

Data and Analytic Approaches for Medical Frailty Exemptions to Federal Medicaid Work Requirements

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Beginning in 2027, Medicaid members — primarily those eligible for coverage through the Affordable Care Act Medicaid expansion — will be required to meet work-related or community engagement requirements to maintain their Medicaid coverage. [These federal Medicaid work requirements](#), established through the [2025 budget reconciliation bill](#), include exemptions for certain groups, including medically frail individuals. Medically frail individuals include people who:

- Are blind or have a disability;
- Have a substance use disorder;
- Have a disabling mental disorder;
- Have a physical, intellectual, or developmental disability that impairs their ability to perform activities of daily living; or
- Have a serious or complex medical condition.

This tipsheet draws on lessons shared by experts from the Harvard T.H. Chan School of Public Health, the Aspen Institute Financial Security Program, and Katch Strategies during a state-only [Medicaid Work Requirements: Tech Implementation and Integration Learning Series](#) session in March 2026 that focused on data and analytic approaches for medical frailty exemptions. The following implementation considerations can help streamline state adoption of the medical frailty exemption and minimize Medicaid application and renewal barriers for medically frail individuals.

Implementation Considerations

To effectively implement medical frailty exemptions, states will need to:

- Incorporate medical frailty screening questions at initial Medicaid enrollment;
- Leverage data to automatically identify and verify medical frailty exemptions at renewal; and
- Where automated or *ex-parte* verification is not feasible, request additional documentation from Medicaid members.

While states are currently working to design and implement their approaches to facilitating these exemptions, CMS is expected to release additional guidance on federal requirements related to medical frailty exemptions by June 1, 2026. Accordingly, state approaches to implementing medical frailty exemptions may need to evolve to ensure compliance with federal rules. States may consider moving forward with elements of implementation now, particularly technical and systems updates, and document those changes for future reference.

Five Best Practices for Implementing the Medical Frailty Exemption

States can minimize barriers for eligible individuals by integrating human-centered design approaches throughout the enrollment and renewal processes, maximizing automated exemption identification, and rigorously testing administrative processes related to exemptions. The following best practices can help streamline implementation of the medical frailty exemption and minimize application and renewal challenges for medically frail individuals.

1. Implement user-friendly approaches to identifying medical frailty at initial enrollment.

States will likely be permitted to accept self-attestation to grant medical frailty exemptions at initial enrollment with an “auditable self-declaration.” Details on this process are expected in future CMS guidance. Verification will be required for renewal. States can begin designing and testing approaches to communicating about medical frailty in a clear, consistent way to members and applicants.

- ✓ **Integrate questions about medical frailty early in the Medicaid application.** Doing so reduces administrative burden for exempt individuals and lowers the risk that otherwise eligible applicants will abandon an application for fear they do not meet work requirements. Embedding questions directly into the Medicaid application, as opposed to a separate, additional form, streamlines information processing for state staff and reduces the risk that applicants will miss steps.
- ✓ **Use plain language in screening questions.** This should include common examples of physical and behavioral health conditions that may exempt people from work requirements via the medical frailty exemption (e.g., schizophrenia, major depression, autoimmune disorder, heart, or kidney failure).
- ✓ **Provide clear instructions about next steps for applicants.** For example, make sure applications and user portals clearly communicate whether additional documentation is needed.
- ✓ **Leverage freely available templates as a starting point.** For example, the civic design firm Civilla developed [user-tested templates](#) for adding work requirement questions to Medicaid applications.

2. Prioritize data sources based on access and impact.

To operationalize the new requirements, states will need to develop medical frailty definitions and map those definitions to available data sources. While Medicaid agencies already have access to some data sources that can support medical frailty identification, they will also need to incorporate new sources.

- ✓ **Identify what relevant data sources your Medicaid agency already has access to.** These may include Medicaid Management Information System (MMIS) diagnosis codes, medical claims/encounter codes, and pharmacy data. In many cases, these data may be sufficient on their own if they capture the expected prevalence of medical frailty exemptions.
- ✓ **Incorporate additional data sources to address information gaps, as feasible and necessary.** Potential sources include MCO care-coordination lists, all-payer claims databases (APCDs) and health information exchanges (HIEs). Availability, ease of access, and robustness of these data sources will depend on individual state contexts.
- ✓ **Evaluate the benefit of additional data sources.** More data sources are only useful if they help identify additional medically frail individuals who qualify for exemptions; otherwise, they just add complexity. Look for the right data when seeking to fill gaps. For example, if a state is struggling to identify medical frailty among recent enrollees, data sources with information about commercially insured individuals (e.g., HIEs and APCDs) may be important additions.

- ✓ **Find the right data for your needs.** Consider both timing and completeness when evaluating data sources. For instance, while MMIS claims and encounter codes are relatively robust sources of information, providers may take up to 12 months to submit these data. Pharmacy data are very timely but may not provide enough information to support medical frailty determinations.
- ✓ **Take steps to safeguard Protected Health Information to minimize privacy risks.** As states integrate new data sources for eligibility determinations, they will need to develop approaches to safeguard sensitive data and minimize risks of HIPAA violations. States may consider transferring only the minimally necessary information on medical frailty (e.g., a broad exemption category) into eligibility and enrollment systems, rather than detailed health data, although forthcoming CMS guidance may further clarify what is required for compliance.

3. Test and refine definitions of medical frailty to align with expected prevalence.

Developing an accurate approach to identifying and verifying medical frailty exemptions will require testing and iteration to determine which data sources are most impactful, as well as how to appropriately set model parameters, such as the timeframe over which claims are assessed (i.e., “lookback periods”).

- ✓ **Identify a list of diagnosis codes that indicate a high likelihood of medical frailty.** States may consider using diagnostic code-based approaches to automatically identify medical frailty exemptions. See the example box for details on one potential approach.
- ✓ **Determine the lookback period for analyzing claims data to identify medically frail individuals.** Preliminary unpublished analysis by academic researchers suggests that the lookback period is the most significant parameter for comprehensive identification of the qualifying medically frail population.
- ✓ **Determine service-utilization thresholds.** Claims-based analysis also requires that states set a threshold for what level of medical service usage indicates medical frailty. Service-utilization thresholds are an additional indicator of condition severity beyond diagnosis code. As with the lookback period, setting an appropriate utilization threshold is important for comprehensive identification of the medically frail population.
- ✓ **Compare the reach of proposed definitions against other population-level data or research.** States will need to compare the number of individuals identified through proposed medical frailty coding with the expected prevalence to assess model accuracy. If the definitions and associated codes identify substantially more or fewer individuals than expected based on population health estimates, they should be refined to better align with the underlying

Example: ICD-10 Coding Methodology to Support Medical Frailty Exemptions

Ari Ne’eman, PhD, and colleagues developed a structured approach for using ICD-10 diagnosis codes to identify medically frail individuals. The methodology identifies codes from two sources: (1) [Chronic Conditions Warehouse](#) (CCW) algorithms (developed by CMS for use in Medicare); (2) additional codes used by states in [Alternative Benefit Plan](#) medical frailty definitions. Specifically, codes were included if they were deemed: (1) likely to require ongoing medical care or limit ability to participate in community engagement activities; (2) likely to last six months or longer; and (3) not easily curable. See memo from Ne’eman et al. in the resources list for more details, including their diagnosis list.

Unpublished analysis by Ari Ne’eman, Adrianna McIntyre, Daniel L. Smithers, and Benjamin D. Sommers on ICD-10-based identification of medically frail individuals. For more information, contact aneeman@hsph.harvard.edu or bsommers@hsph.harvard.edu and see [preliminary workbook](#) featuring ICD-10 codes supporting medical frailty exemptions from community engagement requirements.

population. Comparison data may come from the Census, state public health agency surveys, or other relevant sources.

- ✓ **Thoroughly document state medical frailty definitions, exemption processes, and adherence to those policies.** Where possible, use existing definitions and code lists to show how choices align with federal law (such as the model discussed above built from Medicare coding frameworks). Ongoing submission of plans to CMS can help de-risk different federal interpretations or further CMS guidance.

4. Minimize burden of manual documentation submission.

Medicaid agencies may need to develop processes for requesting additional information from members to verify medical frailty where data does not exist or is insufficient, pending anticipated CMS guidance on the use of self-attestation. As with medical frailty screening at initial enrollment, it is important that states prioritize member experience and clear communication to minimize barriers to Medicaid renewal for eligible members.

- ✓ **Request the least burdensome documentation feasible.** For example, consider requesting doctor's notes rather than medical records.
- ✓ **Provide immediate confirmation that medical frailty documentation is received.** As with the Medicaid application screener, clear confirmations are critical for creating an administrative record and improving member experience.
- ✓ **Implement mobile-friendly member portals and interfaces.** Because many people primarily use mobile devices to access the internet, [offering mobile-friendly options](#) for applications and renewals provides easier access for members.
- ✓ **Provide supports to answer members' questions and troubleshoot documentation challenges.** For medical frailty and broader work requirement-related documentation submission, states should consider multiple strategies to help members submit accurate and appropriate documentation, including call centers, chat support, and [use of AI](#) to catch errors in uploaded documents.

5. Develop parallel processes for implementation and testing.

States have limited time to implement work requirements and may need to evolve their approach in the future. Rather than implementing medical frailty exemptions in a stepwise manner (e.g., first defining the policy, then identifying and implementing technology needs, and finally testing the system), states can consider working on multiple components concurrently.

- ✓ **Determine a structure for coordinating across state teams/departments.** Parallel processing will require tight coordination and communication across Medicaid policy, information technology, and research/data analytics teams. States may consider establishing cross-team workgroups to support this work.
- ✓ **Align on cross-team goals, strategies, and timelines.** Clear direction and alignment across teams will be necessary to break medical frailty exemption work into discrete components.
- ✓ **Build in sufficient time for testing and iteration of medical frailty approaches.** Recognize that developing medical frailty definitions and implementing data queries will require testing and iterating to get it right. States can develop processes for regular testing throughout the planning and implementation period.

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Additional Resources

- **[A Human-Centered SNAP Work Requirements Screener](#)** (Code for America): Sample questionnaire for identifying individuals with SNAP work requirements exemptions. This tool was refined through user research with SNAP clients and employs best practices such as the use of plain language.
- **[Human-centered Application Templates for Medicaid Work Requirements](#)** (Civilla): Toolkit for states implementing H.R. 1 including user-tested templates for paper and online applications, a policy and question guide for states, and other implementation guidance.
- **[Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions](#)** (State Health and Value Strategies): Resource outlining federal statutory definitions for work requirement qualifying activities and exemptions, available or potential data sources, duration of verification and whether new Medicaid application questions are required.
- **[A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid’s New Work Requirement](#)** (Center on Budget and Policy Priorities): Guide providing summary of federal work requirements and guidance on how states policy choices, implementation choices, and technical considerations for reducing Medicaid coverage loss.
- **[Medical Frailty Project Workplan](#)** (State Health and Value Strategies): Sample state workplan outlining key steps and decision points for implementing medical frailty exemptions.
- **[How Health Information Exchanges Can Identify Medically Frail Work Requirement Exemptions](#)** (Manatt): Blog post outlining how use of HIE data can help overcome the gaps in MMIS data and operational considerations for integrating HIEs with Medicaid systems.
- Memo: ICD-10 codes supporting medical frailty exemptions from community engagement requirements (Ari Ne’eman, Adrianna McIntyre, Daniel L. Smithers, and Benjamin D. Sommers): Forthcoming memo describing a structured, validated approach for identifying medically frail individuals using ICD-10 codes. Contact Ari Ne’eman (aneeman@hsph.harvard.edu) or Benjamin Sommers (bsommers@hsph.harvard.edu) for more information. See [preliminary workbook](#) featuring ICD-10 codes supporting medical frailty exemptions from community engagement requirements.



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