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The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-2454-IFC. Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz:

On behalf of the American College of Chest Physicians (CHEST), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) interim final rule (IFR) implementing Medicaid community engagement requirements under Public Law 119-21. CHEST represents more than 19,000 physicians and allied health professionals dedicated to improving the prevention, diagnosis, and treatment of respiratory disease, critical illness, and sleep disorders. Our members care for patients across the continuum of health, from preventing tobacco-related disease and managing chronic illnesses such as COPD, asthma, and interstitial lung disease, to treating life-threatening conditions including sepsis, respiratory failure, pulmonary embolism, and acute respiratory distress syndrome. The patients we serve include those living with some of the nation's most prevalent and preventable diseases, as well as those facing rare, rapidly evolving, and highly complex illnesses that demand continual scientific discovery and clinical innovation.

CHEST's interest in this rule centers on how implementation affects patients with chronic respiratory disease, critical illness, and sleep disorders, as well as the clinicians who care for them. Whatever policy framework CMS adopts, implementation should preserve uninterrupted access to medically necessary care, minimize unnecessary administrative burden, and reflect the clinical realities of complex chronic illness.

Existing evidence reinforces concerns that this rule will disrupt continuity of care for medically vulnerable patients, increase administrative burden on patients and clinicians, and contribute to delays in medically necessary care.[1,2] Analyses of Georgia and Arkansas' implementation of work requirements found that pairing Medicaid expansion with work requirements did not produce meaningful gains in employment and added substantial administrative cost and complexity.[1,2]

CHEST urges CMS to revise the IFR to better reflect the clinical realities of patients with chronic respiratory disease, critical illness, and sleep disorders with the goal of minimizing avoidable barriers to continuous care by: (1) adhering to the Congressionally established medical frailty exclusion, treating a qualifying diagnosis, condition, or status as sufficient, and preserve self-attestation while minimizing administrative burden on patients and clinicians; (2) providing states with good-faith-effort exceptions in line with the standards Congress established; and (3) realigning the verification and assistance regulations to reflect the practical realities of procuring third-party records and receiving timely assistance from state agencies. We address each issue below through the lens of the patients that CHEST members typically treat.

1. Restore the Congressionally Established Medical Frailty Exclusion

CHEST recommends that qualifying diagnoses, conditions, or clinical status remain sufficient to establish the medical frailty exemption. Adding additional functional documentation requirements risks creating barriers for patients whose disease burden is well recognized clinically but difficult to capture through a single administrative assessment. Overdependence on health care professionals to provide verification paperwork would force patients to schedule additional appointments, which are already in a limited supply, solely to obtain eligibility documentation.

Chronic respiratory disease does not fit a single, static impairment test

Patients with chronic obstructive pulmonary disease, interstitial lung disease, pulmonary hypertension, and patients dependent on home oxygen or home mechanical ventilation frequently experience functional limitations including breathlessness, hypoxemia, and fatigue that vary day to day and are difficult to reduce to a single, static determination. A patient may appear stable on a singular claim or encounter record and still be unable to sustain 80 hours of monthly work, education, or community engagement activity. Requiring additional functional documentation beyond an already qualifying diagnosis risks excluding patients whose clinical limitations fluctuate over time despite substantial disease burden.

A national analysis of adults at risk of Medicaid disenrollment under work requirements found that approximately 8.3 million beneficiaries would be at risk of losing coverage due to lacking enough documented work hours, and that this group had significantly higher rates of physical, neuropsychological, and independent-living impairment than beneficiaries who met the requirements, including substantially higher rates of poor physical health and poor mental health.[3] For patients that do not qualify for formal disability protections, but have substantial health limitations, the consequences of losing access to care may be particularly severe.

Asthma illustrates how a diagnosis-based exclusion protects patients

An analysis focused specifically on Medicaid beneficiaries with asthma found that 61.2%, or approximately 2.2 million adults nationally, would be at risk of disenrollment under national work requirements. [4] Among these beneficiaries, more than half used daily preventive asthma medication, nearly two-thirds had used a rescue inhaler within the prior three months, and 48% reported an asthma exacerbation in the past year. This population had significantly higher rates of poor physical health and poor mental health as well as greater impairment across physical, neuropsychological, and independent-living measures. [4] Asthma control depends on consistent access to maintenance medications and timely treatment of exacerbations. A diagnosis of asthma alone would likely be insufficient to meet additional impairment requirements, even though the underlying disease burden, exacerbation risk, and disability are substantial and well documented in the clinical literature.

Sleep disorders carry functional impact that a diagnosis code alone will not convey

Conditions such as severe obstructive sleep apnea, narcolepsy, and other hypersomnolence disorders can significantly impair a patient's ability to work or attend required activities safely. These limitations are rarely reflected in claims data and are not always captured through standard diagnostic coding. Requiring a separate showing of impairment, on top of the diagnosis itself, would create exactly the kind of avoidable documentation burden the exclusion was meant to prevent.

2. Grant Good-Faith-Effort Exceptions According to the Statutory Standard

Patients cared for by CHEST members often experience fluctuating health status that is difficult to predict or capture through fixed administrative processes. Individuals recovering from critical illness may experience months of variable recovery following sepsis or prolonged mechanical ventilation. Patients with chronic respiratory diseases such as COPD, interstitial lung disease, and pulmonary hypertension frequently have periods of stability interrupted by acute exacerbations that temporarily but substantially impair function. Likewise, patients with severe sleep disorders may experience significant functional limitations that are not consistently reflected in claims data or standard diagnostic coding. These clinical realities increase the risk that otherwise eligible patients could experience coverage interruptions despite ongoing medical need.

CHEST encourages CMS to ensure that implementation recognizes the episodic and variable nature of these conditions so that medically vulnerable patients are not disadvantaged by administrative processes that assume static functional status. States may need additional time to build systems that reflect new compliance burdens.

Critical illness is unpredictable, and compliance verification must accommodate that reality

Survivors of sepsis, acute respiratory distress syndrome (ARDS), and prolonged mechanical ventilation often experience post-intensive care syndrome and ICU-acquired weakness that can persist for months after discharge, with recovery trajectories that are difficult to predict at the time of an eligibility determination. The effects of critical illness on patients and their families extend beyond the physical, cognitive, and psychological impairments, as captured in standard post-intensive care syndrome frameworks.[5] Evidence of patients experiencing significant spiritual distress and bereavement following critical illness underscores how insufficiently any documentation-based system can capture the true burden of recovery. [5] Critical illness itself is unplanned and can interrupt a patient's ability to meet a documentation deadline or maintain continuous compliance, regardless of how the patient's condition was coded in the months before or after the event. States need the flexibility the good-faith-effort exception provides to build systems that can account for this kind of episodic, unplanned health event, rather than being forced into rigid verification timelines before those systems exist.

More frequent redeterminations will compound the risk of losing medically complex patients to churn

Beyond community engagement verification itself, CHEST is concerned about the interaction between this rule and the law's shift to more frequent eligibility redeterminations for beneficiaries. Less frequent redeterminations would help stabilize coverage and reduce disenrollment-and-reenrollment "churn," while more frequent checks are likely to increase administrative hurdles and cause eligible beneficiaries to lose coverage inappropriately. For patients who depend on continuous access to pulmonary rehabilitation, home oxygen and ventilator equipment, overnight sleep studies, and ongoing critical care follow-up, even brief procedural coverage gaps can meaningfully disrupt disease management and increase the risk of exacerbation or hospitalization. A good-faith-effort standard that gives states real time to build systems equal to a more frequent redetermination compliance burden is essential to preventing that outcome.

Continuous insurance coverage is an important enabler of continuous clinical care, particularly for patients with chronic respiratory disease who depend on uninterrupted access to medications, oxygen therapy, pulmonary rehabilitation, sleep evaluation, and specialty follow-up.

3. Revise Verification and Assistance Provisions to Reflect Practical Realities

CHEST urges CMS to ensure that verification requirements reflect how complex medical information is generated, documented, and shared across the health care system. The significant additional administrative and resource burdens on states and clinicians must also be considered.

A patient's clinical picture is often fragmented across specialists and care settings

A patient's relevant clinical picture is often distributed across a pulmonologist, an intensivist, a sleep medicine specialist, home health and durable medical equipment suppliers, and hospital records from one or more admissions. No single claim or encounter captures the combined effect of oxygen dependence, sleep study findings, pulmonary function testing, and hospitalization history. The asthma data above draw on maintenance medication use, rescue inhaler fills, and exacerbation history that typically live in different parts of a patient's record. Single-source verification approaches may not fully reflect the clinical status of medically complex patients.

Administrative burden on an already strained workforce undermines both verification and care

Pulmonary, critical care, and sleep medicine physicians already face significant documentation burden and workforce shortages, particularly in critical care and rural practice settings. Additional documentation requirements divert limited clinician time away from direct patient care and risk worsening burnout in specialties essential to the care of medically complex Medicaid patients. As CMS considers verification requirements, CHEST encourages careful consideration of the cumulative burden placed on both clinicians and the patients who depend on timely access to their care, emphasizing that verification processes should not depend primarily on health care professionals producing new documentation not already part of routine care.

Patients need confidence that candor with their clinician will not jeopardize coverage

Patients managing chronic respiratory disease or sleep disorders need to speak candidly with their clinicians about symptoms, functional decline, and daily limitations. If patients perceive that these disclosures could affect their coverage, they may be less forthcoming. The resulting erosion of trust can compromise both clinical care and the accuracy of any resulting eligibility determination. CMS should ensure that beneficiary assistance channels are realistically accessible.

Conclusion

CHEST's comments are grounded in the clinical experience of physicians caring for patients with chronic respiratory disease, critical illness, and sleep disorders. These patients often experience fluctuating disease burden, receive care across multiple clinicians and settings, and depend on uninterrupted access to medically necessary services to prevent exacerbation, hospitalization, and avoidable complications.

As CMS considers the final rule, CHEST encourages careful consideration of the clinical realities described throughout this letter. Policies affecting Medicaid coverage should account for the variable nature of serious respiratory illness, the complexity of caring for medically vulnerable patients, and the importance of maintaining continuity of care while minimizing unnecessary burdens on patients and the clinicians who care for them.

CHEST appreciates the opportunity to comment and remains available as a clinical resource to CMS as it finalizes this rule.

Sincerely,

American College of Chest Physicians (CHEST)

References

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