessed, and by whom, other than seeming to delegate this duty to the states.

As an organization of physician groups who regularly care for medically frail individuals, including seriously ill ones, APG believes that it would be unworkable, unethical, and inappropriate to have state entities in charge of administering Medicaid coverage assess the severity of individuals' health conditions. APG also believes that it would be equally unethical and unworkable to put those who are most capable of assessing the severity of individuals' illnesses – their physicians and other clinicians – in charge of determining whether the sick individuals whom they treat are insufficiently sick that they can still work or meet other aspects of community engagement requirements.

Physicians face ethical and professional obligations to do no harm, but APG believes that if the IFR is adopted as written, harm would be inevitable. The information that physicians recorded about their very sick patients – either in medical records, claims, or other sources – would inherently be used to make judgments about whether their patients were insufficiently sick to avoid working. These judgments, then, could either consign very sick patients to working to preserve their Medicaid coverage, or to losing their coverage if they did not work -- imperiling their treatment and possibly causing their premature death.

To protect individuals' access to care and remove physicians from untenable ethical quandaries, CMS should withdraw its proposal to tie the definition of medical frailty to an inability to work and should instead spell out that being in a state-defined condition of medical frailty is sufficient to enable an individual to be exempt from the work requirements. Other categorial exclusions should be added, such as exempting from work requirements persons 65 and older; those

dually enrolled in Medicare and Medicaid; and family caregivers. This approach would meet the requirements of the law, minimize confusion among Medicaid enrollees and new applicants, and reduce the risk of disparate treatment due to differing interpretations of the IRF.

Recommendation: APG thus recommends that the IFR not exceed the provisions in the law by requiring that a medically frail person also demonstrate inability to meet work requirements, so that a state-defined condition of medical frailty is a sufficient condition for exemption from these requirements. APG also recommends that CMS authorize states to allow for other categorical exclusions from community engagement requirements to mitigate the risk of loss of Medicaid coverage for the most vulnerable Americans. States should be able to categorically exclude from work requirements under the law -- automatically and permanently – persons age 65 and older; those dually enrolled in Medicare and Medicaid; family caregivers; and those who meet the medical frailty definition.

B. Although the underlying statute exempts individuals "with a substance use disorder" from meeting the work requirements without qualification, the IFR unlawfully narrows the definition beyond the text of the law.

It is clear from the legislative history that Congress sought a broad definition of this exemption, in fact dropping the original phrase – "chronic substance use disorder" – from the text in favor of simply referring to those "with a substance use disorder" as being exempt. Notwithstanding this history, the IFR would narrow the exemption by regulation, disqualifying from the exemption from work requirements individuals with a substance use disorder who have been in "stable recovery" for five or more years.

This narrowing goes beyond the statute and raises material implementation, clinical, and operational issues and questions, including but not limited to how "stable recovery" is defined; what criteria must be met, and how, determine that an individual is in stable recovery; and how the term "stable recovery" is to be understood in light of the fact that it is extremely common for individuals in recovery to experience a relapse of their substance use disorder.

Recommendation: APG recommends that CMS reconsider and remove the narrowing of this exemption disqualifying people who have been in stable recovery for five more years.

C. The IFR sets forth an unreasonably short "lookback period" for identifying medical frailty.

The IFR would require that states reverify an individual's medically frail status at least every 12 months and may require that individuals reconfirm their frailty status every six months. The IFR also would place a firm limit on how far states could look back into an individual's history to extract automated diagnostic and service information to determine medical frailty. Specifically, states could not use claims or encounter data older than 12 months to identify medical frailty.

This period is far shorter than the three years' lookback period recommended by many advocates and clinicians to avoid the risk of under-identifying people with cyclical and episodic conditions. By contrast, states have had the flexibility to determine methodologies for identifying medically frail individuals in the Alternative Benefit Plan (ABP), the Medicaid benefit design that allows states to provide health insurance coverage tailored to specific populations, as well as in the 1115 waiver demonstration context. Imposing a greatly foreshortened look-back period risks under-identification of persons who would meet the medical frailty statutory definition.

Recommendation: APG recommends that CMS reconsider the look-back period in the IFR for the purposes of identifying medical frailty and revise it to 36 months.

D. **The law provides exemptions for caregivers of children aged 13 and younger and for individuals with disabilities, but both the law and the IFR lack clarity in how "caregivers" are defined.** Both also lack clarity and specificity as to how exemptions from the community engagement for family caregiving will be approved.

Recommendation: APG recommends that CMS broaden the IFR's caregiver exemption to explicitly include family caregivers of older adults and accept **self-attestation** by a caregiver as sufficient verification to minimize administrative hurdles.

E. Under the IFR, Medicaid beneficiaries can self-attest to both work compliance hours and qualifying exemptions, including their "medically frail" status, for up to 12 months during 2027, but their ability to self-attest is limited beginning in 2028.

Self-attestation as to both work compliance hours and qualifying exemptions is appropriate, but as of 2028, the IFR would severely limit self-attestation and mandate physical documentation whenever it is "reasonably available." States would also have to require third-party documentation (e.g., paystubs, employer statements, school enrollment forms) if data is missing, and self-attestation is only allowed as a last resort if physical documentation is completely unavailable.

APG recognizes that the statute requires states to use automatic data verification as much as possible to confirm an individual's compliance with or exemption from work requirements, but not everyone will be able to be verified this way. APG is thus concerned about the impact that limits on self-attestation will have on cancer patients and others with serious or complex illnesses.

Without self-attestation, people with cancer, or those with end-stage renal disease undergoing periodic dialysis, may have to obtain and submit proof of their diagnosis or treatment, or have their doctor submit a form demonstrating or verifying an inability to work. Individuals who have not had consistent health insurance coverage or who lack easy access to doctors and care, such as those who live in many rural areas, will have difficulty obtaining such proof or the requisite paperwork from physicians. Individuals who are homeless, or experiencing bouts of homelessness, will find such requirements impossible to meet. In short, for millions of medically frail individuals, the inability to self-attest as to their conditions are likely to lose their Medicaid coverage and thus their access to life-saving treatment.

Recommendation: CMS should restore for 2028 and beyond the ability of medically frail individuals to self-attest as to their condition and exemption from work requirements for up to 12 months upon initial enrollment. States should be instructed to develop a process for new enrollees to obtain documentation of their condition by a health care provider within a year of enrollment, and to obtain ongoing revalidation of their condition from a provider have a provider annually thereafter.

F. **The IFR poses major operational challenges for effective state implementation by January 2027, particularly as regards communications with Medicaid enrollees.**

Given the implications of the statutory and IFR requirements, it is essential for states to develop and provide clear and accessible information to applicants and enrollees. Medicaid enrollees are entitled to clear advice about the changes in Medicaid coverage and to have accessible options, such as well-staffed hotlines, to enable them to ask questions or get additional information. Such information should include plain-language, accessible notices in multiple formats and languages explaining the reporting requirements, exemptions, and information about requesting exemptions and accommodations. In the absence of these approaches, many Medicaid enrollees are likely to be confused; miss various deadlines; and run the substantial risk of non-compliance and loss of coverage.

Furthermore, states will have to update and test system and process updates to ensure compliance with the IFR and to ensure that states, counties, and managed care plans are fully staffed and prepared ahead of implementation in January 2027. States need to be explicit about enrollees' right to appeal adverse decisions, including an opportunity to temporarily continue coverage pending appeal and an opportunity for a hearing.

Recommendation: CMS should extend its implementation date for at least one year from January 2027 to January 2028 to allow states sufficient time to update and test their systems and ensure that plans, providers, and enrollees and new beneficiaries are fully apprised of the new eligibility requirements. Alternatively, APG respectfully requests CMS to consider granting extensions to states on a case-by-case basis to help mitigate the adverse effects of complex and medically frail enrollees losing health care coverage when they need it the most.

G. Implementation of the IFR will lead to disparate treatment of highly vulnerable Medicaid beneficiaries within and among states, as well as litigation relating to the adverse impacts of that disparate treatment and the conflicts with the provisions of the Americans with Disabilities Act (ADA).

Under Title II of the ADA, state Medicaid agencies are prohibited from using administrative methods or other criteria that subject individuals with disabilities to discrimination or deny them meaningful access to public services. Because the IFR as written will force vulnerable people to prove repeatedly that they are too disabled or ill to work, and because many such people have profound disabilities that will require their caregivers to consistently report such paperwork for them, it would appear to be a Title II violation. The relevant provisions include the following:

- Requirements to report, verify, and document exemptions that will disproportionately harm people with intellectual, developmental, or psychiatric disabilities who may struggle with complex paperwork and administrative requirements
- The complex tracking and reporting mechanisms implicit in the IFR will act as a barrier to care, effectively denying disabled individuals their health care benefits and prompting them to lose their Medicaid coverage.

Recommendation: Due to the likelihood that provisions of the IFT will violate the Americans With Disabilities Act, CMS has further reason not to go beyond the provisions of the underlying statute and should eliminate the requirement that the "medically frail" exemption must by definition include inability to work.

IV. Conclusion

APG appreciates your careful consideration of its analysis and recommendations above and believes that the adverse impact of the IFR on Medicaid beneficiaries, the physician-patient relationship, the advance of value-based care, and the sustainability of the health care system overall could be mitigated by taking the actions proposed in APG's recommendations. Thank you again for the opportunity to comment on the Interim Final Rule.

Sincerely,

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