American Lung Association.

July 31, 2026

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

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

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals [CMS-2454-IFC]

Dear Secretary Kennedy and Administrator Oz:

The American Lung Association appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) interim final rule (IFR) implementing Medicaid work reporting requirements under H.R. 1.

The American Lung Association is the nation's oldest voluntary public health organization and represents the more than 34 million people in the United States living with lung disease. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy. Central to that mission is ensuring patients have access to quality, affordable healthcare coverage.

The Lung Association is deeply concerned that the interim final rule adopts policies that are substantially more restrictive than those enacted by Congress in H.R. 1. Rather than faithfully implementing the statute, the rule narrows statutory protections for individuals with lung diseases and other serious health conditions, creates unnecessary administrative burdens for patients, healthcare providers and states, and will result in significantly greater coverage losses than initially estimated. For individuals with serious and chronic respiratory diseases, coverage loss will have severe consequences, leading to delayed care, increased emergency department utilization, higher healthcare costs and poorer health outcomes.

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The American Lung Association urges CMS to withdraw the interim final rule and issue a revised rule that implements the statute while protecting patients' access to Medicaid coverage. Critical changes that CMS should make include (1) removing the "significant impairment" standard and aligning the medical frailty exclusion with the categorical protections established by Congress; (2) allowing states to accept sworn attestations; (3) minimizing burdensome reverification requirements for patients; (4) streamlining enrollment and verification processes while respecting due process protections; (5) requiring robust outreach, education and transparency; and (6) granting good-faith exemptions to all states that require additional time to adequately implement work reporting requirements. These changes are necessary to align the regulation with the statutory text of H.R. 1 and ensure individuals with serious and chronic health conditions, including millions of Americans living with lung disease, can maintain access to the healthcare coverage they need.

In addition to the comments submitted jointly with patient advocacy organizations, the American Lung Association respectfully submits the following comments and recommendations.

Medical Frailty Exclusion

1. *Remove the "significant impairment" standard and align the medical frailty definition with the categorical protections established in H.R. 1.*

The American Lung Association is deeply concerned that the IFR fundamentally rewrites the categorical exclusion from Medicaid work reporting requirements for individuals who are "medically frail." Congress deliberately recognized that individuals with serious medical conditions require stable access to healthcare coverage and should not be placed at risk of losing coverage because of work reporting requirements. The IFR changes that statutory protection by adding a new requirement that an individual's condition must "significantly impair" their ability to comply with work reporting requirements.

Nothing in H.R. 1 authorizes this additional standard. CMS's newly created "significant impairment" test will require many individuals whom Congress intended to protect to satisfy work reporting requirements despite having serious chronic illnesses that require continuous access to care. For individuals with lung disease, continuous coverage is essential. There will be real consequences if patients lose coverage or experience gaps in care due to extra paperwork and red tape. For example, people with COPD could experience exacerbations that do irreversible damage to their lungs and people with lung cancer could face delays in treatment that decrease their chances of survival.

This additional standard will create substantial challenges for healthcare providers. Under the IFR, determining whether an individual's condition "significantly impairs" their ability to comply with work reporting requirements may require individualized clinical assessments that are far

more complex than identifying qualifying diagnoses or conditions. In practice, this will require providers to make functional determinations about patients' ability to meet reporting requirements – determinations that are outside the typical scope of diagnosis and treatment. This approach risks placing providers in the untenable position of serving as gatekeepers for Medicaid eligibility rather than focusing on patient care.[1] Clinicians treating patients with serious illnesses, including lung disease, may be required to complete additional documentation, creating significant administrative burdens on top of the already heavy paperwork burden providers face.

The IFR will also create significant implementation challenges for states. CMS previously indicated that states would have flexibility to use available clinical information, including diagnostic codes and existing data sources, to identify individuals who should be excluded from work reporting requirements because of a health condition. States have reasonably relied on that guidance when developing policies, systems and implementation plans. The IFR's significantly narrower interpretation will require states to redesign systems, establish new processes for individualized determinations and develop new provider workflows on an already compressed implementation timeline. These last-minute changes increase the risk that eligible individuals lose coverage because systems are not equipped to accurately identify the patients Congress intended to protect.

The Lung Association urges CMS to remove the "significant impairment" requirement and instead allow a qualifying diagnosis, condition or statutory category of medical frailty to establish the exclusion, including through diagnostic codes and other reliable clinical information. Aligning the medical frailty definition with the statutory text will better protect patients, reduce unnecessary provider and state administrative burdens and allow states to implement the policy in a manner that is consistent with congressional intent.

2. *Withdraw the interpretation suggesting certain diagnoses, including asthma, generally do not qualify.*

The IFR identifies several conditions, including asthma, that CMS “would not typically expect to significantly impair an individual’s ability to meet the community engagement requirement.” The Lung Association is deeply concerned that this language will lead states to categorically exclude diagnoses that often result in substantial physical limitations and ongoing medical needs.

Asthma severity exists on a spectrum, and many individuals experience persistent symptoms, frequent exacerbations, repeated emergency department visits, hospitalizations, limitations on physical activity and dependence on daily medications. Even patients whose disease appears well controlled typically require continuous access to preventive medications to remain healthy. Individuals losing Medicaid coverage because a state follows CMS’s incorrect interpretation and

assumes a diagnosis of asthma is not grounds for an exclusion for medical frailty would increase avoidable exacerbations, hospitalizations and healthcare costs.

Recent research presented at the 2026 American Thoracic Society International Conference underscores these concerns. The analysis of Medicaid enrollees aged 19 to 64 with asthma found that approximately 2.2 million individuals (more than 60%) worked fewer than 20 hours per week and therefore could be at risk of disenrollment under Medicaid work reporting requirements.[2] Those at greatest risk also reported substantially higher asthma-related healthcare needs, greater physical limitations, frequent exacerbations and widespread daily medication use. These findings demonstrate that many individuals living with asthma experience meaningful limitations that warrant an exclusion form work reporting requirements due to medical frailty.

Moreover, disruptions in healthcare coverage are especially dangerous for individuals with asthma. Even brief interruptions in access to care increase the risk of uncontrolled disease, preventable emergency department visits and hospitalization.[3,4] The Lung Association urges CMS to withdraw the language suggesting that particular diagnoses generally do not significantly impair an individual's ability to meet work reporting requirements and instead clarify that states should evaluate qualifying conditions consistent with the statutory protections established by Congress.

3. *Preserve state flexibility to identify serious or complex medical conditions.*

The Lung Association also urges CMS to preserve state flexibility to identify serious or complex medical conditions consistent with the longstanding medical frailty framework in place when Congress enacted H.R. 1. States should be permitted to recognize conditions that satisfy the Institute of Medicine's definition of serious and complex conditions or otherwise determine that a condition warrants medical frailty status.

4. *Remove the restriction preventing individuals with substance use disorders who are in "stable recovery" from qualifying for the medical frailty exclusion.*

The Lung Association urges CMS to remove the IFR's limitation that prevents individuals with substance use disorders who are in "stable recovery" from qualifying for the medical frailty exclusion. H.R. 1 contains no such limitation, and this restriction creates an arbitrary distinction among individuals with substance use disorders based on their stage of recovery rather than their actual medical needs. The relevant question should be whether an individual meets the statutory criteria for medical frailty, not whether the individual has reached a particular stage of recovery.

This issue is particularly relevant to lung health, as tobacco dependence remains the leading preventable cause of lung disease. According to the American Psychological Association Diagnostic and Statistical Manual, 5th edition (DSM-V) and World Health Organization International Classification of Diseases, 11th edition (ICD-11), tobacco use is classified as a substance use disorder. ICD-11 specifically includes “disorders due to use of nicotine” within its substance use disorder framework. Many individuals with tobacco dependence also experience co-occurring substance use disorders or behavioral health conditions.[5,6,7] Continuous Medicaid coverage is critical to maintaining access to evidence-based tobacco cessation treatment, counseling, prescription medications, behavioral health services and preventive care. Interruptions in coverage can delay treatment, increase tobacco use relapse and worsen health outcomes. CMS should remove the “stable recovery” limitation and ensure that individuals with substance use disorders are evaluated for the medical frailty exclusion based on their actual health status and medical needs, consistent with the statutory language enacted by Congress.

5. *Remove the requirement for medical frailty exclusions to be reverified every 12 months, and allow states to grant longer-term exclusions for permanent and progressive conditions.*

The IFR's requirement to repeatedly verify chronic medical conditions at least every 12 months imposes unnecessary burdens on patients, providers and state Medicaid agencies. For example, an individual receiving treatment for lung cancer should not be required to repeatedly submit documentation confirming an ongoing cancer diagnosis every twelve months while simultaneously undergoing surgery, chemotherapy, radiation or immunotherapy. At a minimum, CMS should clarify that states can reverify this exclusion no more than every 12 months, while preserving state flexibility to extend the exclusion for longer periods when warranted, such as for permanent, irreversible and progressive conditions. Individuals living with advanced COPD, pulmonary fibrosis, cystic fibrosis or other irreversible respiratory diseases should not face repeated requests to prove the continued existence of conditions that are permanent by definition.

CMS should remove the arbitrary twelve-month limitation on claims and encounter data used to establish medical frailty. Many clinically relevant diagnoses remain fully supported by medical documentation well beyond one year, and other CMS programs, including the Chronic Conditions Data Warehouse, routinely rely on longer lookback periods to identify chronic conditions. Allowing states to use older, clinically relevant information would reduce unnecessary paperwork, improve administrative efficiency and decrease inappropriate coverage losses among individuals with serious and chronic lung diseases.

Other Specified Exclusions

1. *Finalize language prohibiting states from assessing compliance with work reporting requirements for Specified Excluded individuals at application, renewal or more frequent verifications.*

The Lung Association supports CMS's recognition that Specified Excluded individuals are not required to demonstrate compliance with work reporting requirements as a condition of eligibility, and states may not require such individuals to demonstrate compliance at application, renewal or more frequent verification. Individuals with serious and chronic lung diseases who qualify for an exclusion should not be subjected to additional compliance assessments that create unnecessary administrative burdens, confusion and risk inappropriate coverage loss.

2. *Remove language allowing states to impose minimum time commitment requirements for participation in drug addiction or alcohol treatment programs.*

CMS should eliminate the provision allowing states to narrow the exclusion for individuals participating in drug addiction or alcohol treatment by imposing minimum time commitment requirements for participation. Congress established this exclusion without imposing hour thresholds or minimum participation periods. Additional verification requirements will create unnecessary paperwork and place individuals, including those in evidence-based tobacco cessation treatment programs, at risk of losing coverage.

3. *Finalize policies recognizing a broad range of caregiving scenarios and arrangements.*

Individuals living with serious and chronic lung diseases, including both children and adults, often depend upon caregivers to help manage complex treatments, coordinate care and provide assistance with daily activities. The Lung Association supports CMS's approach, consistent with H.R. 1, to cover a broad range of caregiving scenarios and arrangements that reflect the different needs of families and communities. The Lung Association recommends CMS finalize policies allowing multiple caregivers in a single household to qualify for the caregiver exclusions, clarifying that parents eligible for the exclusion may include those who live or do not live with a child and adopting the existing federal definition of "caretaker relative" (in §§ 435.110 and 435.4), since states are already familiar with applying it when determining Medicaid eligibility for parents and other family caregivers.

Short-Term Hardship Exceptions

1. *Allow hardship exceptions for events occurring either during the month of application or the preceding months.*

The short-term hardship exceptions established in H.R. 1 are an important safeguard to ensure that eligible individuals do not lose Medicaid coverage during periods of acute illness, family

medical crises or other temporary disruptions. The Lung Association appreciates CMS's recognition that Congress intended to protect individuals who experience temporary circumstances that prevent compliance with work reporting requirements. However, the Lung Association is concerned that the IFR limits the evaluation of eligibility for certain short-term hardship exceptions to events occurring during the one- to three-month lookback period preceding a Medicaid application, rather than also recognizing qualifying events occurring during the month of application itself. As drafted, the rule creates an operational flaw that will deny relief to individuals who become hospitalized or experience a serious medical event during the month they apply for Medicaid.

Patients experiencing severe asthma attacks, pneumonia, respiratory failure, lung cancer surgery or COPD exacerbations may apply for Medicaid while hospitalized. Under the current policy, many would be denied the hardship exception because the qualifying hospitalization did not occur during the month preceding application. This result is inconsistent with congressional intent and undermines the very purpose of the hardship exception. CMS should revise the hardship provisions to allow individuals to qualify based on events occurring either during the month of application or the preceding month(s).

2. *Finalize the interpretation allowing hardship exceptions for situations in which a dependent is traveling for medical care, even without the parent or guardian.*

CMS should finalize its interpretation allowing hardship exceptions for situations in which a dependent is traveling for medical care, even if the parent or guardian is not physically traveling with the child. This interpretation appropriately reflects the realities faced by families managing serious medical conditions. Specialized pulmonary care, pediatric respiratory specialists, lung transplantation services and certain cancer treatments are frequently available only at regional or national centers of excellence. Families often coordinate complex caregiving arrangements that may not require every caregiver to travel but nevertheless significantly disrupt employment, transportation, childcare and household responsibilities.

Verification, Compliance and Due Process

The Lung Association is deeply concerned that verification, compliance and noncompliance procedures established in the IFR will create unnecessary administrative barriers that will result in eligible individuals losing Medicaid coverage. The IFR, however, significantly narrows flexibility provided in H.R. 1 by limiting the use of self-attestation, imposing repeated verification requirements and creating compliance processes that are likely to result in coverage losses unrelated to an individual's eligibility.

1. *Preserve states' ability to accept self-attestation to verify medical frailty exclusions.*

The Lung Association strongly urges CMS to preserve states' ability to use sworn attestation to verify compliance and medical frailty status, as expressly permitted by H.R. 1. Congress included sworn attestation as an important implementation tool because it recognized that administrative complexity can become a barrier to coverage. The statute provides states with flexibility to accept sworn attestations, reflecting an understanding that eligibility systems must be accessible and workable for patients, states and providers.

Evidence from prior work reporting requirement demonstrations, including Georgia's current demonstration, shows that paperwork failures, rather than ineligibility, frequently drive coverage losses.[8] CMS's own research similarly demonstrates that many Medicaid beneficiaries struggle to understand whether they qualify for statutory exclusions.[9] Sworn attestation is particularly important for individuals with serious and chronic health conditions. For example, a patient with severe asthma, COPD or pulmonary fibrosis may receive care from multiple providers across different systems. Requiring patients to obtain and submit documentation from these providers creates unnecessary burdens for patients and increases administrative workload for clinicians.

The IFR sharply limits states' ability to accept sworn attestations to verify medical frailty after January 1, 2028. This approach is inconsistent with the flexibility Congress provided and risks creating significant administrative burdens without improving program integrity. CMS should allow states to continue using sworn attestation to verify compliance and medical frailty status, consistent with the flexibility Congress explicitly provided in H.R. 1.

2. *Strengthen due process protections.*

The Lung Association also urges CMS to strengthen protections by (1) requiring states to maximize *ex parte* verification before requesting documentation from beneficiaries; (2) eliminating the option for states to send prepopulated forms and noncompliance notices contemporaneously, which will create unnecessary confusion; (3) extending presumptive mailed-notice receipt timelines to ensure meaningful opportunities to respond; (4) finalizing the provision confirming that compliance months need not be consecutive; and (5) finalizing the requirement for states to continue Medicaid coverage throughout the full noncompliance notice period and until a final determination of ineligibility has been made. These due process protections are essential to prevent eligible individuals from losing healthcare coverage because of administrative errors or misunderstandings.

Outreach and Education

1. *Require states to conduct robust, targeted outreach only to populations subject to work reporting requirements.*

The Lung Association recognizes that clear, timely and accessible communication will be essential to the implementation of Medicaid work reporting requirements under H.R. 1. Effective outreach and education are necessary to ensure that individuals understand whether they are subject to reporting requirements, whether they qualify for exclusions or hardship exceptions and what steps they must take to maintain coverage. CMS should require states to target outreach only to populations that are actually subject to work reporting requirements. Sending notices to individuals who are categorically exempt will create unnecessary confusion and may inadvertently cause eligible beneficiaries to lose coverage.

CMS should also require states to provide eligibility assistance through multiple, accessible communication channels and extended hours so that working families and individuals managing serious chronic illnesses can receive timely assistance. During Arkansas's Medicaid work reporting requirement demonstration, many beneficiaries lost coverage after failing to understand reporting obligations or successfully complete required reporting processes.[10,11,12] The experience demonstrated that communication failures can become a major driver of coverage loss even among eligible individuals.

CMS should require states to:

- Clearly explain whether the individual is subject to work reporting requirements.
- Clearly identify available exemptions and hardship protections.
- Explain how individuals can request assistance or submit information.
- Use plain language and accessible formats.
- Provide consistent messaging across written notices, websites, call centers and community partners.
- Monitor outreach effectiveness and evaluate whether communication failures contribute to inappropriate coverage losses.

Data Reporting and Transparency

1. *Require states to collect, analyze and publicly report detailed, disaggregated data.*

The Lung Association strongly supports robust transparency measures to monitor the implementation and impact of Medicaid work reporting requirements established under H.R. 1. Given the scope and complexity of these new requirements, comprehensive and publicly available data will be essential to understanding how implementation is functioning and whether eligible individuals are losing Medicaid coverage because of administrative barriers rather than ineligibility. CMS should require states to collect, analyze and publicly report detailed, disaggregated data regarding implementation outcomes, including information about exclusions, hardship exceptions, compliance rates, application processing times, *ex parte* renewals, procedural disenrollments and coverage losses. Publicly available data will be critical for CMS,

states, Congress, patient advocates and the public to determine whether implementation is preserving access to care for patients or creating new barriers and coverage losses for eligible individuals.

Good Faith Effort Exemptions

1. *Grant good faith effort exemptions to all states that demonstrate the need for additional time to implement work reporting requirements.*

The Lung Association urges CMS to recognize the significant implementation challenges facing states and grant good faith effort exemptions to all states that demonstrate additional time is necessary to build functional and consumer-friendly systems. H.R. 1 established an already tight timeline for states to implement work reporting requirements by January 1, 2027, and many states have already invested significant resources based on earlier CMS guidance indicating, for example, that diagnostic codes alone could be used to identify individuals who quality for the medical frailty exclusion. The interim final rule will require states to redesign policies, data systems and administrative processes on an extremely compressed timeline. Rushed implementation will increase administrative errors, burden states and providers and place eligible individuals at risk of unnecessary coverage losses that create grave risks for their health. Granting flexibility to states that need additional implementation time is fully consistent with the statutory standard enacted by Congress and will help avoid preventable disruptions to Medicaid coverage.

Conclusion

Thank you for the opportunity to provide these comments. The Lung Association is committed to working with CMS and states to carefully and thoughtfully implement H.R. 1 in a manner that protects patients' access to care to the maximum extent possible. Many of the policies in the IFR would do the opposite. By imposing restrictions beyond those enacted by Congress and creating unnecessary administrative barriers, the rule will lead eligible individuals to lose coverage. The Lung Association urges CMS to withdraw the interim final rule and issue a revised rule that implements H.R. 1 while protecting patients' access to Medicaid.

Sincerely,

American Lung Association

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