AMERICAN COLLEGE of RHEUMATOLOGY
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July 31, 2026

The Honorable Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Sent electronically via regulations.gov

Re: CMS-2026-2047-0002; Medicaid Community Engagement Requirements for Certain Individuals Interim Final Rule

Dear Dr. Oz,

The American College of Rheumatology (ACR), representing over 10,400 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to respond to the Interim Final Rule interpreting and implementing the work and community engagement requirement in Medicaid codified under section 1902(xx) of the Social Security Act. The ACR is concerned that some provisions of the rule, particularly the guidance around the medical frailty exemption, would introduce new unfunded administrative burdens for physicians while threatening health outcomes and continuity of care for a core segment of the rheumatology patient population: individuals living with chronic illnesses with fluctuating disease states.

The ACR urges the following changes to the Interim Final Rule:

- Adopt a more inclusive definition of "medically frail" for the purposes of the exemption that recognizes the fluctuating and chronic nature of rheumatic diseases
- Use existing claims and care utilization data, as well as self-attestation to the greatest extent possible to determine medical frailty before requiring supporting documentation from a physician or other health care practitioner
- Allow a 60-day grace period for enrollees to submit supporting documentation for compliance with (or exemption from) work requirements
- Develop a standardized medical exemption screening form that physicians and other practitioners can use to determine medical frailty status
- Allow enrollees to maintain existing treatment plans throughout periods of administrative review of work requirement compliance or exemption
- Require states to monitor and report indicators of care disruption resulting from work requirements
- Provide advance notice of coverage termination through multiple communication platforms before disenrollment

The IFR introduces a definition of "medically frailty" that is more restrictive than that used to determine if an enrollee qualifies for an Alternate Benefit Plan. This definition may introduce challenges for both physicians and enrollees.

To determine frailty, states must develop lists of health conditions but cannot use these lists to categorically exempt people based on diagnosis alone. Rather, to be exempted, enrollees must demonstrate impaired functional capacity that makes them unable to perform 80 hours per month of work or community engagement activities. Though states are encouraged to first use claims and utilization data to determine which beneficiaries are likely to be medically frail, where this data does not exist, provider documentation must be provided.

The ACR opposes this narrow definition of medical frailty because it does not recognize the fluctuating nature of rheumatic and autoimmune diseases. In rheumatic disease, frailty is dynamic and responsive to treatment. Defining and applying it as a stable eligibility category, subject to repeatable reverification at least every 12 months leaves the exemption dependent on treatment response at the designated point in time, rather than by any stable measure of work capacity. There is no existing clinical indicator or documented measure that reliably assesses a patient's capacity to perform 80 hours per month of work or community engagement.

Instruments used in rheumatology practice, including patient reported outcome measures such as PROMIS physical function, the Health Assessment Questionnaire Disability Index (HAQ-DI), and composite disease activity measures such as the CDAI or DAS28, capture disease activity and general functional status. None has been validated as a predictor of occupational capacity at a defined monthly hour threshold. At most these instruments could serve as a preliminary screen, and any such use would require additional confirmatory assessment and formal validation before it could support an eligibility determination. **Requirements also differ by the nature of the work. The capacity relevant to manual labor differs from the capacity relevant to sedentary or cognitive work, and no single measure spans both.**

The rule treats medical frailty as a status to be confirmed and then reconfirmed at least every 12 months. In rheumatic disease this is difficult to reconcile with the underlying biology. Frailty in rheumatoid arthritis is dynamic and often improves as disease activity is controlled. In the Scottish Early Rheumatoid Arthritis cohort, as disease activity fell with treatment, 46% of moderately frail participants improved to a mildly frail or robust state within six months (Mair et al. RMD Open, 2022).

We encourage CMS to develop a definition of medical frailty that incorporates functional limitations, treatment burden and episodic incapacity, in addition to diagnoses and ability to meet work requirements. Individuals undergoing intensive treatment regimens or experiencing intermittent, but severe limitations should be eligible for exemptions even if they do not meet traditional definitions of disability. Rheumatic diseases fluctuate in severity and can flare unpredictably, particularly when doses of medication are missed. Medical frailty determinations should also incorporate the physician's perceived risk of flare within the upcoming twelve months. For those patients that remain at high risk of flare annually, a permanent category of medical frailty could be assigned, preventing the need for annual recertification.

Additionally, the IFR encourages states to verify medical frailty using existing claims and encounter data before requesting supporting documentation. Self-attestation is allowed prior to

January 1, 2028, for verification of medical frailty but can only be used once during the period of a beneficiary's enrollment.

However, current medical records, including visit notes, imaging, laboratory results, and treatment history, are generally not sufficient to demonstrate functional limitations for this purpose. These records are created to document diagnosis, disease activity, treatment response, and safety monitoring. They are not structured to establish capacity or incapacity for a defined quantity of work, and the functional information they do contain is often recorded as free text that automated data matching cannot reliably retrieve.

Diagnosis codes, claims, and procedure histories do not accurately reflect the severity or functional impact of rheumatic disease. Diagnostic codes identify the presence of a condition but do not encode disease activity, functional status, or work capacity. This gap reflects both a fundamental limitation of administrative data and a lack of integration across the records that would be needed to assemble a complete functional picture. Even the strongest research grade claims-based frailty measures have sensitivity of 73% and specificity of 68% (Kim et al. analysis in Medicare beneficiaries). Applied at the scale of an eligibility system, error rates of that magnitude would produce large numbers of incorrect determinations in both directions.

Meaningful documentation of severity and functional impact typically accrues over the first year after diagnosis, as disease activity is characterized, treatment response is observed, and the patient's trajectory becomes clear. This creates a timing problem that works against the sickest new patients. A rheumatology patient with new onset severe disease is often most functionally impaired at presentation, precisely when the 12-month lookback of claims and encounter data typically used to calculate a frailty index or comorbidity index contains little or nothing. A grace period after diagnosis, during which severity and trajectory can be established, would be needed for any verification process to reflect these patients accurately.

The ACR urges CMS to broaden the use of self-attestation. For enrollees who have no current source of coverage, expecting that claims data will be available or that the enrollee has sufficient access to medical care to produce documentation is unrealistic. **New applicants should be allowed to self-attest medical frailty past the 2028 date and existing enrollees should also be allowed to self-attest at least once during their period of enrollment following application.**

To reduce administrative burden on physicians and other health care practitioners and to support beneficiaries' continuity of coverage, **we also recommend that CMS allow enrollees and physicians a 60-day grace period following the date of application or redetermination to produce supporting documentation verifying exemption from or compliance with the work requirement.**

For physicians, producing individualized functional determinations at scale would require new standardized instruments, clinician and staff training, dedicated visit time, and workflow redesign, with no corresponding billing mechanism to support these added demands. Because the rule requires reverification at least every 12 months, the burden recurs annually for each affected patient rather than arising once. Prior experience indicates that this administrative burden, rather than genuine ineligibility, is the primary driver of coverage loss under such requirements. In Arkansas, where a comparable requirement operated from 2018 to 2019, more than 18,000

people, about 25% of those subject to the requirement, lost coverage, primarily because of difficulty reporting or documenting status, even though the large majority already met the requirement or qualified for an exemption (Kaiser Family Foundation summary of the Arkansas experience, 2025).

The ACR urges CMS to develop a standardized medical exemption screening form that physicians and other health care practitioners can use to verify medical frailty. The rule allows states flexibility in defining which conditions qualify, and it does not specify a single validated instrument for assessing functional impairment. Measurement choice alone drives large differences in who is identified as frail. This is not only an artifact of comparing different study populations. When four frailty instruments were applied to the same cohort of patients with rheumatoid arthritis, the proportion classified as frail ranged from 15% to 36% depending solely on the instrument used, and the instruments agreed with one another poorly. Agreement between measures was slight-to-moderate for most pairings, meaning that two accepted instruments frequently reached opposite conclusions about the same patient (Wysham et al, Arthritis Care and Research, 2026; similar findings in SLE Katz et al., Arthritis Care Res 2025). Without a specified instrument, otherwise similar patients could receive opposite determinations from one state to the next, and even a single patient could be classified differently depending only on which tool a clinician happened to use.

Determining a patient's eligibility for coverage based on ability to work is a task that treating rheumatologists are not positioned to make and should not be asked to own. The treating clinician's role is diagnosis, treatment, and monitoring. A determination of work capacity, especially one that governs coverage, calls for a distinct and dedicated assessment process with appropriate expertise, and it raises unresolved questions of clinician liability where a required attestation about a future functional capacity is inherently uncertain. Additionally, disability determinations may place the treating rheumatologist at odds with their primary focus, supporting the health and wellbeing of their patient by placing the rheumatologist in a position to of power of their patient's risk for loss of healthcare coverage as well as financial insecurity. If any individualized functional determination is to be required, responsibility should rest with a purpose-built process rather than with the treating rheumatologist in the course of usual care.

The ACR is also concerned that the coverage loss that results from implementation of the work requirement may result in care disruptions, particularly for individuals with chronic rheumatic diseases. For arthritis, lupus and other chronic illnesses, continuity of care is crucial for preventing disease flares and worsening of symptoms. **CMS should require that states implement protections that allow beneficiaries to maintain access to their existing providers and continue ongoing treatment plans during periods of eligibility review or reporting compliance.** Particular attention should be paid to individuals receiving complex or high-cost therapies, including biologics, infused medications, and specialty pharmacy treatments. Interruptions in these therapies, even for a short duration, can lead to disease progression, loss of treatment efficacy, and increased long-term healthcare costs.

To assess the real-world impact of work reporting requirements, **CMS should also require states to monitor and report key indicators of care disruption, including missed appointments, treatment interruptions, increased emergency department utilization, and avoidable hospitalizations.** These metrics will be critical for evaluating whether policies are supporting or undermining patient health outcomes.

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Finally, states should be required to provide advance notice of coverage termination and to make multiple outreach attempts through multiple communication methods before disenrollment. Currently, states are only required to provide 10 days of advance notice prior to coverage termination, and which communication platforms are required for outreach is not specified. Given the complexity of the new requirements and the major changes they make to the functioning of the Medicaid program, as well as the potential for procedural coverage terminations, the ACR recommends that advance notice of 30 days be given before termination and that multiple notices be sent before disenrollment. Establishing clear and reasonable "cure periods" would allow individuals to resolve missing documentation or reporting issues before coverage is terminated due to procedural noncompliance.

Please contact Sweta Haldar, MSPH, ACR Manager of Regulatory Affairs, at shaldar@rheumatology.org or (202) 807-5262 should you have any questions or if we can provide additional assistance.

Sincerely,

William F. Harvey, MD, MSc, FACR
President, American College of Rheumatology