AMERICA'S ESSENTIAL HOSPITALS

March 12, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: Implementation of Section 71119 of the Working Families Tax Cut Legislation

Dear Administrator Oz:

On behalf of our nearly 400 member hospitals that serve the most vulnerable Medicaid patients, we write to offer comments on the Centers for Medicare & Medicaid Services' (CMS') preliminary guidance on the Working Families Tax Cut's legislation (WFTCL's) community engagement requirement provisions. We appreciate the administration's efforts to provide early guidance and work with Medicaid technology vendors to help states prepare for implementation. We hope to continue working with CMS to make these policies work for essential hospitals' patients. In particular, **we urge CMS to create pathways to streamline enrollment of eligible patients who qualify for hardship and medical frailty exemptions so that essential hospitals can provide the urgent care their patients need and support patients with pathways to continued community engagement.**

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to keeping all Americans healthy, including people who cannot afford other options for care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our nearly 400 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

The mission of essential hospitals closely aligns with President Trump's vision to make all Americans healthy. Essential hospitals are committed to serving people in all communities that need access to quality care. Although essential hospitals account for only 6% of acute-care hospitals nationwide, they provided 29% of the nation's charity care in 2023. About three-

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quarters of the patients our members serve are uninsured or enrolled in Medicaid or Medicare.[1] In addition, nearly two-thirds of essential hospitals provide services to rural patients and communities.[2] To meet the needs of all patients, essential hospitals constantly engage in robust quality improvement initiatives and have created programs that improve quality and access, including efforts to combat chronic health conditions, while lowering health care costs and health care spending.

Essential hospitals are well positioned to help Medicaid beneficiaries contribute to their community through community engagement. Our hospitals support their patients in many ways beyond health care to help them reenter the workforce, further their skills, or participate in their community through paid training programs and partnerships with educational institutions. Essential hospitals also play an important role in helping their patients navigate Medicaid eligibility and enrollment processes so that they can get access to the care they need.

Based on the experience of essential hospitals caring for the most vulnerable patients, we write to make sure policymakers consider common scenarios of patients who seek care at essential hospitals when they are eligible for Medicaid coverage but not enrolled. **We urge policymakers and eligibility system developers to ensure that these patients can have expedited paths to access the care and coverage that they need.**

1. CMS should provide accessible hardship exclusions for Medicaid-eligible patients with unexpected hospitalizations.

SCENARIO: UNEXPECTED HOSPITALIZATION

Sometimes, essential hospitals meet patients on some of the most challenging days of their life. While representing only 6% of hospitals nationwide, essential hospitals account for 21% of psychiatric beds, 31% of level I trauma centers, and 43% of burn care beds, treating patients experiencing extreme physical and mental trauma.[3]

Many essential hospitals have financial assistance departments that employ staff to help patients apply for applicable health coverage, including Medicaid. Staff begin working with patients to get them covered as soon as the patient is able, though this process can be delayed when patients are hospitalized and are incapacitated. Also, it is unlikely that patients would bring paystubs and other documentation of community engagement to the hospital.

When patients are hospitalized with serious, sometimes life-threatening medical conditions, they should focus on getting better, not their Medicaid eligibility or related paperwork. Keeping their health care coverage at this critical moment means patients can get healthy and continue to participate in community engagement activities once their health improves.

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[1] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed Jan. 28, 2026.
[2] America's Essential Hospitals. *Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas*. March 2025. https://essentialhospitals.org/wp-content/uploads/2025/03/2025-Access-to-Care-in-Rural-Areas-Brief.pdf. Accessed Jan. 28, 2026.
[3] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed Jan. 28, 2026.

SOLUTION: SHORT-TERM HARDSHIP EXCLUSION

The optional short-term hardship exclusion will be critical for these patients to obtain Medicaid coverage while hospitalized. To be effective, the hardship exclusion policy must be implemented in a practical manner so there is a streamlined pathway for hospitals to help Medicaid-eligible patients get coverage.

CMS and technology vendors should make it as easy as possible for hospitalized beneficiaries to request hardship exclusions. For example, requests for hardship exclusions could be automatically considered when a patient is hospitalized or somehow included as part of the application that hospitals help patients submit.

In addition, CMS should provide clear guidance on how hospitals can help patients enroll if they do not have documentation of community engagement prior to their hospitalization. Hospitalizations do not neatly fit into Medicaid eligibility months. Regardless of how months are counted, either calendar months or 30-day windows, patients eligible for a hardship exclusion should be exempt from community engagement requirements during hospitalization and post-discharge recovery.

More clarity on the interaction between the community engagement requirements, hardship exclusions, and retroactive eligibility could help states design solutions that help ensure access to care for patients experiencing unexpected hospitalizations. For example, in a state that elects the hardship exclusion and has a one-month lookback period for verification of community engagement requirements, patients who do not have documentation of their community engagement before admission should still be able to receive coverage for hospital services through retroactive eligibility if their Medicaid enrollment is dated one month after their admission. If a state chooses a three-month lookback period for verification of community engagement requirements, CMS should allow states to select a shorter lookback period option in emergency situations to make sure hospitals can provide the care that their patients need. Ultimately, uninsured individuals who are otherwise eligible for Medicaid and experience an unexpected hospitalization should be able to enroll in coverage under the optional hardship exclusion without needing to provide additional documentation. This policy would enable patients to receive coverage for the care provided in the hospital and enable the patient to access the care they need after discharge.

2. CMS should provide clear pathways to continuous coverage for patients who are newly diagnosed with conditions that qualify for medical frailty exemptions.

SCENARIO: NEWLY DIAGNOSED MEDICAL FRAILTY CONDITION

Essential hospitals serve many medically complex patients that struggle with daily living tasks. It is not uncommon for patients to seek care for a physical ailment, such as diabetes, but also have an undiagnosed condition, such as a mental health disorder or substance use disorder. For example, just over 50% of adults with mental illness received treatment in 2024, leaving the other half going undiagnosed or undertreated. Nationwide, the average delay between the onset of mental illness symptoms and treatment is 11 years.[4] Plus, due to workforce shortages, it can

[4] Mental Health by the Numbers. *National Alliance on Mental Illness*. https://www.nami.org/mental-health-by-the-numbers/. Accessed Feb. 13, 2026.

take weeks to months to see a mental health professional to be evaluated and diagnosed with a mental illness.[5] This means patients with mental illness can go years without receiving a diagnosis and treatment while experiencing symptoms that make it harder for them to manage other health conditions or participate in their community.

SOLUTION: ENABLING PROVIDERS TO HELP PATIENTS APPLY FOR MEDICAL FRAILTY EXEMPTIONS

The WFTCL exempts individuals who are "medically frail" from the community engagement requirements, which otherwise apply to Medicaid-eligible individuals in the adult expansion group. The law broadly defines "medically frail" to include individuals with special needs or those who have a substance use disorder, a disabling mental disorder, have a physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living, or who have a serious or complex medical condition. Medicaid coverage is critical for these patients to receive treatment. If their conditions go undiagnosed and they do not qualify as medically frail, it will inappropriately subject them to community engagement requirements.

CMS must account for undiagnosed medical conditions in its medical frailty policy and provide Medicaid coverage while these patients receive a full diagnosis. Given the length of time it takes to get a diagnosis and proper documentation for medical conditions qualifying a patient as medically frail, CMS should allow a grace period or modify documentation requirements to allow patients to receive Medicaid coverage in the interim. Medicaid coverage will be critical for these patients to become self-sufficient. Subjecting them to the community engagement requirements without treatment is counterproductive.

We urge CMS to ensure that states have the flexibility to consider inpatient hospitalization as evidence of a serious or complex medical condition warranting exemption from the requirements. Doing so will ensure that such individuals are able to access the full range of care needed to address their condition and guard against a significant increase in uncompensated care costs for the hospitals that care for them.

We appreciate CMS' efforts to explore how claims data in Medicaid Management Information Systems can be used to help facilitate identification of beneficiaries who are eligible for medical frailty exemptions, but we are worried that the data lag inherent in these data sources will inhibit the ability of providers to provide real-time access to care. In these circumstances, states and CMS should provide mechanisms for providers to help patients expedite medical frailty decisions so that they can access the care that they need.

3. CMS should support the efforts of essential hospitals to help their patients engage in their community after they are discharged.

SCENARIO: CHALLENGES MAINTAINING COMMUNITY ENGAGEMENT AFTER HOSPITALIZATION

When a patient has a medical condition that requires hospitalization, it is often difficult for them to maintain the same job or community engagement activity that they had before they got sick. Essential hospitals have recognized this need and have developed partnerships with community organizations and educational institutions to help support patients after discharge.

[5] Sun C, Correll C, Trestman R, et al. Low availability, long wait times, and high geographic disparity of psychiatric outpatient care in the US. *Gen Hosp Psychiatry*. 2023;84:12-17. https://pubmed.ncbi.nlm.nih.gov/37290263/#:~:text=Results:%20Altogether%2C%20948%20psychiatrists%20were,for%20rural%20disparities%20in%20access. Accessed Feb. 13, 2026.

Because essential hospitals are major employers in their area, they are uniquely positioned to help their patients meet community engagement requirements. In 2023, essential hospitals employed over 960,000 people and invested $210 billion in their local communities. These jobs include many entry-level positions, including community health workers, certified recovery specialists, and peer support workers.[6]

In addition, many essential hospitals offer training and employment programs to meet the needs of their communities while addressing health care staff shortages at their hospitals. Programs include those for certified nursing assistant (CNA) degrees, technicians, phlebotomists, and patient access representatives. Other programs include mentoring opportunities throughout the hospital systems, aiming to place participants in entry-level positions upon program completion. One essential hospital program pairs CNAs with nursing mentors while they take educational classes at the hospital to advance their degree. Further, many essential hospitals are academic medical centers that conduct research, providing other entry-level training opportunities, such as clinical research professionals.[7]

Unfortunately, these services and supports that essential hospitals provide to Medicaid patients are not currently funded by Medicaid or other payers.

SOLUTION: TARGETED MEDICAID FUNDING FOR COMMUNITY ENGAGEMENT SUPPORTS AT ESSENTIAL HOSPITALS

Community engagement policies should enable essential hospitals to support their patients to meet these requirements. In particular, CMS should leverage demonstration opportunities under section 1115(a)(2) of the Social Security Act to invest in community engagement supports. With the flexibility available under Section 1115 waivers, the Medicaid program can implement workforce initiatives to develop and sustain a health care workforce that reflects the needs of health care providers while empowering beneficiaries through community engagement activities so they can achieve self-sufficiency.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Robert Nelb, MPH, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Jennifer DeCubellis
President and CEO

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[6] Oguagha A, Kpamegan H, Alteras T, et al. *Transforming Care: Insights from Social Medicine in Opioid Use Disorder Treatment*. America's Essential Hospitals. September 2025. https://essentialhospitals.org/wp-content/uploads/2025/09/Opioid-Use-Disorder-Treatment-Initiative-Report.pdf. Accessed Feb. 13, 2026.

[7] Essential Communities. *America's Essential Hospitals*. https://essentialcommunities.org/program-map/. Accessed Feb. 13, 2026.