**Operationalizing the Medical Frailty Exemption:**
**A Step-by-Step Implementation Toolkit for States**

*November 2025*

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## Context

The enactment of H.R.1 introduces mandatory work reporting requirements for Medicaid expansion adults, while explicitly exempting individuals who are medically frail. The statute further requires states to attempt to verify medical frailty exemptions *ex parte*—using data already available to the state, where possible, without requiring information from individuals.[1] These requirements present significant challenges. States must align clinical definitions, programmatic eligibility, data architecture, and information technology (IT) systems to ensure that the most at-risk individuals can enroll in and maintain coverage.

This toolkit provides a structured roadmap for defining medical frailty, developing, and validating data-driven code lists, and integrating those requirements into state eligibility and enrollment workflows. It also describes how states should engage individuals with lived experience and community partners throughout design and operational planning. The toolkit draws from existing federal guidance, prior state experience implementing medical frailty definitions, and work assisting states in Medicaid program design and systems implementation.

The toolkit provides a step-by-step guide for how states can tackle the operationalization of medical frailty exemptions, while reducing burden on individuals and state administration and making accurate eligibility determinations.

## Step 1. Establish a Cross-Division Governance Structure

Effective implementation of the medical frailty exemption requires coordination across multiple divisions within a state Medicaid agency and robust engagement with external partners. While most states have appropriately anchored the implementation of work reporting requirements within a state's Eligibility and Enrollment Division, defining and operationalizing medical frailty requires state agency subject matter expertise beyond the Eligibility team. A structured cross-agency governance model ensures that clinical, eligibility, operational, and technical perspectives are aligned. States can ground their governance structures through collaboration with community partners and people with lived experience in Medicaid and with medical frailty. This will help ensure that policy decisions and implementation design will support consistent and compliant exemption determinations. Such engagement is also a core strategy for states to build and sustain trust, strengthen accountability, and mitigate coverage loss.[2]

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[1] Specifically, H.R.1 requires, "[f]or the purposes of verifying that…an individual is a specified excluded individual…, the State shall, in accordance with standards established by the Secretary, establish processes and use reliable information available to the Sate (such as payroll data or payments or encounter data under this title for individuals and data on payments to such individuals for the provision of services covered under this title) without requiring, where possible, the applicable individual to submit additional information."

[2] Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel, Health Equity Solutions, "Transformational Community Engagement to Advance Health Equity," State Health and Value Strategies, (January 2023).

The internal and external partners that should be engaged in designing and operationalizing medical frailty should include, at a minimum:

- *Eligibility and Enrollment Division*: Integrates medical frailty flags within the data verification hierarchy and eligibility workflows and oversees the development, in partnership with the clinical team, of the medical frailty screener at application and renewal. The team is responsible for ensuring compliance with the federal requirements, developing eligibility guidance, and training the eligibility and enrollment workforce. This team will also oversee the development of the work reporting requirement business rules, in partnership with the IT Systems Implementation Team.
- *Medicaid Management Information System (MMIS)*[3] */ Data Acquisition and Analytics Team*: Design and develop data architecture, processes for data acquisition, ingestion, people matching, and analytics required to aggregate data sources and conduct analyses to support medical frailty designations.
- *Clinical Policy Experts*: Validate medical frailty definitions and identify state-specific programs that meet medical frailty definitions. These experts are also responsible for identifying data sources needed to develop medical frailty definitions and providing technical guidance on and validating the medical frailty screener and the development of code lists for data verification processes.
- *Individuals with Lived Experience:* Provide their expertise and validate the policy and implementation process design, support user testing, and inform development of consumer-facing materials. Individuals with lived experience include but aren't limited to the state's Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) advisory groups.
- *Community Partners.* External clinician experts in academic medicine, managed care plan Chief Medical Officers and care managers, advocacy organizations, community-based provider organizations, and others who can provide their expertise and validate policy and implementation process design, support user testing, and inform development of consumer and provider-facing materials.
- *Program Policy and Legal Teams*: Ensure federal and state policy compliance and guide implementation, including intersections with other policy changes in process across the agency, and ensuring that necessary data sharing agreements are in place to acquire external data.
- *Medicaid Managed Care Team*: Engages with managed care plans and oversees the implementation of new requirements of managed care plans in supporting the identification of medical frailty.
- *IT Systems Implementation Team (Agency and Contracted Vendors):* Implements medical frailty policy and operational business rules. Responsible for integrating screening tools, exemption indicators, and data exchange capabilities into eligibility and enrollment systems to ensure accurate identification and tracking of medically frail individuals.

[3] For the purposes of this toolkit, MMIS is used as the catch-all phrase for the data system that holds fee-for-service claims and/or managed care encounter data. Some states may use a different named system.

- *Agency Overseeing the Supplemental Nutrition Assistance Program (SNAP):* Ensures the sharing of information with the Medicaid agency of SNAP medical-related exemptions.
- *Leadership from Health Data Utilities (HDUs)/Health Information Exchanges (HIEs)/All Payer Claims Databases (APCDs)*: Assist the state Medicaid Agency in understanding the potential for providing information on complex medical conditions or hospitalizations that could meet frailty conditions and coordinate with data exchange.

The cross-division agency team should meet regularly during design and testing phases, engaging people with lived experience in key meetings throughout the process, and transitioning to either monthly or quarterly meetings once the system is live.[4] It will be especially critical to regularly engage with people with lived experience once the system goes live to ensure that it is working for applicants and enrollees, and for the state to spot and mitigate any unintended consequences that are negatively impacting people.

### Step 2. Define Medical Frailty

H.R.1 statute provides that medically frail exemptions from work reporting requirements extend to individuals who have special medical needs and include those: (1) with a substance-use disorder (SUD); (2) with a disabling mental disorder; (3) with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; (4) with a serious or complex medical condition; or (5) who are blind or disabled (as defined in section 1614 of the Social Security Act).[5] It is an open question whether the Centers for Medicare & Medicaid Services (CMS) will provide definitions that are more granular than what is in the federal statute in sub-regulatory guidance and/or the forthcoming interim final rule that must be released by June 2026. In the meantime, CMS has communicated publicly that it will generally rely on existing federal guidance and regulations for definitions.[6] Considering CMS' public statements and tight implementation timeframes, states could reasonably assume that they will have flexibility to define medical frailty as they determine appropriate, within minimum federal standards. State Health and Value Strategies (SHVS) recently released a toolkit that: (1) describes the factors that states may want to consider when developing definitions; and (2) provides examples of potential state definitions. This toolkit could serve as a jumping off point for developing state-specific definitions.

States can begin the development of a medical frailty definition by first reviewing how medical frailty has been previously defined by other states that have used these criteria when operationalizing their Alternative Benefit Plans (ABP) for their expansion adults.[7] Existing ABP

[4] Not included here are two additional important processes to work with: (1) the Advance Planning Document team to develop federal funding requests; and (2) the Procurement and Contracting unit for hiring new vendors and executing data acquisition, as needed.
[5] The terms used in this document are those from the statutory language of H.R.1.
[6] As communicated by Caprice Knapp on September 11, 2025. See the Kaiser Family Foundation (KFF) article, "How Will States Implement Medicaid Work Requirements?" (September 11, 2025).
[7] KFF, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," (June 26, 2019).

definitions, which were used to identify individuals eligible for a more robust benefit package than what was offered through the ABP, provide a framework for linking clinical conditions and service needs to medical frailty criteria. Because the purpose of defining medical frailty for the ABP is different than the purpose of defining medical frailty exemptions from work reporting requirements, the ABP definitions should serve as a jumping off point for states and should be considered the floor and not the ceiling. Further, it is also important to note there are some variations in the definitions—an important example: the ABP medical frailty subcategory of a SUD diagnosis is more restrictive than H.R.1's work reporting requirements subcategory for SUD.

States can also engage individuals with lived experience and community partners in the development of medical frailty definitions including through strategies like creating a subcommittee of their BAC; hosting focus groups with key stakeholder organizations; conducting key informant interviews; establishing a specific working group that includes a broad range of stakeholders; and creating a subcommittee of the MAC. It will be important to engage community partners with expertise in groups who typically face barriers to healthcare as these groups will be most vulnerable to losing access to Medicaid. Community partners could include clinicians with expertise in behavioral health, chronic and complex medical conditions, state disease-specific advocacy organizations, and disability rights and other advocates. These partners can provide critical insights on whether all medical frailty conditions have been accurately identified and defined.

Translating statutory medical frailty categories into definitions is a critical step to supporting the development of a medical frailty screener for the application and renewal forms as well as the business rules for identifying medically frail individuals as described in *Step 10* below.

***Key Players**:* Eligibility and Enrollment Division, Individuals with Lived Experience, Community Partners, Program Policy and Legal Teams.

### Step 3. Identify Medicaid Programs Where Eligibility Aligns with Medical Frailty Definitions

States may begin by conducting a crosswalk of existing Medicaid programs and services to identify those with eligibility criteria that align with the medical frailty exemptions under the work reporting requirements. For example, expansion adults enrolled in certain specialized programs—such as behavioral health managed care plans, home- and community-based services waivers, programs for individuals with intellectual and developmental disabilities, or other types of programs may meet the same clinical or functional criteria used to define medical frailty.

By mapping these programs' eligibility standards to the medical frailty definition, states can automate exemptions for participants already known to qualify. This approach reduces administrative burden, promotes consistency in applying exemptions, and ensures that individuals with complex health needs are appropriately exempted from work reporting requirements.

***Key Players**:* Eligibility and Enrollment Division, Program Policy and Legal Teams.

### Step 4. Develop and Validate a Code List for Data Verification

A state needs to develop a clinical coding list for conducting medical frailty data verification. International Classification of Diseases (ICD)-10 and Current Procedural Terminology (CPT)/Health Care Common Procedure Coding System (HCPCS)[8] codes serve distinct but complementary coding within Medicaid data systems. ICD-10 codes capture diagnostic information that reflects an individual's underlying health conditions, while CPT/HCPCS codes record the specific services and procedures delivered during care encounters that can be indicators of clinical conditions. When analyzed together, these data elements provide a full picture of the presence and intensity of health conditions and the frequency and type of medical services utilized.

Reliance on diagnostic (ICD-10) codes alone will not capture data for people in all the medical frailty subcategories and risks omitting individuals whose health status results in significant service use, but whose conditions are coded inconsistently or nonspecifically. Conversely, service utilization data (CPT/HCPCs) alone may not reveal the underlying clinical complexity driving care needs. Integrating both ICD-10 and CPT/HCPCS data allows states to develop more accurate, data-driven algorithms to flag potential medical frailty, reduce reliance on manual screening, and better target exemptions for individuals whose health and functional needs Congress intended to exempt from work reporting requirements.

States should then develop a comprehensive code list—incorporating ICD-10, CPT, and HCPCS codes—that aligns with the specific medical frailty definitions they have established for work reporting exemptions. To complement code list development, states should also consider developing specialized algorithms that use both diagnostic and service utilization data to identify potential medical frailty**.** These algorithms might flag individuals based on patterns such as multiple hospitalizations within a defined period or a hospitalization combined with specific diagnosis codes associated with serious or complex medical conditions.

To further inform the development of the combination of ICD-10 and CPT/HCPCs data, states should consider engaging with clinical experts in academic medicine and the community-based provider community, such as SUD treatment providers, behavioral health providers, and Federally Qualified Health Centers and Rural Health Centers, to validate and inform the coding definitions for individuals who would meet the medical frailty criteria.

***Key Players**:* Eligibility and Enrollment Division, MMIS/ Data Acquisition and Analytics Team, Clinical Policy Experts, Community Partners, Medicaid Program Policy and Legal Teams.

[8] HCPCS codes expand upon CPT by including a broader range of services and supplies not captured in the CPT system. HCPCS codes cover items such as durable medical equipment (e.g., wheelchairs, oxygen supplies), non-physician services (e.g., ambulance transport, prosthetics), and certain drugs or supplies.

### Step 5: Conduct MMIS Data Analysis Testing

Accurate identification of medically frail individuals requires data that captures both diagnoses and patterns of service utilization. In Medicaid, this information is housed primarily within two data sources: fee-for-service (FFS) claims and managed care encounters. While both contain valuable clinical and service details, their structure and purpose differ. FFS claims are submitted directly by providers to the state Medicaid agency to request reimbursement for individual services. These claims contain standardized financial, diagnostic, and procedural information, reflecting services paid directly by the state. In contrast, managed care encounters are submitted by managed care plans to document services delivered to enrollees under capitated payment arrangements. Both claims and managed care encounters use standard Health Insurance Portability and Accountability Act compliant X12 837 transactions and should include similar diagnosis and procedure code information that can be combined and used for exemption analyses. In most states, both FFS and encounter data are stored or processed through the MMIS, which serves as the backbone for claims adjudication, data exchange, and reporting.[9]

To operationalize medical frailty identification, states can conduct MMIS-based claims and encounter analytics (aka "MMIS data scraping") to systematically flag individuals who meet exemption criteria using the code set that was developed in *Step 4*. States should begin with initial testing using historical MMIS data to assess how many individuals would have qualified for an exemption over the past three and six months, extending to longer periods to evaluate the timeliness and completeness of data capture. Clinical experts should work closely with data teams throughout this process to ensure that selected codes and utilization indicators are clinically relevant and comprehensive.

Key tasks in this approach include setting thresholds for encounter frequency and lookback periods, validating the code list and methodology against historical MMIS data, and scheduling monthly or quarterly updates to reflect new codes or evolving utilization patterns. It is important to factor in claims and encounter "lag": the difference between when the actual service was delivered, and when the claim or encounter was received and processed by the state. Claim/encounter lag can be three to six months or more depending on the type and complexity of the service and the service provider. States should also develop business rules that establish duration limits for codes, where clinically appropriate. For example, an individual who has a diagnosis of schizophrenia is unlikely to experience a change in their diagnosis over the course of multiple renewal periods.

***Key Players:*** Eligibility and Enrollment Division, MMIS/ Data Acquisition and Analytics Team, Clinical Policy Experts, Program Policy and Legal Teams, Medicaid Managed Care Team.

### Step 6: Link MMIS and Eligibility and Enrollment Systems

The next step is for the IT Systems team to establish a bridge between MMIS-based data analytics and the Medicaid eligibility and enrollment system. This connection allows real-time or near-real-time transfer of identified exemption flags from MMIS to the system that determines

[9] As states modernize their data ecosystems, some have begun integrating or replicating MMIS data into enterprise data warehouses, modular data hubs, or shared analytics platforms.

eligibility and processes renewals, ensuring that individuals who meet medical frailty criteria are automatically recognized and exempted from work reporting requirements. Building this bridge requires collaboration between IT systems teams, policy staff, and eligibility operations to define data exchange protocols, maintain data integrity, and implement automated updates.

***Key Players**:* Eligibility and Enrollment Division, MMIS/Data Acquisition and Analytics Team, IT Systems Implementation Team (Agency and Contracted Vendors).

### Step 7. Leverage SNAP Work Reporting Requirements Exemptions

States can leverage existing SNAP medical exemptions to support the identification of medically frail individuals for Medicaid work reporting requirements exemptions. As described in a separate SHVS toolkit, some exemptions in SNAP overlap with Medicaid's new work reporting requirements exemptions under H.R.1, and information already captured in the state's public benefit system can be used to identify individuals who should not be subject to work reporting requirements. By mapping SNAP medical exemptions—such as documented disabilities or medically limiting conditions—to the state's Medicaid medical frailty criteria, states can leverage existing data already known to the state.

***Key Players**:* Eligibility and Enrollment Division, IT Systems Implementation Team (Agency and Contracted Vendors), Agency Overseeing SNAP.

### Step 8. Leverage Medicaid Managed Care Plan Information

Managed care plans are uniquely positioned to support state Medicaid agencies in identifying individuals who qualify for medical frailty exemptions because they maintain- claims and encounter data and care/case management systems that document conditions that might qualify an enrollee for an exemption; and plans have a vested interest in maintaining continuity of coverage and care.[10]

States may supplement their own MMIS and encounter data with more current data from managed care plans by, for instance, requiring plans to share near-real-time service utilization reports or encounter-level data to capture recent care patterns and ensure timely identification of medically frail individuals. In some cases, states may also consider adjusting managed care plans' submission timelines to align reporting more closely with eligibility and exemption workflows.

Managed care plan case managers also hold valuable qualitative information about enrollees' functional limitations and complex care needs. Leveraging care and case management information obtained from care needs assessments and the development of a care plan can enhance identification of medically frail individuals. Doing so requires establishing data-matching protocols to integrate case management information with MMIS or state eligibility systems, ensuring that personal health information is accurately and securely linked. By combining MMIS, managed care plan service utilization or encounter data, and case-

[10] State Health and Value Strategies, "Leveraging Managed Care Plans to Support Implementation of Medicaid Work Reporting Requirements," Prepared by Manatt Health (October 24, 2025).

management insights, states can create a more comprehensive and timely approach to identifying medically frail enrollees.

***Key Players**:* Eligibility and Enrollment Division, MMIS/Data Acquisition and Analytics Team, Clinical Policy Experts, Community Partners, Program Policy and Legal Teams, Medicaid Managed Care Team, IT Systems Implementation Team (Agency and Contracted Vendors).

### Step 9. Link to HDUs, HIEs, and APCDs

States may also wish to explore the potential of leveraging HDUs, HIEs, and APCDs for identifying medical frailty exemptions. These entities have existing infrastructure that could provide states with standardized and near-real-time information on an individual's complex medical conditions or hospitalizations that could potentially meet the medical frailty conditions.[11]

HIEs receive and/or may query participating healthcare organizations' electronic health records for information–for permitted purposes–on patients' clinical visits, diagnoses, and procedures, as coded using ICD10, HCPCS, CPT, Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT) and Logical Observation Identifier Names and Codes (LOINC) codes. HIEs also commonly broker Admit Discharge and Transfer event notification information that may comprise information relevant to identify Medicaid enrollees that may newly qualify for exceptions or exemptions. States should evaluate other types of data that can be provided by these entities and explore the potential for integrating these data into eligibility and enrollment systems and analyses to proactively identify individuals who meet the medical frailty criteria.

State APCDs may be another resource for state Medicaid programs to identify permanent health indicators that might qualify Medicaid members for exemptions. State APCDs comprise claims and encounter data for individuals insured through most private and public coverage sources (excluding data for the self-insured-covered populations).

***Key Players**:* Eligibility and Enrollment Division, MMIS/Data Acquisition and Analytics Team, Medicaid Program Policy and Legal Teams, IT Systems Implementation Team (Agency and Contracted Vendors), HDUs/HIEs/APCDs***.***

### Step 10. Develop a Medical Frailty Screener for Use at Application and Renewal

To ensure accurate and consistent identification of medically frail individuals, especially individuals who are new to the Medicaid program or have not yet utilized services that would be reflected in the data sources described above, states should develop a medical frailty screener that would be incorporated into the state's application and renewal processes.[12] The medical frailty screener should be aligned with the state's medical frailty definitions, code list developed through MMIS data analysis, and utilization algorithms. This alignment ensures that self-

[11] Jessica Kahn, "The Potential of Health Data Utilities to Support Implementation of HR 1 Requirements for Medicaid," The Consortium for State and Regional Interoperability (October 27, 2025).
[12] Emily Zylla and Elizabeth Lukanen, "The Disability Gap in Medicaid: Implications for the Federal Work Requirement Proposal," SHADAC, (June 2025).

reported information corresponds directly to the state's policy, definitions, and clinical and service utilization indicators.

The screener should use clear, plain language that avoids technical jargon and be integrated into a streamlined application and renewal workflow. Application questions should be grouped logically, using conditional logic to avoid irrelevant prompts, and should be accessible to people with disabilities, culturally appropriate, and offered in the languages spoken by Medicaid enrollees and applicants in the state.[13] SHVS intends to release a forthcoming toolkit on considerations when developing a medical frailty screener.

This is a critical step in which states should engage people with lived experience in the design and testing of these screeners. This may include strategies like engaging with the MAC, which is comprised of community partners and providers, and the BAC, which is comprised of members, in the design, testing, and implementation of the medical frailty screener. These advisory bodies can provide valuable insight into how individuals and community members interpret and experience the screening process, helping to ensure that the tool is understandable, accessible, and reflective of real-world health and functional limitations. Engaging the MAC and BAC early allows states to identify potential barriers, improve question framing and tone, and enhance cultural and linguistic appropriateness. MAC and BAC involvement should not be limited to one-time review but should extend into ongoing evaluation and refinement, ensuring that the screener remains responsive to evolving enrollee needs and maintains trust among individuals most affected by the policy. States could also consider more robust user testing of the screener in addition to testing efforts with their MACs and BACs to ensure the screeners reflect the diverse needs of the states' Medicaid population including with Medicaid enrollees who are not represented on the BAC or MAC (for example: individuals with disabilities, multi-lingual members, etc.).

***Key Players**:* Eligibility and Enrollment Division, Clinical Policy Experts, Individuals with Lived Experience, Community Partners, Medicaid Program Policy and Legal Teams, IT Systems Implementation Team (Agency and Contracted Vendors).

## Conclusion

A truly effective approach to identifying individuals eligible for the medical frailty exemption must be both human centered and data driven. It is essential to design policies and processes that not only leverage robust analytics, cross-agency collaboration, and multiple data sources, but also prioritize the lived experiences and needs of the people who will be most impacted. States must ensure that every step—from code list development to screener design and system integration—is crafted to minimize barriers for medically frail individuals and proactively identify those who should be exempt from work reporting requirements. The consequences of poorly constructed or rigid policies are significant: Medicaid-eligible individuals with significant health needs and risks may fall through the cracks, losing access to vital coverage or care.

[13] Civilla, "Human-Centered Work Requirements for Medicaid" (Fall 2025).

Once these policies and processes are implemented, states can take a flexible and responsive approach to continuously monitoring and overseeing policy implementation, using real-time data and ongoing feedback from community partners and people with lived experience to assess whether the process is working as intended. When gaps or unintended barriers are identified, states must act swiftly and nimbly to adjust criteria, tools, or workflows, ensuring that no eligible person is left behind.

A human centered, data-driven, and adaptable approach supports the core goal of medical frailty exemptions: protecting access to coverage and care for those who need it most and upholding the intent of federal policy.

Support for this toolkit was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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## ABOUT MANATT HEALTH

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