POLITICS & REGULATION

How Medicaid work rules just got more complicated

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By **Bridget Early**
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Key Takeaways

- A court decision vacated the Centers for Medicare and Medicaid Services' definition of "medical frailty" for Medicaid work requirement exemptions.
- States must reconsider planning already in the works and reconcile the court order with CMS directives.

- Full, nationwide implementation of Medicaid work requirements by the Jan. 1 deadline may be at risk.

AI-assisted summary, editor reviewed

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A court ruling relaxing a key aspect of Medicaid work requirements could alleviate pressure on states and providers, but critical questions about federal enforcement remain.

Last Thursday, U.S. District Court for the District of Massachusetts decided that the Centers for Medicare and Medicaid Services impermissibly narrowed the "medical frailty" exemption from work requirements.

While this ruling will enable states to conduct simpler medical frailty exemption verifications, they nevertheless will have to revisit elements of their work requirements planning as a Jan. 1 implementation deadline approaches. In addition, the court order doesn't fully address how CMS may enforce work requirements in light of the ruling.

Related: Court voids CMS' Medicaid medical frailty work requirement policy

What led to the litigation?

Democratic officials from 25 states and the District of Columbia filed a lawsuit challenging the medical frailty definition and other aspects of the rule in June.

Under President Donald Trump's tax law, most Medicaid enrollees without disabilities must log 80 hours per month of work, school or volunteering as a condition of coverage unless they qualify for an exemption such as medical frailty.

The CMS rule took a stricter approach to medical frailty than laid out on the statutory language. The law defines a person as medically frail if they have a physical disability, a disabling mental

health condition, substance use disorder, an impairment impeding activities of daily living, or a "serious or complex" illness.

The CMS rule would have instituted a two-part test for medical frailty. Under the policy the court partially struck down, Medicaid applicants would have had to meet one of the statutory criteria and also prove their conditions "significantly impair" their ability to work.

The rule also directs states to look back at a maximum of 12 months' worth of claims data to make medical frailty determinations and limited enrollees' self-attestations that they are medically frail. These policies remain in place after the court decision.

What did the court decide?

The ruling does three overlapping things.

First, the court determined CMS' medical frailty definition was impermissibly narrower than the law and vacated the policy, meaning CMS' "significant impairment" standard is gone nationwide, said Leo Cuello, a professor at the Georgetown University Center for Children and Families.

Second, the court issued an injunction against CMS' medical frailty policy. This functions as a second layer of protection for plaintiff states, according to a Center for Children and Families analysis published Monday. Even if a higher court were to allow CMS to enforce its two-part test, the agency still couldn't do so in the plaintiff states unless the injunction were also overturned, according to the Georgetown analysis.

Finally, Judge Richard Stearns issued a six-month stay on CMS enforcement because the ruling may require plaintiff states to adjust their verification processes. The pause will run from the date of the ruling through late April.

Stakeholders are waiting for the court to issue a clarification because two court documents that comprise the ruling are worded slightly differently, which could affect the scope of the stay.

The official court order blocks CMS from enforcing "any errors or delays in implementing" the medical frailty provisions of the rule. But Stearns' opinion, which explains his rationale, implies the stay would only apply to medical frailty determination errors.

What does this mean for states?

The ruling is a "short-term pain, long-term gain" scenario for states, which secured both an ideal outcome and a challenging, last-minute rule shift, Cuello said.

The ruling escalates the need for states to seek "good faith" implementation waivers to delay coverage denials or terminations while they adapt to the altered requirements, said Kinda Serafi, a partner at the law and consulting firm Manatt Health.

States will need to revise policies and operational processes wherever they intersect with medical frailty, Serafi said. That entails revising code lists, updating information technology systems, editing application and renewal forms, conducting end-to-end system testing, and educating the eligibility workforce and call center workers, she said.

"It is extremely unlikely that states will be able to do this eight weeks out. So, if states are required to go forward on Jan. 1 without a 'good faith' waiver, it is extremely likely that eligible people are going to lose coverage," Serafi said.

What does this mean for providers?

The ruling will reduce the complexity of the verification process, according to an analysis the health policy research organization KFF published Monday. It could also ease pressure on providers to determine whether their patients are significantly impaired by their health conditions, KFF concluded.

But the ruling doesn't alleviate the overall documentation burden for providers or enrollees' need to demonstrate their work history, said Susan Dentzer, president and CEO of America's Physician Groups.

What happens next?

CMS could opt to extend the Jan. 1 implementation deadline, either for all states or on a case-by-case basis for states that weren't involved in the lawsuit. CMS also may fight the ruling, which could further muddy the waters, Serafi said. "If the government appeals this decision, that's going to create confusion for states' implementation efforts," she said.

A CMS spokesperson declined to comment on whether it would appeal the ruling or whether it would issue new guidance and did not respond to questions about whether it would offer deadline extensions.