Issue Brief: Medicaid Work Requirements' Medical Frailty Exemption

FEBRUARY 2026

The enactment of the One Big Beautiful Bill Act of 2025 (OBBBA, Public Law 119-21) adds mandatory community engagement and work reporting requirements (work requirements) for Medicaid expansion adults, effective January 1, 2027. OBBBA requires states to exempt individuals who are medically frail or have special medical needs, including individuals with serious or complex medical conditions; disabling mental disorders; substance use disorders; or physical, intellectual, or developmental disabilities. Implementing this exemption effectively will be crucial to helping eligible individuals maintain coverage and, thus, access to needed medical care.

A clinically grounded, clear, and comprehensive approach to implementing medical frailty is one of the most important safeguards to ensure eligible people do not lose coverage because of administrative barriers. At a minimum, this requires establishing clear policy definitions of medical frailty; translating those definitions into a comprehensive data strategy to identify people who meet this definition by building a clinically grounded code list; and using all available data sources to automatically verify medical frailty at application and renewal whenever possible.

Decisions made by state Medicaid agencies over the next year regarding medical frailty definitions, screening tools, and verification will determine whether the medical frailty exemption serves as a meaningful protection for patients. Physicians and other clinicians will be central to: (1) advocating at the state level for medical frailty definitions and verification pathways that reflect clinical reality and do not rely on narrow diagnosis lists or onerous clinician certification processes; and (2) helping patients navigate new rules, identifying when they may qualify for an exemption, and encouraging them to make timely responses to requests for information.

This issue brief:

- Describes how OBBBA's work requirements and medical frailty exemption are structured in statute and expected to function in practice;
- Summarizes what is known and not yet known about forthcoming guidance from the Centers for Medicare & Medicaid Services (CMS);
- Outlines key implementation choices facing states and the implications for physicians and patients; and
- Identifies advocacy opportunities for medical associations to help ensure those who meet this exemption are protected and the administrative burden on patients is minimized.

SUMMARY OF WORK REPORTING REQUIREMENTS

OBBBA requires states to implement work requirements for "applicable individuals" aged 19-64 who are enrolled through Medicaid expansion or through comparable coverage under certain section 1115 waivers that qualify as minimum essential coverage. These individuals must:

- Demonstrate at least 80 hours per month of qualifying activities (e.g., employment, community service, participation in an approved work program, part-time education); or

- Show earned income equivalent to 80 hours at the applicable minimum wage, which equates to $580 per month under current federal wage standards.

Individuals who qualify for an exemption are not required to meet work requirements as a condition of eligibility. Federal law requires states to exempt specific populations, including individuals who are medically frail or have significant health needs, parents or caretakers of young children, pregnant individuals, American Indian/Alaska Native individuals, people with disabilities, among others.

Individuals must demonstrate their compliance or exemption when applying for Medicaid coverage and when renewing their eligibility every six months thereafter. The statute includes certain required "lookback periods": At application, individuals must demonstrate compliance for one to three months (at the state's option) preceding their application. At renewal, individuals must demonstrate compliance for one or more months (as defined by the state) within the prior eligibility period. These months may be non-consecutive; a state cannot require that an individual satisfy work requirements for a specific month.

OBBBA directs states to rely on data sources (e.g., wage records, claims and encounter data, and other administrative databases) to verify individuals' compliance and exemptions as much as possible (i.e., to use "*ex parte*" processes). If a person's compliance or exemption cannot be verified using these data sources, states must:

- Provide notice to the individual describing the information needed; and
- Allow at least 30 days for the individual to make a "satisfactory showing" of compliance or exemption.

If individuals cannot provide the requested information, their Medicaid coverage will be denied or terminated. Individuals terminated for non-compliance with work requirements will also be barred from receiving subsidized Marketplace coverage, increasing their risk of becoming uninsured.

The Congressional Budget Office estimated that 5.3 million people could become uninsured because they are unable to meet or navigate Medicaid work requirements. This makes it essential that exemptions—especially for people who are medically frail—are identified without unnecessary barriers.

MEDICAL FRAILTY EXEMPTION

Federal Parameters

OBBBA exempts individuals who are "medically frail or otherwise have special medical needs" from work requirements. Drawing on longstanding federal medical frailty standards, the statute defines medically frail to include:

- Individuals with substance use disorders;
- Individuals with disabling mental disorders;
- Individuals with significant physical, intellectual, or developmental disabilities that impair activities of daily living;
- Individuals with serious or complex medical conditions; or
- Individuals who are blind or who otherwise meet the Social Security Act disability standard.

Defining Medical Frailty

Within those federal guardrails, states retain flexibility to determine how specific diagnoses, conditions, medications, durable medical equipment, and functional limitations fit within the statutory categories, provided their definitions remain clinically grounded and sufficiently protective.

While OBBBA establishes a clear definition of those who must meet mandatory Medicaid work requirements, it gives states discretion in how they operationalize the medical frailty exemption. States can and should ensure that their operational definitions are clinically grounded and capture the full range of serious and complex conditions. This includes recognizing conditions that are episodic, relapsing, or co-occurring, and risk of harm from coverage loss rather than diagnosis labels alone, and presuming exemption for individuals already served through high-intensity programs (e.g., behavioral health or intellectual or developmental disability programs) aligned with medical frailty.

Data Verification

OBBBA requires states to prioritize *ex parte* verification—using available data to determine exemption status without requiring additional documentation from enrollees—as the primary mechanism for identifying medically frail individuals. Core verification pathways may draw on Medicaid claims and encounter data. In addition, health information exchanges can provide real time service utilization data and all-payer claims databases may further supplement Medicaid data, particularly for individuals with recent non-Medicaid coverage.

Medically Frailty Screener at Application and Renewal

Data may not always be available – particularly in light of claims data lags, challenges accessing appointments (especially in rural areas or for specialists), and where certain conditions do not require regular engagement with the medical system. Given these challenges, states should adopt pragmatic strategies allowing medically frail individuals to qualify for these exemptions where data is not readily available without creating new administrative or paperwork barriers. For example, states can use a simple medical frailty screener at application and renewal to flag individuals who may qualify. This approach allows individuals to self-identify as medically frail when data is not available.

Documentation Verification

CMS has communicated to states that, during the first year of implementation in 2027, states may rely on self-declarations to identify individuals who qualify for a medical frailty exemption from work requirements. However, notwithstanding the statutory language that permits states to accept self-declarations without requiring additional documentation, CMS has signaled an expectation that if no data is available, states will ultimately be required to obtain documentation to substantiate claims of medical frailty. Such documentation could include a physician- or other healthcare professional-completed attestation form or submission of relevant medical records. Requiring documentation to verify medical frailty is likely to introduce new administrative burdens and workflow pressures for physicians.

STATUS OF CMS GUIDANCE

OBBBA requires the Department of Health and Human Services to release an interim final rule no later than June 1, 2026. In light of the extraordinarily tight implementation timelines and absent formal guidance, states have already begun to develop eligibility workflows, verification systems, and medical frailty processes.

On December 8, 2025, CMS issued a Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) providing initial guidance on work requirements. The CIB closely tracks statutory language and leaves core implementation questions around the medical frailty exemption unanswered, including, for example:

- How states should verify compliance or exemption when available data are inconclusive.
- Whether lookback periods apply to medically frail individuals and other excluded groups.
- Whether states may adopt longer-term or permanent medical frailty exemptions for individuals with lifelong or complex conditions.

- What documentation, timing standards, and verification flexibilities CMS will require for medical frailty determinations.

Looking ahead, states intend to rely on a combination of formal and informal federal guidance as implementation proceeds. This will include official CMS issuances, such as CIBs, as well as unofficial materials, such as ongoing technical assistance sessions and verbal clarifications provided from CMS to states. Until the interim final rule is published in 2026, these sources will serve as the primary federal direction available to states as they design medical frailty definitions, build verification systems, and prepare for the January 2027 implementation timeline.

STATE ADVOCACY OPPORTUNITIES FOR MEDICAL ASSOCIATIONS

The new Medicaid work requirements directly affect patients' access to coverage and may potentially require physicians to assist individuals in documenting their medical frailty status. As individual states develop their policy and operational plans to implement work requirements by January 1, 2027, state and national medical specialty societies should consider incorporating the following advocacy priorities into their discussions with legislators and Medicaid agencies.

States could be encouraged to take the steps described below:

- **Establish clinically grounded medical frailty definitions.** Medical societies should work with states to:
    - Ensure the medical frailty exemption subcategories are defined in ways that reflect current clinical evidence;
    - Develop a code list to be used for verification that explicitly includes diagnoses, medications, service utilization, and durable medical equipment that accurately reflect the breadth of the definitions;
    - Recognize episodic and relapsing conditions; and
    - Emphasize functional impairment and risk of harm from coverage loss.

  To complement the code list development, medical associations may consider asking states to develop specialized algorithms that use both diagnostic and service utilization data to identify potential medical frailty. These algorithms might flag individuals based on patterns such as multiple hospitalizations within a defined period or a hospitalization combined with specific diagnosis codes associated with serious or complex medical conditions.

- **Provide longer-term or permanent exemptions for individuals with chronic or long-term conditions, as appropriate.** CMS is currently evaluating whether certain medical conditions can confer a longer or permanent exemption for individuals. Medical associations can play a critical role by advising Medicaid officials on which conditions are clinically long-term or permanent and therefore should not require individuals to frequently or ever reverify their eligibility. This input will be essential to supporting state advocacy and informing exemption verification and renewal standards.

- **Engage physicians in the development of the medical frailty definitions and code list.** To further inform the development of the code list that will include the combination of ICD-10 and CPT/HCPCS data, medical associations should work with Medicaid officials to ensure collaboration with clinical experts in academic medicine and the community-based provider community, such as SUD treatment providers, behavioral health providers, and Federally Qualified Health Centers and Rural Health Centers, to validate and inform the coding definitions for individuals who would meet the medical frailty criteria.

- **Make medical frailty identification processes patient-friendly and streamlined.** Medical associations should advocate that states integrate the medical frailty exemption process into existing Medicaid application and renewal process flows. This includes incorporating medical frailty questions in the application and

renewal forms; prioritizing *ex parte* verification (e.g., through previous claims or diagnosis); and minimizing the need for individuals to submit paperwork, if not required.

  - **Design user-friendly and accessible medical frailty screeners.** Medical associations should advocate for application and renewal screening tools that use clear, plain language that avoids technical jargon and meet language access and disability accessibility standards. States should be encouraged to test medical frailty screener language with beneficiaries to ensure patients can easily understand what is being asked.

  - **Maximize the use of available data sources.** To verify medical frailty while minimizing reliance on paper-based documentation, medical associations should ask states to maximize the use of existing administrative and clinical data sources. This includes leveraging Medicaid claims and managed care encounter data to identify diagnoses, procedures, and utilization patterns that are indicative of medical frailty, as well as incorporating real-time or near–real-time data feeds from state and regional health information exchanges (HIEs).

  - **Minimize paperwork requirements by allowing individuals to submit self-declarations of medical frailty when data is unavailable.** Medical associations should encourage states to allow individuals to submit self-declarations of medical frailty to the maximum extent possible when *ex parte* verification is incomplete, delayed, or unlikely to verify medical frailty (depending on CMS guidance). This will be critical for patients whose data may not be available due to claims lags, challenges accessing physician appointments, or where conditions do not require frequent engagement with the medical system, as described above.

  - **Avoid burdensome physician certification requirements.** Medical associations should advocate that individuals not be required to seek clinician certifications of medical frailty; doing so would add significant process hurdles for patients and add administrative burdens for physicians. To the extent states allow individuals to submit documentation from physicians and other healthcare professionals, medical associations should advocate for simple, accessible, standardized attestation forms for clinicians. Unnecessary documentation diverts clinical time from patient care and can function as a barrier to access.

- **States should provide transparency into the impact of work requirements on coverage.** Publishing information about how these major changes are impacting individuals' ability to access and renew coverage will be crucial to identifying systems issues and administrative barriers that may be leading eligible people to lose coverage.

- **Utilize bi-directional feedback loops between states and physicians.** States should be encouraged to work closely with physicians, other healthcare professionals, and medical associations to monitor real-time impacts of work reporting requirements on medically vulnerable populations and use those insights to make timely adjustments to the medical frailty policy and operations.

- **Leverage physicians as trusted messengers.** Outreach and engagement are foundational to successful implementation of work requirements, especially when eligibility depends on understanding new reporting expectations, deadlines, exemptions, and documentation pathways. To ensure individuals understand and can effectively navigate these new requirements, medical associations should collaborate with state officials to engage trusted community partners, including physicians, in designing outreach efforts.

AMA ADVOCACY

AMA policy opposes work requirements as a criterion for Medicaid eligibility (H-290.961), and the AMA continues to make preservation of access to Medicaid a core advocacy priority at both the federal and state levels. As states prepare to implement Medicaid work requirements and associated exemption processes beginning in 2027, the

AMA remains focused on minimizing coverage disruptions, reducing administrative burdens on patients and clinicians, and ensuring that exemption policies, particularly those related to medical frailty, are clinically appropriate and workable in practice.

At the federal level, the AMA has advocated to CMS for increased state flexibility in designing and administering work requirement policies, streamlined and accessible exemption processes, safeguards to prevent inappropriate coverage losses, robust data monitoring and transparency, and meaningful engagement with physicians and other stakeholders during implementation. The AMA continues to closely monitor CMS guidance and subregulatory actions related to work requirements and exemptions and to raise concerns as implementation details evolve.

The AMA Advocacy Resource Center is committed to supporting state medical associations and national medical specialty societies as states undertake OBBBA implementation. This includes sharing federal updates and analysis, elevating physician perspectives, and providing technical assistance and advocacy support related to medical frailty definitions, exemption duration, documentation standards, and beneficiary protections.

Please contact Annalia Michelman, Senior Attorney in the AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org for assistance with Medicaid work requirements in your state.