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July 31, 2026

The Honorable Robert Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454–IFC); Interim Final Rule with Comment Period

Dear Secretary Kennedy and Administrator Oz:

The American Kidney Fund appreciates the opportunity to submit comments on the interim final rule with comment period (IFC) issued by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) regarding the Medicaid community engagement requirement for certain individuals

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 1 in 7 American adults living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 96 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

AKF is deeply concerned with several provisions in the IFC implementing the community engagement requirements of Public Law 119-21, especially CMS's restrictive definition of medical frailty that goes well beyond the intent of Congress in establishing the medical frailty exclusion. We also have serious concerns with CMS's provision eliminating the state option to use on-going sworn attestations. We are particularly concerned about how these provisions will impact people

11921 Rockville Pike | Suite 300 | Rockville, MD 20852
301.881.3052 voice | 301.881.0898 fax | 800.638.8299 toll-free | 866.300.2900 Español
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living with end-stage kidney disease (ESKD) and who rely on Medicaid expansion coverage as their primary source of health insurance. The increased administrative and financial burden on patients, providers and states and the short timeline for states to implement the IFC provisions will lead to adverse outcomes for people with serious and chronic health conditions such as kidney failure.

We focus our comments on why certain IFC provisions will be harmful to people living with ESKD specifically but also those living with other serious or complex medical conditions, and our recommendations for mitigating that harm.

Medically Frail Definition

PL 119-21 includes mandatory exceptions to the community engagement requirements, including people who qualify as "specified excluded individuals." Under PL 119-21, one category of specified excluded individuals is "medically frail or otherwise has special needs," and the statute defines medical frailty to include a person who is blind or disabled under Section 1614 of the Social Security Act; with a substance use disorder; with a disabling mental disorder; with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition. However, in the IFC, CMS has added a new requirement to the medical frailty definition that in addition to having a qualifying health condition, the condition also "significantly impairs the individual's ability to comply with the community engagement requirement."

CMS's alteration of the medical frailty definition in the IFC is highly problematic for several reasons and will jeopardize the coverage and healthcare of people with serious or complex conditions such as ESKD. CMS's definition goes well beyond the definition of medical frailty Congress applied in PL 119-21, which itself is a well-established term that has been used previously in other statutes and regulations. CMS has no basis to interpret medical frailty as being a proxy for one's ability to work or otherwise meet the community engagement requirements of PL 119-21. In addition to Congress's clear application of medical frailty in the legislation, there is an extensive record of statements and remarks by members of Congress that their intent was to exempt people from the community engagement requirements if they were medically frail—

there is no record that implies Congress's intent was to also link that exemption to their ability to work.[1, 2, 3, 4, 5]

From a practical standpoint, CMS's stricter definition of medical frailty will result in people with serious or complex medical conditions who should be exempt from community engagement requirements losing their Medicaid coverage, including people with ESKD. The exclusion process in PL 119-21 requires states to use an automated (ex parte), data driven process to verify compliance with community engagement requirements or exceptions. Specifically, the statute requires states to "establish processes and use reliable information available to the state… without requiring, where possible, the applicable individual to submit additional information." CMS has, in previous guidance and in the IFC, restated this requirement and the expectation that states will use reliable information available to them in an automated verification process.

However, by changing the medical frailty definition to also require an assessment of significant impairment—and giving states only seven months to implement the change—it will be nearly impossible for states to automate their processes for verifying medical frailty. While claims and clinical data allow states to automatically verify that a person has a serious or chronic condition such as ESKD, there is not a comparable reliable data source to automatically verify significant impairment. Coupled with the restrictions on the use of self-attestations in the IFC, there will be a substantial burden on patients, providers and states to document and assess that a person's medical condition significantly impairs their ability to meet the community engagement requirements. Considering the short time frames for implementation, the complexity of reprogramming state eligibility systems, and the significant changes in policy required under the

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[1] Opening statement from Chairman Guthrie in House Energy and Commerce Committee hearing, May 13, 2025, https://energycommerce.house.gov/posts/chairman-guthrie-delivers-opening-statement-at-full-committee-markup-of-budget-reconciliation-text: "Let me be clear – these work requirements would only apply to able-bodied adults without dependents who don't have a disqualifying condition."

[2] Opening statement of Chairman Guthrie in House Rules Committee hearing, May 21, 2025, https://energycommerce.house.gov/posts/chairman-guthrie-delivers-opening-statement-at-committee-on-rules-hearing-on-the-one-big-beautiful-bill-act: "Let me be clear – these work requirements only apply to able-bodied adults without dependents who don't have a disqualifying condition like a disability or substance use disorder."

[3] Op-ed by Chairman Guthrie in the *NY Post,* June 22, 2025, https://nypost.com/2025/06/22/opinion/dont-buy-the-lies-about-the-gops-plan-for-medicaid-were-actually-strengthening-it/: "Let me set the record straight: This policy applies only to able-bodied, unemployed adults who have chosen not to work… You're exempt if you're medically frail, which includes anyone who's blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer…"

[4] Floor remarks by Senator Grassley, June 24, 2025, https://www.grassley.senate.gov/news/remarks/grassley-supports-common-sense-medicaid-work-requirements-for-able-bodied-adults: "We have reasonable exemptions for: Veterans with [a] disability rated as total. Individuals who are medically frail or otherwise have special medical needs. Individuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition."

[5] Congressional Record, floor remarks by Senator Crapo, June 29, 2025, https://www.congress.gov/119/crec/2025/06/30/171/113/CREC-2025-06-30.pdf: "This bill does not take Medicaid away from children, the elderly, the disabled, or the medically frail, adults caring for children and elderly relatives, or any recipient the program was originally designed to help."

IFC, it is foreseeable that many states will be materially unprepared to operate community engagement requirements on January 1, 2027. Creating more administrative hurdles for patients with a serious or complex medical condition to obtain and keep their health coverage while they navigate ill-equipped state eligibility systems will inevitably result in lost coverage and adverse health outcomes.

People living with ESKD have complex healthcare needs, as CMS well knows. Individuals living with ESKD and on dialysis may: have comorbidities such as diabetes and hypertension; balance multiple doctors and specialty visits; take 20 or more pills a day; manage dietary restrictions; experience higher hospitalization rates than people without ESKD; receive dialysis for 12-15 hours per week; and require recovery from dialysis treatments that can add up to 6-18 hours per week.[6]

CMS recognizes the complex care needs of people of living with ESKD in the preamble of the IFC when discussing the medical frailty exclusion: "We considered including specific conditions within our definition of a serious or complex medical condition, including human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/ AIDS), end stage renal disease (ESRD), cancer, and sickle cell disease (SCD) but, for reasons stated in a later paragraph, we do not believe it is reasonable to categorically consider conditions as serious or complex without factoring in criteria such as the severity of the condition."[7]

However, we would dispute the notion that it is unreasonable to categorically consider certain conditions such as ESKD as serious or complex without factoring in severity. A main reason is that even for a person who is managing their condition well, their situation can change quickly. For example, there are people with ESKD who do home dialysis and continue to work and therefore can meet the community engagement requirement. But medical complications can suddenly occur, either related to their ESKD or because their ESKD causes another medical issue to impact them more severely, and it could impact their ability to work. Then the person would have to deal with the administrative burden of seeking a medical frailty exclusion or a short-term hardship event exception—if they live in a state that has opted to provide short-term hardship exceptions. Regardless, the person must be aware of their options and devote mental and physical energy to navigating the process, in addition to dealing with their medical situation. And the added administrative hurdles make it more likely that they will lose their coverage.

For all the above reasons, we urge CMS to not finalize the requirement that to meet the medical frailty definition, a person's medical condition must significantly impair their ability to comply with the community engagement requirement. Instead, CMS should issue a final regulation that requires only that an individual meet the clinical medical frailty definition (e.g., by reference to a diagnosis code), as specified by statute.

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[6] Rayner HC, Zepel L, Fuller DS, et al. Recovery time, quality of life, and mortality in hemodialysis patients: the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney* Dis. 2014;64(1):86-94. doi:10.1053/j.ajkd.2014.01.014

[7] Federal Register, Vol. 91, No. 106, Wednesday, June 3, 2026: 33375.

We also urge CMS to reconsider including specific conditions within its definition of a serious or complex medical condition and include ESKD specifically, either through a final regulation or sub-regulatory guidance.

It is critical for people living with ESKD to remain connected to their health coverage and healthcare to manage their condition and live their best life, which can include continuing to work if they are able to. A recent study demonstrates the impact that Medicaid expansion coverage has had in reducing the one-year mortality rate for young adults with ESKD and starting dialysis. The study examined changes in outcomes between 4,791 young adults age 19 to 23 years with ESKD who were starting dialysis relative to 2,348 children age 14 to 18 years (a comparison group with unchanged eligibility) in states that expanded Medicaid eligibility. The results showed that one-year mortality declined from 3.6% before Medicaid expansion to 2.1% after the expansion among 19 to 23-year-olds. Medicaid coverage for 19- to 23-year-olds increased from 37.1% to 48.5% and uninsurance rates declined from 19.4% to 7.8%. Medicaid expansion was also associated with higher rates of predialysis nephrology care, prescribed hemodialysis sessions of 4 or more hours, and the use of peritoneal dialysis.[8] The study authors note that "the substantial mortality reductions observed in this study underscore the critical importance of continued Medicaid coverage for children with serious health conditions transitioning into young adulthood… Our findings suggest that for young adults with life-threatening conditions like kidney failure, timely access to insurance coverage may both facilitate access to critical specialty care as well as lengthen life."[9]

Given the complex care needs of people living with ESKD and the meaningful impact that access to Medicaid expansion coverage has on health outcomes, our recommended changes to the medical frailty definition would mitigate the harms of coverage loss due to administrative burden and ensure that people living with ESKD will keep their life-saving coverage.

Verification and Sworn Self-Attestations

We generally support the requirements of the statute and the IFC to require states to implement an automated, data-driven approach to verifying community engagement compliance and exceptions. The statute also allows states the option to use sworn self-attestation to verify; this flexibility is particularly useful if CMS proceeds with its significant impairment requirement for the medical frailty exclusion. However, in the IFC CMS allows sworn self-attestation for verification generally only until the end of 2027, and starting in 2028 self-attestation for medical frailty will be allowed only once for an individual. To protect individuals with serious or complex medical conditions, as required in PL 119-21, we urge CMS to allow for sworn self-attestations without limitations.

[8]Swaminathan S, Kim D, Sommers BD, Mehrotra R, Trivedi AN. Medicaid Expansion and 1-Year Mortality Among Young Adults Initiating Dialysis. *JAMA Pediatrics.* Published online May 11, 2026. doi:10.1001/jamapediatrics.2026.1530.

[9] Ibid.

In the IFC, CMS sets a policy that allows states to reverify medical frailty status every 12 months, at state option. We urge CMS to expand this policy to require states to set the duration of medical frailty exclusions for at least 12 months, and to allow states to offer longer durations for exclusions when consistent with the exclusion granted. For permanent medical conditions such as ESKD, this would allow states to offer a permanent medical frailty exclusion.

Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,

LaVarne A. Burton
President and CEO