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Inside CMS' medical frailty, Medicaid work requirements guidance



There are multiple paths to a Medicaid enrollee being deemed medically frail and exempt from work requirements. (Modern Healthcare Illustration/Adobe Stock)

By [Bridget Early](#) September 14, 2026 05:00 AM CDT

The Centers for Medicaid and Medicare Services has provided the greatest detail to date about how states can determine who is exempt from Medicaid work requirements for “medical frailty.”

The guidance, issued in the form of a slide presentation last Tuesday, offers a blueprint for states as they [hustle to figure out](#) how to implement the “[medical frailty](#)” exemption, which

has been a sticking point. Yet it leaves many questions for states, providers and insurers to sort out.

Work requirements must be in force no later than Jan. 1 under President Donald Trump's signature [tax law](#), leaving states with [little time to get ready](#) to cull the Medicaid rolls and to manage exceptions to the rule.

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The law includes a narrow set of exemptions for enrollees who are too old, too young or too sick to meet the requisite 80 hours of work, school or volunteering per month. One key exemption is for [medically frail beneficiaries](#).

The statute defines a person as medically frail if they have at least one of these five characteristics: a physical disability, substance use disorder, a disabling mental health condition, an impairment impeding activities of daily living or a "serious or complex" illness.

But the [interim final rule](#) to implement work requirements created a [strict two-part test to determine medical frailty](#). Enrollees must meet one of the criteria in statute and also verify that the underlying condition significantly impairs their ability to work or participate in other qualifying activities.

The new guidance offers greater clarity about how the agency will judge how states manage medical frailty decisions and suggests an optional, three-tiered approach to promote compliance.

The first includes instances when states can confirm enrollees are significantly impaired based on a code alone, such as people being treated for ALS or pancreatic cancer.

Tier two includes baseline billing codes that could qualify an enrollee as medically frail, but for which the state may require additional information to make a determination.

The third tier involves situations in which the state doesn't have enough information to discern medical frailty.

CMS also recommends data states could use to verify medical frailty, such as ICD-10 codes, fee-for-service and Medicaid managed care claims, and short-term disability claims.

"Because an exclusion on the basis of medical frailty depends on whether a health condition or conditions significantly impairs an individual's ability to comply with the community engagement requirement, determining whether an individual qualifies for the exclusion may require consulting multiple data sources," the guidance says.

There are real positives to the new information, said Kinda Serafi, a partner at the legal and consulting firm Manatt Health. The guidance gives states a practical roadmap for using diagnoses, claims, utilization data and other information to help make medical frailty determinations, she said.

While this gives states a jumping-off point, it presents challenges.

For instance, CMS makes clear that states must develop their own verification methodologies and code lists, which creates compliance risks for states, Serafi said.

“Without granular guidance from CMS, they’re going to be asked to make thousands of clinical and policy judgments, and there’s a real possibility that those decisions are going to be scrutinized years later,” Serafi said.

The suggested tiers also leave questions for states to hash out.

States will have to decide the extent to which they plan on instituting a tiered structure, said Susan Dentzer, president and CEO of America’s Physician Groups. They’ll need to set parameters for each tier and determine whether they will partner with physicians and managed care organizations, Dentzer said.

In practice, the tiers are clearer-cut than patients’ conditions occur in reality, and this approach puts providers in an ethically difficult position when patients need clinical evaluations to document they are exempt from work requirements, Dentzer said.

“This violates every principle of medical ethics known to humankind,” Dentzer said. “It’s going to put clinicians in the position of sitting as judge and jury over whether their patients not only can work or not but, frankly, whether they can still be on Medicaid.”

Technology vendors will need to establish analytics that capture both diagnosis codes and ongoing claims information, since CMS requires significant detail on enrollees’ medical histories, many of whom go in and out of care as their condition changes, Susan Harrison, an associate director in Guidehouse’s State Health and Human Services practice, wrote in an email.

Medicaid managed care organizations have significant data readily available, so communication and data-sharing with insurers could play a crucial role, but that requires a lot of foresight and planning by states that just isn’t there yet, said Emma Liebman, associate director of policy for the Alliance of Community Health Plans, which represents provider-affiliated health insurance companies.