AMERICA'S ESSENTIAL HOSPITALS

July 30, 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: CMS-2454-IFC Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz:

On behalf of our more than 400 member hospitals that serve the most vulnerable Medicaid patients, we share comments on the Centers for Medicare & Medicaid Services' (CMS') interim final rule (IFR) on the Working Families Tax Cut legislation's (WFTCL's) community engagement requirements. We hope to work with CMS to make these policies work for essential hospitals' patients. **We urge CMS to simplify enrollment and renewal procedures while implementing the community engagement requirements, particularly for patients who qualify for medical frailty and short-term hardship exemptions, so essential hospital providers and their patients can focus on improving patient health rather than on paperwork.**

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 more than 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.

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-quarters of the patients our members serve are uninsured or enrolled in Medicaid or Medicare.[1] In addition,

[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 June 29, 2026.

essentialhospitals.org
AMERICA'S ESSENTIAL HOSPITALS
401 Ninth St NW Ste 900
Washington DC 20004
t: 202 585 0100
f: 202 585 0101
e: contact@essentialhospitals.org

nearly two-thirds of essential hospitals serve 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.

Medicaid coverage is critical for essential hospital patients. Health coverage is the first step to reaching their optimal health and self-sufficiency. With that in mind, we urge CMS to implement community engagement requirements in ways that help ensure Medicaid-eligible patients maintain their coverage. Most Medicaid beneficiaries under the age of 65 already work, and many Medicaid enrollees that safety net providers serve likely will be exempt from the requirements.[3,4] CMS should ensure states implement evidence-based data collection practices so working beneficiaries do not lose coverage due to administrative errors.

CMS must also employ evidence-based policy in defining and verifying medical frailty. The IFR's definition of medical frailty and the verification procedures it will require are unworkable. Instead, CMS should look to existing definitions of medical frailty in the Medicaid program, which have proven workable and with which state Medicaid programs have experience. Otherwise, beneficiaries with complex medical conditions will be subject to community engagement requirements, likely losing coverage when they need it the most. Implementing these requirements is already a heavy administrative lift for states, providers, and patients. Implementing a medical frailty policy without evidence that it will properly identify individuals who qualify will increase administrative burden and costs and worsen health outcomes. **We urge CMS to implement the community engagement requirements using evidence-based practices to ensure providers and patients can focus on improving health and not paperwork.**

1. CMS should allow states to define medical frailty solely based on a condition or diagnosis.

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; a physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living; or a serious or complex medical condition. Nothing in the law suggests Congress intended or authorized CMS to apply the type of two-step test outlined in the IFR. Moreover, nothing in CMS' December 2025 informational bulletin suggested CMS was considering adding additional criteria to those outlined in the WFTCL.

Under the IFR, in addition to determining that an individual has a specific diagnosis or medical condition that may qualify an individual as medically frail, the state must also determine that

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[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 June 29, 2026.
[3] Tolbert J, Cervantes S, Rudowitz R, et al. Understanding the Intersection of Medicaid and Work: An Update. *KFF*. May 30, 2025. https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/. Accessed July 23, 2026.
[4] Everhart R, Gillespie S, Maguire M, et al. Minimizing H.R. 1-related Medicaid coverage disruptions for high-risk patients. *Health Affairs Scholar*. 2026;4(7). https://academic.oup.com/healthaffairsscholar/article/4/7/qxag162/8722812?login=false. Accessed July 23, 2026.

the condition or diagnosis significantly impairs the individual's ability to comply with the community engagement requirements.

The additional requirement to demonstrate that the diagnosis or medical condition significantly impairs the individual's ability to meet the requirement introduces unnecessary complexity for states, providers, and beneficiaries. These stakeholders have been preparing to implement the medical frailty exclusion according to the definition in the statute, which is repeated verbatim in CMS' 2025 informational bulletin. The guidance, just as the statute does, excludes from the community engagement requirements any

> individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a physical, mental, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition.

Nothing in the law authorizes the agency to separately require verification that the condition or diagnosis significantly impairs the individual's ability to comply with the community engagement requirements. The IFR definition will impose significant burdens on beneficiaries, providers, and states. A determination of whether a condition or diagnosis significantly impairs an individual's ability to meet the community engagement requirements will not be verifiable based on an *ex parte* basis. This is contrary to the WFTCL's requirement that states establish processes and use reliable information to determine whether an individual is a "specified excluded individual" without requiring the individual to submit additional information. The IFR suggests that states may accept provider documentation regarding whether a condition significantly impairs the individual's ability to work, however, providers are unlikely to be able to make such determinations based solely on an individual's health condition, which will impose significant burdens on patients and providers.

a. Claim and encounter data does not capture information on the inability to meet community engagement requirements.

CMS proposes to use claim and encounter data as the main source of information to help verify an individual as medically frail, which entails a diagnostic code and information indicating the condition significantly impair the individual's ability to comply with the community engagement requirement. Claim and encounter data are designed to capture services provided during a medical visit with supporting documentation of diagnostic and procedure codes that are specific to that encounter. Therefore, claim and encounter data will have diagnostic codes to determine if an individual has a diagnosis or condition that qualifies them as medical frail. The data will not likely have information regarding the individual's *inability* to comply with community work requirements.

There is no diagnostic code for the inability to work, go to school, or volunteer. Z codes capture the impact of employment and education on health, not an individual's health condition impact on the ability to work or go to school. These codes act primarily as supplementary indicators for patient circumstances rather than primary diagnoses for physical illnesses. If the information is available regarding their inability to work, go to school or volunteer, it will not easily be pulled from T-MSIS, as this information is not documented uniformly or in a format that is easily queried in claim and encounter data.

CMS should allow states to determine medical frailty by qualifying diagnoses or medical condition determined by the state that is verified using diagnostic codes, like how Social Security quickly identifies diagnoses and medical condition that, by definition, qualify an individual for disability benefits.[5] **CMS must remove the additional requirement in the IFR's definition of medical frailty because the proposed definition is unworkable, lacking data sources to verify compliance, and takes providers away from focusing on medical care.**

b. Providers should be allowed to focus on providing care.

The job of a medical provider is to provide medical care. They diagnose illness and medical conditions, design treatment plans, coordinate patient care and are overall concerned about the health of their patients. At essential hospitals, providers care for patients that are medically complex, have higher acuity, and experience challenges managing their health. They must spend their time with patients focusing on the patient's biggest health concerns. Despite this, providers have limited time with their patients, usually only 15 to 30 minutes per patient. Rarely is that enough time to cover all a patient's health concerns. In a survey from the Physicians Foundation, only 11% of patients and 14% of physicians felt they had enough time to provide high quality care.[6] Providers also spend significant time documenting medical visits that takes away from patient care and requires time outside of office hours to be completed, averaging 1.84 hours a day.[7] CMS failed to account for the providers' role in determining medical frailty under the IFR's definition and the overall burden on providers in its regulatory impact analysis.

A medical provider can reasonably determine if a patient is medically frail given the patient's medical conditions, as they are trained to do. However, it is unreasonable for medical providers to assess an individual's inability to meet the community engagement requirements according to the IFR's definition. **CMS must allow providers to focus on providing medical care and improving the health of their patients.**

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

Essential hospitals serve many medically complex patients that struggle with managing their conditions and have undiagnosed conditions. 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 undiagnosed or undertreated. Nationwide, the average delay between the onset of mental illness symptoms and treatment is

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[5] Social Security Administration. Compassionate Allowances. https://www.ssa.gov/compassionateallowances/index.htm. Accessed July 23, 2026.
[6] Regina Corso Consulting. 2017 Patient Survey Report for the Physicians Foundation. June 2017. https://physiciansfoundation.org/wp-content/uploads/Physicians_Foundation_2017_Patient_Survey_Report.pdf. Accessed July 23, 2026.
[7] Medical Documentation Burden among US Office-Based Physicians in 2019: A National Study. *JAMA Internal Medicine*. 2022; 182(5): 564-566. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790396/. Accessed July 23, 2026.

11 years.[8] Plus, due to workforce shortages, it can take weeks to months to see a mental health professional to be evaluated and diagnosed with a mental illness.[9] 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. Delayed diagnosis is not restricted to mental health and substance use disorders. Factors such as co-morbidities and access to specialists can also delay diagnosis. **CMS must consider situations in which patients are medically frail but are waiting for a diagnosis when considering compliance policy for medical frailty exemptions.**

a. CMS must account for conditions that are not yet diagnosed in determining that an individual meets the medically frail definition.

CMS must provide Medicaid coverage when patients have symptoms that present as medically frail while they await a diagnosis. Medicaid coverage is critical for these patients to receive treatment. 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.

b. CMS should allow states to consider inpatient hospitalization as evidence of medical frailty.

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.

c. CMS must allow for repeated use of self-attestation of medical frailty after 2028.

Beginning on Jan. 1, 2028, the IFR allows an individual to self-attest to medical frailty once during their period of enrollment. If CMS maintains the two-step definition of medical frailty, this will be insufficient to account for the long path to diagnosis for some conditions that prevent an individual from meeting the community engagement requirements but meet the definition of medical frailty. Further, claim and encounter data are poor sources to determine the inability of an individual to meet the community engagement requirements. **Until states have access to an efficient and accurate data source that clearly documents that a diagnosis significantly impairs an individual's ability to comply with the community engagement requirements, CMS must allow individuals to self-attest that they cannot meet the requirements**. Otherwise, many individuals who should be

[8] Mental Health by the Numbers. *National Alliance on Mental Illness*. https://www.nami.org/mental-health-by-the-numbers/. Accessed July 7, 2026.
[9] 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 July 7, 2026.

exempt from the requirements will be subject to them, likely losing Medicaid coverage and access to the care they need.

Further, there is significant data lag between the date of service and documentation of a diagnosis and when this information appears in claim and encounter data that the state can access. Many states allow up to 12 months to submit a Medicaid claim.[10] This lag will inhibit the ability of providers to provide real-time access to care for individuals who are medically frail but waiting for the documentation for Medicaid eligibility. Waiting for this data may subject patients to community engagement requirements when they should be exempt, potentially losing access to care when they need it the most. **CMS should not limit self-attestation for medical frailty until the data lag can be reduced so that it does not impede access to care for medically frail patients.**

3. CMS should not require qualified entities to assess community engagement requirement compliance from patients who qualify for Medicaid presumptive eligibility.

The IFR requires qualified entities making determinations of presumptive eligibility to include the community engagement requirement as a factor of eligibility. Presumptive eligibility provides immediate, temporary health coverage to vulnerable patients, providing access to care and a seamless path to ongoing Medicaid coverage while protecting patients from medical debt and providers from uncompensated care. Qualified entities, including hospitals, that perform presumptive eligibility determinations do so on the basis of patients' income using readily available financial and other data. While we appreciate that CMS will allow self-attestation to meet the community engagement requirements, **we do not believe patients qualifying for presumptive eligibility should have to provide additional documentation at that time or that providers should assess compliance with the community engagement requirements**.

4. CMS should ensure states have the maximum flexibility to implement optional hardship exclusions to preserve access to coverage for Medicaid-eligible patients.

The optional short-term hardship exclusion will be critical for patients to maintain 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.

a. Hospitals must be able to help patients apply for hardship exclusions.

CMS and technology vendors should make it as easy as possible for hospitalized beneficiaries to request hardship exclusions. The IFR requires individual to affirmatively request a hardship exception, or a state must also accept the request from an adult in the individual's household or family, or, if the individual is a minor or incapacitated, someone acting on the individual's behalf. **CMS should consider allowing requests for hardship exclusions to be**

[10] MedStates. Medicaid Timely Filing Limits by State: MCO and State Rules with Compliance Tips. 2026. https://www.medstates.com/medicaid-claim-filing-deadlines-2025/. Accessed July 23, 2026.

automatically considered when a patient is hospitalized or allow hospitals to help patients submit applications.

b. Patients who are hospitalized in the month of or the month prior to application should be deemed in compliance with the community engagement requirements.

CMS should ensure that hospitalized patients applying for Medicaid during a hospitalization or in the month immediately preceding a hospitalization are deemed to be in compliance with the community engagement requirements for the relevant month. 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.

c. Hardship exclusions for hospitalizations should end 30 days post discharge.

The IFR states exceptions due to hospitalization will end on the last day of the month in which the beneficiary was discharged. However, 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 for at least 30 days after they are discharged**.

5. CMS must monitor and evaluate the effect of community engagement requirements on enrollment and eligibility and make this information publicly available in a timely manner.

In 2018, CMS issued guidance allowing states to design Section 1115 demonstrations to make work and community engagement requirements a condition of Medicaid eligibility for certain beneficiaries. Thirteen states elected to pursue this requirement believing that the expectation to work or contribute to the community would lead to improved health and wellbeing, increased self-sufficiency and reduced reliance on public programs. Six states proceeded far enough to provide early insight into the anticipated enrollment effects and administrative spending associated with the requirements. Observed and projected coverage losses were substantial, significant barriers to employment and administrative barriers were named as top reasons for non-compliance, and administrative costs were high.[11]

Given this experience, CMS must monitor and evaluate the effect of community engagement requirements on enrollment. CMS should develop a transparent plan to monitor the effect of community engagement policies on eligibility and enrollment and evaluate the effect of the requirements on employment, health, and state and federal administrative and program

[11] Medicaid and CHIP Payment and Access Commission. Report to Congress: Implementing Community Engagement Requirements in Medicaid. June 2026. https://www.macpac.gov/wp-content/uploads/2026/06/Chapter-1-Implementing-Community-Engagement-Requirements-in-Medicaid.pdf. Accessed July 23, 2026.

spending. If CMS finds that the requirements or administration of the requirements cause excessive disenrollments of eligible beneficiaries, unnecessarily limits to care access, worsens beneficiaries' overall health, does not increase employment as predicted[12], are excessively costly relative to gains in employment, CMS must pause the community engagement requirements. The requirements are to promote economic stability, self-sufficiency, and independence.[13] **CMS must closely monitor the implementation and outcomes of the community engagement requirements to ensure they are achieving CMS' goals and eligible Medicaid beneficiaries maintain coverage.**

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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

[12] Berman D, Burnszynski J, Ghertner R, et al. Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce Poverty. Office of the Assistant Secretary for Planning and Evaluation. June 1, 2026. https://aspe.hhs.gov/reports/medicaid-work-requirements-should-incentivize-employment-reduce-poverty. Accessed July 23, 2026.
[13] Centers for Medicare U Medicaid Services. CMS Launches Nationwide Framework to Implement Medicaid Work Requirements. June 1, 2026. https://www.cms.gov/newsroom/press-releases/cms-launches-nationwide-framework-implement-medicaid-work-requirements. Accessed July 23, 2026.