May 22, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Sent Via Electronic Mail to mehmet.oz-at-cms.hhs.gov and stephanie.carlton-at-cms.hhs.gov

Re: Medicaid Community Engagement Requirements and Self-Attestation

Dear Administrator Oz:

On behalf of Protect Our Care Illinois and our partner medical providers, we share our concerns about rules to be issued shortly by the Centers for Medicare and Medicaid Services (CMS) to states on the implementation of work requirements and exemptions in H.R. 1.

CMS has apparently shared with stakeholders that the final rule (which Congress required CMS to release by June 1) will differ from what CMS has been communicating to states since H.R. 1 passed. Specifically, CMS is now planning to require states to implement a narrower medical frailty exemption and more restrictions on self-attestation, including necessitating physician certification.

POCIL is deeply concerned that these changes will add unnecessary burdens to providers and beneficiaries and increase coverage losses among eligible people, including people with serious health conditions. The changes are also at odds with the language of H.R. 1, where Congress promised to protect people who are medically frail, and instructed states to use available state data to avoid burdening beneficiaries and providers.

These dramatic changes are coming after states have spent months implementing H.R. 1. If these changes are in the proposed final rule on work requirements, it will cause great harm to recipients, burden already over-worked providers, and derail state implementation.

Burden to Providers

The American Medical Association has issued briefs and letters to Congress on the significant burden on doctors and loss of coverage for patients that will come if the definition of medical frailty is too narrow, hard to document electronically, or if beneficiary-initiated self-reporting is curtailed in favor of burdensome doctor certification. The nation's largest medical association has recommended that CMS should aim to:

> Minimize paperwork requirements by allowing individuals to submit self-declarations of medical frailty when data is unavailable. [E]ncourage 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…. 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….[1]

In particular, the AMA said that CMS should "***[a]void burdensome physician certification requirements***" (emphasis added), and urged that "[i]ndividuals 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."[2] For CMS to change the rules now would substantially harm the providers who will be asked to provide these certifications. CMS must consider these costs and the cost of needed technological investments to provide these certifications from these providers. CMS must seriously consider this practical impact on stakeholders like medical providers and allow self-attestation and other low-lift proof to support a broad medical frailty definition.

In addition, a recent article published in JAMA by physicians who are members of the Medicaid Medical Directors Network, a network of over 40 state medical clinicians, urged CMS to follow the statute and define medical frailty based on clinical risk; not the ability to work. The H.R. 1 statutory language exempts people who cannot work based on a Social Security finding of disability, but it goes well beyond that: the medical directors point out that "the statute also further recognizes exemptions on a clinical basis, including for people who have a serious or complex medical condition." The Medicaid Medical Directors Network also emphasized the need for "operational flexibility" in medical frailty definitions, recognizing the variety of state-specific circumstances that states are in the best position to understand and address, while mitigating unnecessary burdens to clinicians and patients.

Burden to States

CMS must appreciate how much work Illinois and other states have had to complete already. June 1 was already a late date for CMS's key guidance on H.R. 1 implementation. The states have relied on CMS's guidance each month since H.R. 1 was issued because June 1 was far too long to wait and even CMS "recognize[d] that planning must begin now, as states begin

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[1] American Medical Association (AMA), *Issue Brief: Medicaid Work Requirements' Medical Frailty Exemption* (Feb. 2026), https://www.ama-assn.org/system/files/issue-brief-medicaid-work-requirements-medical-frailty-exemption.pdf.

[2] *Id*.

procurement of new systems and services to support implementation of the broad range of Medicaid provisions in the WFTC legislation…."[3] Navigating the coordination between SNAP and Medicaid under the H.R. 1 framework was already complicated, and the rumored changes magnify the burden on states. For CMS to now change course on that guidance will wreak havoc and force states to undergo significant rework. States have been making policy decisions for months to meet the H.R. 1 deadlines, with CMS's blessing. System changes and updates of this scope require extended development time and extensive user testing before they should go live. We are urging CMS to grapple with how difficult it already was for states to meet the drastic timelines that H.R. 1 demands, and stand by the policy decisions it has already authorized in consultation with states.

Conclusion

CMS must follow the statutory language in H.R. 1. Congress insisted that states implement work requirements without more red tape and burden, and CMS cannot ignore this statutory mandate. CMS must continue to make explicit in guidance to states that vocational assessments are not the only assessment that can or should be used to assess medical frailty, that all available verifiable data sources must be maximized, and that states have the obligation to accept beneficiary self-attestation for medical frailty and other exemptions rather than provider certifications. CMS must also ensure that Illinois and other states are not dissuaded from seeking, or unfairly denied, the good faith extensions that Congress included in H.R. 1.

POCIL appreciates your consideration of our concerns and recommendations. If you have any questions, please reach out to Meghan Carter, Director of Health Advocacy at Legal Council for Health Justice, mcarter-at-legalcouncil.org or (312) 427-8990.

Sincerely,
Protect Our Care Illinois

Protect Our Care Illinois (POCIL) is a coalition of nearly 100 organizations across the state of Illinois committed to defending Medicaid and the Affordable Care Act (ACA). Our coalition encompasses a diverse array of partners, including provider and payer associations, advocates, community organizations, consumer groups, healthcare providers, and researchers. We use proven strategies like community engagement, policy analysis, lobbying, and storytelling to engage communities and inform the healthcare debate.

[3] Dear State Medicaid Director, SMD #26-001, "Implementation of 'Eligibility Redeterminations,' Section 71107 of the 'Working Families Tax Cut' Legislation (Public Law 119-21) (Mar. 6, 2026), https://www.medicaid.gov/federal-policy-guidance/downloads/smd26001.pdf