MEDICAID FOREFRONT

Work Requirement Exemptions Based On Medical Frailty: We'd Better Get Them Right This Time

Elizabeth Kaplan and Carmel Shachar • January 12, 2026

SHARE

The federal government and state Medicaid agencies must adopt comprehensive, flexible definitions of medical frailty that meaningfully protect the categories of individuals whom Congress has designated for protection from work requirements under H.R. 1. They must not to rely on the existing, inconsistent definitions of medical frailty in Medicaid, which have likely left out many people who should be entitled to this designation.

Health Affairs
Health Policy at a Crossroads

Editor's Note

This article is the latest in the Health Affairs Forefront *featured topic, "Health Policy at a Crossroads," produced with the support of the Commonwealth Fund and the Robert Wood Johnson Foundation. Articles in this topic offer timely analysis of regulatory, legislative, and judicial developments in health policy under the Trump-Vance Administration and the 119th Congress.*

Under H.R.1, enacted last year, states must start requiring members of the Medicaid expansion group to demonstrate compliance with the new community engagement requirements by January 2027: to maintain coverage, nonexempt Medicaid enrollees in Affordable Care Act (ACA) expansion states must document 80 hours per month in activities including work, volunteer hours, or school. This is an extremely short implementation timeline, with important interpretive decisions to be made by CMS and the states well before next year's deadline. These decisions will have a huge impact on how many Medicaid members are deemed exempt from the work requirements—and therefore able to keep their coverage.

One important area where these decisions will matter enormously is in defining who is exempt from work requirements due to being "medically frail" or otherwise having "special medical needs." This concept of medical frailty and special medical needs, along with its five broad subcategories, has long existed in Medicaid, but the stakes for its application to individual Medicaid members have never been as high as they will be under H.R. 1. For the first time, qualifying for the medically frail or special medical needs designation will exempt individuals across the country from having to meet an onerous work requirement in order to maintain their health insurance.

Given the importance of medical frailty to determining whose access to healthcare will be protected under the new work requirements regime, the federal government and state Medicaid agencies must adopt comprehensive, flexible definitions of medical frailty that meaningfully protect the categories of individuals whom Congress has designated for protection from work requirements under H.R. 1. And they must be careful not to rely on existing definitions of medical frailty in Medicaid, which have been inconsistent and have likely left out many people who should be entitled to this designation.

Medical Frailty And Special Medical Needs In Medicaid Law—An Old Concept With New Significance

Medical frailty as a concept has existed in Medicaid law for decades, but with substantial variation in whether states implement it, and, where they do implement it, how and how effectively they do so.

Since 2005, states have been allowed to offer certain Medicaid members a narrower benefit package than the benefits available under traditional Medicaid. These benefits packages are modeled after commercial insurance coverage and referred to as alternative benefits plans (ABPs).

Medical Frailty In The Context Of Medicaid Expansions Under The ACA

After passage of the Affordable Care Act (ACA), states adopting Medicaid expansion were required to do so through ABPs. However, states that require Medicaid expansion members to enroll in an ABP that differs from the benefits offered in traditional Medicaid must enable expansion members who fall into one of several exemption categories to opt into a plan that is as generous as traditional Medicaid. These exemptions include an exemption for individuals who are "medically frail" or who otherwise have "special medical needs." Defined at 42 C.F.R. § 440.315(f), this category uses a six-pronged definition for "medically frail" or having "special medical needs" that is very similar to, though not exactly the same as, the five-pronged definition Congress adopted in H.R. 1.

As of 2019, only 12 states were determining medical frailty for adult Medicaid members for the purpose of assessing whether they were entitled to opt out of an ABP. Among the states determining medical frailty, KFF researchers found substantial differences in how states implemented this process. States differed on questions such as who could initiate a determination of medical frailty, who could make the final determination of medical frailty, what information was required in the determination process, and when the determination was made. There were also differences in how the states defined medical frailty within the confines of 42 § C.F.R. 440.315(f), with states looking to different combinations of diagnoses and functional needs criteria.

A more recent scan of available state Medicaid policy documents showed that at least some states that adjudicate medically frail status in the ABP context have guidance documents that say or imply that a person with a serious or complex medical condition must also have impairments in activities of daily living (ADLs) to qualify. For example, New Hampshire has a certification document for medical professionals assessing medical frailty that requires them to certify that an individual has a serious and complex medical condition *and* the condition "significantly impairs" ADLs. Under 42 C.F.R. § 440.315(f), this definition is too narrow, as it conflates two separate paths to a medical frailty designation under the regulation—having a serious and complex medical condition *or* having a disability that significantly impairs ADLs. Similarly, Arkansas's screening questions for medical frailty lack a separate screening question based solely on whether an individual has a serious and complex condition.

Medical Frailty In The Context of Section 1115 Waiver Work Requirements

Medical frailty and special medical needs exemptions were also incorporated into efforts to impose work requirements through Section 1115 waivers prior to H.R. 1's passage. Of the 13 waiver requests the first Trump Administration approved, only Arkansas's waiver was ever implemented with consequences for noncompliance. (Arkansas's waiver was later halted by the courts, while a different kind of work requirements waiver—conditioning a limited Medicaid expansion on affirmatively meeting a work requirement—was eventually implemented in Georgia.)

Of the waivers that included exemptions for medical frailty and special medical needs, definitions, including specific conditions flagged for inclusion, were also varied. Arkansas's experience implementing a medical frailty exemption for work requirements is particularly instructive: While over half of nonelderly adults in Arkansas during this time reported a disability and 18,000 lost coverage due to work requirement implementation, in 2018 Arkansas received only 904 requests for exemptions and 69 appeals. This suggests that a significant number of Arkansans who were eligible for a medical frailty exemption either did not know to apply for the exemption or could not

Forefront Series

Health Policy At A Crossroads

Article Metrics

4

Topics

Medicaid
Access To Care
Beneficiaries
Activities Of Daily Living
Complex Conditions
Affordable Care Act
State Medicaid
Health Conditions
Disability
Code Of Federal Regulations

DOI

10.1377/forefront.20260108.344162

Cite As

"Work Requirement Exemptions Based On Medical Frailty: We'd Better Get Them Right This Time," Health Affairs Forefront, January 12, 2026.

DOI: 10.1377/forefront.20260108.344162

successfully navigate the process.

Given the substantial differentiation in how states implement a medical frailty definition, and for what purpose, it is unsurprising that, at least as of 2019, states were identifying widely varying proportions of their Medicaid expansion population as medically frail, ranging from as much as 24 percent of Medicaid expansion adults in Indiana to less than 1 percent in New Jersey and North Dakota. This wide range emphasizes the importance of state choices in shaping how many individuals will be designated medically frail. It also suggests that, since the stakes were not as high as access to Medicaid entirely, at least some states have gotten away with inadequately defining medical frailty and/or inadequately educating patients and providers about how to pursue a medical frailty determination.

Moreover, even toward the higher end of this range, states are likely undercounting the number of people within the Medicaid expansion population who would be qualify under a proper reading and robust implementation of 42 C.F.R. § 440.315(f), which includes those with a "serious and complex condition" as its own pathway to the medical frailty exemption. Forty-four percent of adults enrolled in Medicaid expansion have at least one chronic condition, and 34 percent of all Medicaid enrollees report having a disability, even though only 10 percent qualify for Medicaid through a disability pathway. Many of those with chronic conditions have more than one such condition.

State implementation of medical frailty and special medical needs has thus far been scattershot at best, making it essential that CMS and state Medicaid agencies be prepared to rethink and depart from how this exemption has been implemented in the ABP and Section 1115 contexts.

The New Definition of Medical Frailty And Special Medical Needs Must Be Broader, More Accurate, And More Consistently Applied Than Its Predecessors

H.R. 1 provides five broad subcategories of people who must be included within the medical frailty exemption for work requirements: people who are "blind or disabled" as defined in the Social Security Act; people with a "substance use disorder"; people with a "disabling" mental illness; people with "a physical, intellectual or developmental disability" that "significantly impairs" their ability to perform ADLs; and people with a "serious or complex medical condition." To comply with the law, all states adopting Medicaid expansion will have to implement systems designed to identify and adjudicate whether a beneficiary is medically frail or has special medical needs. For many beneficiaries, this determination will dictate whether they can keep their Medicaid coverage without having to meet onerous community engagement reporting requirements. Because medical frailty and special medical needs have risen to a new level of importance in Medicaid law, states must resist the temptation to copy existing approaches to medical frailty determinations.

In implementing these determinations, CMS and the states must adhere to Congress's unambiguous directive as to who is entitled to this exemption. In listing the five subcategories of people who qualify as medically frail or having special medical needs, Congress chose to use "or", not "and," meaning that a person needs to meet only *one* of the five subcategories included in the definition qualify for the exemption. This includes those with a "serious or complex medical condition," regardless of whether their conditions cause impairment in ADLs or prevent them from working.

Similarly, H.R. 1, unlike the ABP regulations, uses "serious *or* complex medical conditions" instead of "serious *and* complex" (emphasis added). This again creates room for a more expansive approach to who qualifies as medically frail, including an understanding that people often live with multiple health conditions, which in aggregate rise to the level of medical complexity.

It is important that states follow this more expansive language because subjecting people with serious or complex health needs to potential disruptions in access to care risks deterioration of their health. People should not have to let their serious or complex conditions worsen in order to gain access to Medicaid coverage to allow them to stabilize their health. Such a policy risks worsening individual and community health burdens and disincentivizing people with serious or complex conditions from managing their conditions well.

In addition, CMS must ensure that all states are prepared to rigorously implement the medical frailty exemption. For example, H.R. 1 requires states to use ex parte data where available to determine compliance with the community engagement requirement, including for determinations of whether an individual should be exempt. This requirement will theoretically help reduce the administrative burden of compliance on beneficiaries, but state implementation of ex parte determinations in the Medicaid renewal context has been uneven and has improved with policy and technical expertise support from the federal government.

To prevent many of the most health-burdened Medicaid beneficiaries from losing coverage due to the new work requirement, CMS must ensure that all states have sufficient policy guidance and technical capacity to use ex parte data effectively to identify individuals with serious or complex conditions and not assume this capacity already exists. Additionally, states must have robust, accessible systems for identifying Medicaid beneficiaries who meet the definition of medically frail but who won't necessarily be flagged by data matching, such as those who are new to Medicaid and who had limited access to health care prior to enrolling, and those with new diagnoses. These systems should include education for many stakeholders within the system, such as beneficiaries, providers, and managed care organizations, as well as a well-designed medical frailty screener tool that reflects all five pathways under the law to the medical frailty designation.

There Is A Lot Of Work Left To Be Done To Implement Medical Frailty Exemptions In Ways That Meaningfully Reach The Individuals Who Qualify

With less than a year remaining until state Medicaid programs and individual beneficiaries must begin to comply with the new law, planning for implementation is well underway. Already, there are signs that at least one state (New Hampshire) may seek to continue to implement a medical frailty definition that is narrower than H.R. 1 requires, as it contains no provision at all for individuals with a serious or complex condition. Both CMS and states should understand that they cannot rely on existing approaches to medical frailty and that there is a lot of work left to successfully develop the necessary exemptions.

For example, CMS should issue guidance clarifying that approaches such as the New Hampshire proposal above, and indeed any approach that relies solely on existing definitions and policies, violate H.R. 1. The agency should articulate the minimum steps that states must take to ensure they fully comply with the law's exemption for people who are medically frail or have special medical needs. With access to health care for millions of Medicaid beneficiaries now on the line, too much is at stake to allow scattershot and insufficient definitions of medical frailty to scrape by.

Medicaid
Access To Care
Beneficiaries
Activities Of Daily Living
Complex Conditions
Affordable Care Act
State Medicaid
Health Conditions
Disability
Code Of Federal Regulations

Health Affairs Comment Policy

Comment moderation is in use. Please do not submit your comment twice -- it will appear shortly.

Please read our Comment Policy before commenting.

Got it

0 Comments
Login ▼

Start the discussion…

LOG IN WITH
OR SIGN UP WITH DISQUS ?

Name

♡ • Share
Best Newest Oldest

Be the first to comment.

Subscribe Privacy Do Not Sell My Data
DISQUS

Health Affairs Publishing, LLC, is a subsidiary of Project Hope, a nonprofit global health and humanitarian organization. Health Affairs Publishing is editorially independent from Project HOPE.

Health Affairs is an official journal of AcademyHealth.

Copyright 1995 - 2026 by Health Affairs Publishing, LLC, eISSN 2694-233X.