July 17, 2026

Robert F. Kennedy Jr.
Secretary
United States Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Secretary Kennedy,

The American Association of Nurse Practitioners appreciates the opportunity to provide comment on the interim final rule with comment period (IFC) which interprets and implements the community engagement requirement in Medicaid under section 1902(xx) of the Social Security Act. As noted within this IFC, CMS is statutorily mandated to implement changes as included within public law 119-21[1] as enacted by the 119th Congress. At the time of the passage of this legislation, AANP was deeply concerned with the negative impact of the community engagement requirements and continues to oppose these policies. While we recognize the agency's statutory obligations for implementation, the proposed medical frailty certification requirements place an unsustainable burden on patients and health care providers. NPs are essential providers of care to Medicaid patients, and the proposals within this IFC will have a significant impact on them and their patients. We respectfully request the agency reconsider its proposed implementation of the medical frailty and community engagement requirements. We look forward to working with the agency on implementation of PL119-21 through policies which are minimally burdensome to NPs and their patients, while staying within the confines of the agency's statutory authority.

As you know, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform nearly one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority (FPA), granting patients full and direct access to nurse practitioners.

NPs practice in nearly every geographic region and health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and provide the most home-based care to Medicare beneficiaries.

NPs provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require. According to the Centers for Medicare and Medicaid Services (CMS), as of 2024, there were over 243,000 NPs billing for Medicare services, making NPs the largest Medicare designated provider

[1] untitled
[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.

specialty,[4] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[5] NPs have a particularly large impact on primary care as approximately 70% of all NP graduates are prepared in primary care.[6]

According to the Medicare Payment Advisory Commission (MedPAC), APRNs and physician assistants (PAs) comprise approximately one-third of our primary care workforce, and up to half in rural areas.[7] As stated in MedPAC's July 2025 data book, Medicare "encounters with APRNs and PAs grew rapidly from 2018 to 2023 (50 percent in total), and encounters with primary care physicians declined substantially (–22 percent)."[8] Further, the Commission highlights that these changes "continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs."[9] Fifty-seven percent of Medicare beneficiaries received a primary care service from an NP or PA, and sixty-six percent of rural Medicare patients received a primary care service from an NP or PA.[10] The Medicaid and CHIP Payment and Access Commission (MACPAC) found that the number of NPs prescribing buprenorphine for the treatment of OUD, and the number of patients with OUD treated with buprenorphine by NPs, increased substantially in the first-year NPs were authorized to obtain their DATA waiver. This increase was particularly notable in rural areas and for Medicaid beneficiaries.[11]

Therefore, as the agency implements the requirements of PL119-21, it is essential that the IFC considers the perspective of providers who care for Medicaid patients. While this IFC considers the burden it may place on states, there is no assessment of the implications of the verification requirements on providers such as NPs. Specifically, as it relates to certification of medical frailty, much of the burden is placed on health care providers. The IFC as proposed does not provide clarity on a process for this certification, does not establish a clear national minimum standard for medical frailty, relies on states' interpretation of federal guidance, and does not clarify a health care provider's role if a patients' eligibility status is contested. Further, for patients with serious and challenging medical conditions, the proposed requirements and timeframes for recertification are unnecessary and present a tangible burden. Therefore, we respectfully request the agency revise the IFC based on these concerns. Included below are our comments on the specific provisions of the proposed rule.

II. Provisions of the Interim Final Rule With Comment Period

B. Applicable Individuals

As stated in this IFC, "section 71119(a) of the WFTC legislation amended section 1902 of the Act to add subsection (xx). Section 1902(xx) of the Act requires that "applicable individuals" demonstrate, as a condition of their Medicaid eligibility, "community engagement" (generally, that they work, are enrolled in an educational program, complete community service, participate in a work program, or any combination thereof) for a minimum period of time preceding their Medicaid application and during their Medicaid enrollment."[12] Further, "section 1902(xx)(9)(A)(i) of the Act defines the term "applicable individual" to mean an individual who is not a "specified excluded individual" described in section 1902(xx)(9)(A)(ii) of the Act (as further discussed in section II.E. of this IFC) and who (1) ". . . is eligible to enroll (or is enrolled) under the State plan under" section 1902(a)(10)(A)(i)(VIII) of the Act; or (2) ". . .

[4] https://www.cms.gov/files/zip/cy-2026-pfs-proposed-rule-specialty-impacts-practitioner.zip
[5] https://storage.aanp.org/www/documents/NP_Infographic.pdf
[6] Ibid
[7] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[8] July 2025 Data Book: Health Care Spending and the Medicare Program – MedPAC
[9] Ibid
[10] Ibid
[11] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid
[12] 91 FR 33353

is otherwise eligible to enroll (or is enrolled) under a waiver of such plan" and meets the criteria of 1902(xx)(9)(A)(i)(II)(aa) and (bb)."[13] In this IFC, the agency establishes a new § 435.551 to implement this statutory definition of applicable individual.

As stated within this section, a person could still "be an applicable individual if that person is "otherwise" eligible for or enrolled in Medicaid under certain section 1115 demonstrations."[14] Further, "States that cover the State plan adult group might *also* have a section 1115 demonstration population that meets the criteria described above and, therefore, also have applicable individuals under the demonstration."[15] Further, there are "several demonstrations providing Medicaid eligibility under section 1115(a)(2) expenditure authority to populations generally meeting the definition of an applicable individual in section 1902(xx)(9)(A)(i)(II) of the Act, but in which not all individuals would always meet the criteria of a specified excluded individual or a mandatory exception for certain populations. These demonstration populations could be subject to the community engagement requirement."[16]

As part of the agency's section 1115 demonstration review and approval process, CMS states it will "evaluate proposals which seek to provide Medicaid eligibility under section 1115(a)(2) expenditure authority to a population not eligible under the State plan to determine if the community engagement requirement might apply to the demonstration population."[17] We support the agency's goal to "create an eligibility pathway for individuals who are not eligible under the State plan to determine which demonstrations cover individuals who could be subject to the community engagement requirement."[18] Further, we strongly encourage CMS to adopt population-level exclusions, rather than requiring individual-level exemptions, for specified groups subject to community engagement requirements. A population-level approach would reduce administrative complexity, lessen the risk of eligible individuals being improperly subjected to community engagement requirements. This would achieve the agency's goal of creating eligible pathways while minimizing the burden placed on individuals and states.

E. Specified Excluded Individuals
5. An Individual Who is Medically Frail or Otherwise has Special Medical Needs

In this section, the agency proposes new § 435.554(c)(5) which implements the statutory definition of specified excluded individuals. As stated in the IFC, Section 1902(xx)(9)(A)(ii) of the Act lists nine categories of individuals meeting the definition of a "specified excluded individual"[19] who are excluded from the community engagement requirements to qualify for the State plan adult group or for eligibility under an applicable section 1115 demonstration.

This section would implement section 1902(xx)(9)(A)(ii)(V) of the Act which provides that specified excluded individuals must include an individual, "(V) who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual—(aa) who is blind or disabled (as defined in section 1614 of the Act); (bb) with a substance use disorder (SUD); (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more ADLs; or (ee) with a serious or complex medical condition."[20]

The agency proposes to define medically frail individuals as individuals who meet one or more of the five categories identified at section 1902(xx)(9)(A)(ii)(V) of the Act at § 435.554(c)(5) as "an individual

[13] Ibid
[14] Ibid
[15] Ibid
[16] 91 FR 33354
[17] Ibid
[18] Ibid
[19] Ibid
[20] 91 FR 33372

whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement in this subpart and who is blind or disabled (as defined at section 1614 of the Act); with an SUD; with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more ADLs; or with a serious or complex medical condition."[21] Individuals only need to fit within one of these categories to qualify for the medically frail exclusion to the community engagement requirement.

As stated by CMS, this mandatory exclusion from the community engagement requirement "protects access to necessary health care services for individuals who are medically frail and may have physical or behavioral health conditions that significantly impair their ability to consistently work or participate in other community engagement activities defined at § 435.552."[22] The Secretary has discretion to implement these definitions as recognized by CMS in the IFC, stating that "section 1902(xx)(9)(A)(ii)(V) of the Act provides the Secretary with the authority to define the term medically frail for community engagement purposes (as long as the definition includes the five categories specified at section 1902(xx)(9)(A)(ii)(V) of the Act)."

It is our hope that the agency will use its discretion to implement this requirement with a focus on straightforward operational conditions with a goal of preserving coverage. We agree with the importance of ensuring protection of access for medically frail individuals and not imposing further barriers on this vulnerable population. Loss of Medicaid coverage for these patients can interrupt care, worsen their current conditions, and increase confusion and burden on patients and their health care providers. It is essential that the medical frailty determination process provides long-term stability, reduces administrative burden, while also maintaining coverage. Additionally, unnecessary and unintended care interruptions lead to added costs to the Medicaid program.

Therefore, we strongly disagree with the proposed inclusion of the requirement that an individual's condition "significantly impairs"[23] their ability to comply with the community engagement requirement, nor does the agency have the authority to include this as a requirement. While the statute delegates certain definitional authority to the Secretary, it does so only to establish a further definition of "special medical needs" as clearly stated in Sec. 71119, Section 9, subsection V.[24] Congress did not empower the Secretary to further restrict this definition, nor did it intend "to establish standards governing the scope and application of this term in the context of administering the statute"[25], as Congress clearly defined these conditions within the statue. In subsection dd of the statute, Congress explicitly included this statutory clarification, however, it did not do so to the broad categorization of medically frail as the agency proposes in this IFC. Had it wanted to place these further restrictions, Congress would have done so in its definition which is very clearly laid out in the statute.

The term 'significantly impairs' as proposed in this IFC is ambiguous and does not provide clarity on what the agency would expect from a healthcare provider making a clinical determination. This lack of specificity may empower state Medicaid agencies to impose additional restrictions on these conditions, further disenfranchising vulnerable patients. Further, it is unclear how a patient demonstrates their inability to meet the community engagement requirements if they already fall under the definition of "medically frail."[26] The underlying qualifying conditions are inherently inhibiting in nature as described in § 435.554(c)(5)(i). The agency does not establish an objective test or provide guidance on how a

[21] 91 FR 33373
[22] 91 FR 33372
[23] Ibid
[24] PL 119-21
[25] 91 FR 33373
[26] Ibid

medically frail, and likely complex patient, could possibly demonstrate their inability to meet what is inherently a physical examination of their abilities. The paradoxical and confusing nature of this additional requirement will only lead to further confusion and disenfranchisement, rather than providing effective guardrails for the purposes of administration.

In § 435.554(c)(5)(i)(A)(B)(C)(D)(E), the agency proposes to establish the categorical definitions included under "medically frail" exclusions. While we broadly support the categorical inclusion of these conditions as established in the legislation, we do not support further restrictions beyond what is included in the statutory definition. For example, in § 435.554(c)(5)(i)(B), the agency proposes a blanket exclusion of eligibility for individuals with a substance use disorder (SUD) who are in "stable recovery" which means "in recovery for 5 or more years."[27] As stated above, Congress did not place this limitation in its definition, and the agency is not empowered to categorically exclude these individuals. For individuals in recovery who may relapse beyond the established period, this only serves to further stigmatize and disenfranchise them. Further, this requirement would require the agency and a health care provider to improperly establish an invasive timeline of a patient's recovery journey. This requirement is harmful and would not contribute to the overall wellbeing of a patient, despite the statements included by the agency in the IFC.

In§ 435.554(c)(5)(i)(D), the agency establishes the fourth medically frail exclusion as "an individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more ADLs and who otherwise meets the criteria at § 435.554(c)(5)(i) is medically frail."[28] As correctly noted in the IFC, the statute "specifically requires that the individual's physical, intellectual, or developmental disability significantly impair their ability to perform one or more ADLs."[29] We appreciate the agency's decision to not impose a further definition of a physical, intellectual, or developmental disability that significantly impairs an individual's ability to perform one or more ADLs in the regulation. We agree that "it would be incredibly difficult to set one standard that appropriately defines individuals who would qualify for such an exclusion."[30]

While we recognize that Medicaid is a state-administered program, we believe it is important to establish a minimum national standard for this exclusion. As noted within the IFC, the agency provides a non-exhaustive list, but does not establish a minimum parameter for states to consider. This may lead to states choosing to be overly restrictive instead of relying on health care providers education and clinical training. A minimum standard definition, similar to the agency's proposal in § 435.554(c)(5)(i)(E), would help reduce burden and confusion.

In § 435.554(c)(5)(i)(E), the agency proposes additional conditions beyond what Congress included in the statutory definition in PL 119-21. The IFC proposes that "States will need to ensure fidelity to the definition at § 435.554(c)(5)(i)(E) and our criteria at § 435.554(c)(5)(i) that an individual's physical, mental, or other behavioral health condition significantly impair their ability to comply with the community engagement requirement, when determining if an individual has a serious or complex medical condition for purposes of the community engagement exclusion."[31] It is important to note that this additional burden of proof on impairment of ability will primarily rest with an individual's health care provider. This criteria was not included by Congress, and is yet another unnecessary hurdle included within this IFC. We request the agency resort to the statutory definitions as provided by Congress.

[27] 91 FR 33374
[28] 91 FR 33375
[29] Ibid
[30] Ibid
[31] 91 FR 33376

I. Verification of Compliance With and Exceptions and Exclusions From the Community Engagement Requirement

6. Verifying Compliance With Community Engagement Activities
E. Individuals Who Are Medically Frail or Otherwise Have Special Medical Need

This section of the IFC establishes procedures for verification of compliance with community engagement activities, including those individuals who are exempt from the requirements as medically frail or otherwise having special medical needs. While we recognize there are statutory requirements for verification as established in PL 119-21, these regulations must ensure that patients and their health care providers are not burdened by the implementation.

We support the inclusion of nurse practitioners as a provider that "States may accept provider documentation from" as "qualified to determine that an individual's condition qualifies them as medically frail or having other special medical needs under State scope of practice laws."[32] According to CMS data, as of 2024, there were over 243,000 NPs billing for Medicare services, making NPs the largest Medicare designated provider specialty,[33] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[34] NPs have a particularly large impact on primary care as approximately 70% of all NP graduates are prepared in primary care.[35] The requirements in this IFC will place a major burden on health care providers and the patients they care for. Ensuring that patients are able to see the provider of their choice is essential to minimizing disruption.

As CMS continues to work with states on this implementation, we respectfully request the agency make clear its expectation that states are fully inclusive of the provider types that meet the above criteria. It is important for the agency to clarify that for states that unnecessary restrictions on providers who otherwise meet the certifying criteria will lead to unnecessary delays. As proposed within this section, there is no national standard for verification criteria as established by the agency. While we recognize the need for flexibility in implementation, the patchwork of regulations resulting from this proposal will be challenging to implement. This will lead to confusion, delay, and interruptions in patients' coverage and care.

Therefore, the agency must develop a clear national verification standard for health care providers tasked with verifying a patient's medical conditions for the purposes of an exemption from the community engagement activity requirement. These standards should be the basis of the process for States to use in their verification requirements. This must include specific information on what is expected of a health care provider when they are providing patient attestation and information.

Further, in accordance with requirements in section 1902(xx)(5) of the Act, States must, where possible, verify medical frailty or other special medical needs on an *ex parte* basis using reliable information available to the State without requiring the individual to submit additional information. In order to meet this requirement, the agency provides that the State "must attempt to verify that an individual is a specified excluded individual on the basis that the individual is medically frail or has other special medical needs as defined at § 435.554(c)(5) using reliable information available to the State."[36] We

[32] 91 FR 33406
[33] https://www.cms.gov/files/zip/cy-2026-pfs-proposed-rule-specialty-impacts-practitioner.zip
[34] https://storage.aanp.org/www/documents/NP_Infographic.pdf
[35] Ibid
[36] 91 FR 33476

support the utilization of reliable information to verify on an *ex parte* basis that an individual meets this criteria.

However, we do not support the provision establishing that "States may not consider information older than 12 months when verifying medical frailty or other special medical needs, because older information may not reflect the individual's current condition."[37] For certain patients with established medical conditions, there medical history likely spans beyond this 12-month interval. This makes it difficult for these individuals to establish their exemption without obtaining further information through their health care provider.

There is significant concern that these verifications will require significant clinician and practice time and resources. As a result, they will place additional administrative burdens on practices and limit the time available to see and treat patients. Allowing clinicians to use medical histories beyond the 12-month interval would ease some of this burden and align with other CMS priorities that put patients and providers over paperwork in effort to ease provider burnout and administrative costs. Therefore, we respectfully request the agency authorize utilization of "relevant information which may extend beyond the 12-month interval" if determined by a health care provider. This will ensure that patients and providers are able to include the necessary relevant information in this process.

Additionally, we do not support the requirements for reverification as proposed within this IFC. The agency proposes that "States must reverify that an individual is medically frail or otherwise has other special medical needs at least every 12 months, although States may reverify more frequently, such as at each renewal."[38] For patients who meet these criteria for these exemptions, the initial verification process will be challenging to navigate. Requiring them to meet these criteria every 12 months, and authorizing states to require verification at even closer intervals, is unnecessary.

The underlying criteria to meet these exemptions includes patients with life-altering conditions. For example, § 435.554(c)(5)(i)(A) establishes that an individual who is blind or disabled is considered medically frail. In § 435.554(c)(5)(i)(D) the agency exempts individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more ADLs from the community engagement requirements. Subjecting these patients to frequent reverification will likely be a significant challenge.

Therefore, we respectfully request the agency include exemptions for individuals with long-term medical conditions. In section II.B. the agency discusses potential exemptions based on populations. We encourage the agency to consider adopting broad population-based exemptions for the purposes of the section of the regulation as well. Further, the agency should authorize telehealth appointments and electronic verification as approved methods to reverify a patient's medical frailty. This will ensure that patients with mobility and other limitations are able to meet the requirements without requiring an in-person health care appointment.

Conclusion

We recognize that CMS is statutorily mandated to implement changes as included within public law 119-21[39] as enacted by the 119th Congress. However, the agency must also recognize its responsibility to reduce burden on patients and their health care providers. Many of the provisions included within this IFC increase the burden through unnecessarily restrictive policies. NPs are essential providers of care to Medicaid patients, and the proposals within this IFC will have a significant impact on them and their

[37] 91 FR 33405
[38] 91 FR 33407
[39] untitled

patients. We respectfully request the agency reconsider its proposed implementation of the medical frailty and community engagement requirements in a way that reduces burden on patients and providers. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

Jon Fanning, MS, CAE, CNED
Chief Executive Officer
American Association of Nurse Practitioners