



Medical Frailty Exemption Guide:

A 2025 federal law created new work requirements for Medicaid. But if someone is "medically frail," they're excused from those work requirements; the first time this kind of exemption has applied nationwide like this.

H.R.1 includes an exclusion from work reporting requirements for individuals who are medically frail, defined as those who have a “serious or complex medical condition,” “substance-use disorder (SUD),” “disabling mental disorder,” or “disability.” The final rule adds a new requirement that individuals who otherwise would be classified as medically frail must meet to qualify for an exclusion. Along with having a qualifying condition, individuals must demonstrate that the condition “significantly impairs” their ability to comply with the work reporting requirements.

The CT Health Policy Project estimated that roughly 110,000 Connecticut adults could lose Medicaid coverage once the new work requirements take effect.

Who does this apply to?

The medical frailty exemption is relevant primarily to adults who would otherwise be subject to Medicaid work requirements. In Connecticut, the new rules generally apply to certain HUSKY D adults ages 19–64. People who qualify for other exemptions, such as certain parents/caregivers, pregnant or postpartum individuals, veterans with qualifying disability ratings, and people recently released from incarceration, may not need to rely on the medical frailty exemption at all.

The requirement that a medical condition must also limit a person's ability to work was not part of the original HR-1 statute Congress passed; CMS added it through its interim final rule.

Who counts as medically frail (federal rules)

There are five groups:

1. People who are blind or disabled
2. People with a physical, intellectual, or developmental disability that makes it hard to do daily tasks (like bathing, eating, getting dressed)



3. People with a substance use disorder
4. People with a disabling mental health condition
5. People with a serious or complex medical condition

Again, fitting into one of these groups isn't enough on its own. States also have to check whether the person's condition actually makes it hard for them to meet the work/activity requirements. The condition has to "significantly impair" the person's ability to comply. For substance use disorder specifically, it doesn't matter if the person is currently in treatment; they still qualify. But if someone's been in recovery for 5+ years, they no longer qualify under this category.

Problems this creates

States already had a hard deadline, January 1, 2027, to get new work-requirement systems running. The extra "significantly impairs" step makes that harder, and states risk fines if audited and can't show good enough evidence for their decisions. Because the rules are more complicated now, it'll also be harder for states to explain them clearly to applicants, which could mean more people losing coverage by accident. Notably, 25 states plus D.C. have sued CMS over parts of this rule, including the work-limitation requirement itself. A judge declined to block the rule while the case continues, so it's still in effect for now.

What this looks like in Connecticut

- CT's Department of Social Services estimated that about 57,000 residents would qualify as medically frail and be exempt.
- A separate June 2026 analysis of medical claims data found 206,000 people who could potentially qualify.
- State lawmakers asked Governor Lamont's administration this spring to investigate options, including maybe a state-funded backup insurance program for people who lose HUSKY D coverage.
- Rep. Lesser (D-Middletown) said helping this group will likely be a top priority when the legislature's next regular session starts January 6.

How states decide who qualifies



States build their own lists of diagnosis codes to identify potentially qualifying people, for all five categories. These lists must be updated regularly and can be audited. If a state can't back up why someone was marked medically frail, it risks financial penalties.

CMS didn't publish one master list of qualifying conditions; it gave examples but left the details to each state, saying a single national standard would be too hard to set. Substance use disorder counts even without active treatment (except 5+ years in recovery); and "serious or complex" conditions now require a stricter, more severe threshold than some other common definitions, which instead ask whether losing coverage would seriously harm the person's health.

For every category, states must confirm two things: does the condition qualify as medically frail, AND does it get in the way of the person working or doing the required activities. A diagnosis code alone can't be used to verify this; something must show the condition limits the person's ability to comply.

Documentation & submission process

- States check existing records first. They must look at Medicaid claims/encounter data from the last 12 months; anything older doesn't count.
- If that's not enough, the state reaches out and gives the person at least 30 days to submit what's needed, like a provider form or medical records.
- Self-attestation (just saying "I qualify," no proof) is allowed through 2027, especially for new applicants where the state has no data yet.
- Starting January 1, 2028, self-attestation only counts once per person for their whole enrollment period — after that, they need real documentation.
- If someone genuinely can't get documentation (e.g., an unpaid caregiver for an elderly parent), the state can't deny or cut coverage just for missing paperwork — it must accept other information, though each state decides what "enough" means.
- Frailty status gets rechecked at least every 12 months (some states may do it every 6).
- Doctors are paid through Medicaid to treat the same patients whose coverage depends on the form, which can be a conflict of interest. Some doctors have historically resisted declaring a patient "too impaired to work" since that's outside normal clinical practice.



If someone is not recognized as medically frail

Individuals who believe DSS incorrectly determined that they do not qualify may have rights to challenge an eligibility determination through the Medicaid notice and fair-hearing process. Patients should review their notice carefully and follow the appeal instructions and deadlines provided by DSS.

Clinical / assessment language cues

A diagnosis alone won't satisfy the new rule; documentation needs to connect the diagnosis to a specific, concrete limitation. Instead of "patient has chronic pain," something like "pain prevents standing for more than an hour" holds up better. A few patterns that tend to help:

- Naming a specific functional limit tied to the actual work-related demand, not just the general symptom.
- Noting whether the limitation is temporary or permanent, with a rough timeframe if temporary.
- Being clear on whether the assessment is based on an exam, the patient's own report, or both.
- Distinguishing between a full restriction (can't do the activity at all) and a partial limitation (can do it, just slower or with less capacity).

CMS hasn't endorsed any specific clinical tool or scoring method, so states can use whatever assessment approach they want as long as it fits the federal categories. And well-managed chronic conditions are a tricky case. Someone whose serious condition is stable because consistent treatment might look "less impaired" on paper, even though losing coverage could cause them to decompensate. Physician and advocacy groups have flagged this as a flaw; if documenting a stable-but-serious condition, it may help explicitly note that the stability depends on continued treatment access.

Sources:



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