

Next PACE Network Call: October 20 @ 1 p.m. ET; Register [here](#)

Next Adult Day Network Call: September 24, 2026 @ 1 p.m. ET; Register [here](#)

Weekly National Policy Pulse Calls. Join more than 1000 of your LeadingAge peers for our National Policy Pulse calls where we keep members equipped to navigate the ever-evolving landscape of aging services national policy. The calls are on Mondays at 3:30 p.m. ET. If you're interested in signing up for these members-only calls, please sign up using [the link on our National Policy Pulse webpage](#).

CMS Releases Guidance to States on Medicaid Work Requirements and Medical Frailty. The Centers for Medicare and Medicaid Services (CMS) held a webinar for states, where CMS shared information on the application of medical frailty exemptions within the new work reporting requirements. Work reporting requirements are applicable to the Medicaid Expansion population, those between 19 and 64, with income slightly over legacy eligibility requirements. During the call, CMS outlined optional steps states can take to verify medical frailty for exemption from work requirements. The slides provided a three-tiered option as an available framework for establishing exemption. CMS shared potential data sources and medical codes for consideration, as well as examples in an effort to help states understand their options and obligations. Though more information was and remains necessary on how CMS intends to support states in implementing community engagement medical frailty exemptions, the slides provide little new information, with examples not addressing the harder-to-determine grey areas, but providing obvious examples of exemption eligibility within tiers. Additionally, the guidance provides no information to states about how claims data can actually demonstrate an individual's ability to work, as was required by the interim final rule. The [slides](#) and call come quite late in the timeline for states. With the January 1 compliance date, states are already communicating with enrollees to whom the new requirements apply. Pivoting to a new policy practice on medical frailty exemptions would add complexity to an already capacity-limited policy and timing challenge. States opting to accept self-declaration of exemption eligibility could find limited utility in the CMS presentation, with longer timelines to finalize exemption criteria.

CMS Report on MFP Highlights Successful, Though Stagnant Program. The Money Follows the Person Demonstration (MFP), initially introduced in late 2007, was established by Congress to provide enhanced funding to transition individuals for whom community living was desired and suitable from nursing homes into their homes in the community. The program has successfully transitioned more than 144,600 individuals through 2025. Growth from 2023 to 2024 was above 8%, while growth from 2024 to 2025 stagnated to .1%. CMS indicates the report should be available [here](#), though it does not appear the resource was added upon the writing of this blurb. Despite the more recent slowing in transition numbers, the administration's desire to publish the report and include an email release highlighting notable growth from '23 to '24 seems to indicate a broader support for the program. MFP is a voluntary program, with most states participating at some point over the history of the program. Currently the program is reauthorized through federal fiscal year 2027, though not guaranteed beyond September 30, 2027. More on MFP is available [here](#).

CDC Releases Updated Return-to-Work Guidance. The Centers for Disease Control & Prevention (CDC) has released updated guidance outlining recommendations for [work restriction for healthcare personnel](#) related to respiratory viruses. LeadingAge has vigorously advocated for such guidance for years. The guidance replaces the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to

SARS-CoV-2 previously used for work restrictions for healthcare personnel exposed to or infected with COVID-19. The new guidance is based on recommendations from CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), approved during the Committee's last meeting in November 2024 before it was disbanded in March 2025. The new guidance applies to respiratory illnesses "not addressed elsewhere" in CDC guidance, including flu, respiratory syncytial virus (RSV), and COVID-19. According to this guidance, asymptomatic healthcare personnel who have been exposed to a respiratory illness do not need to be restricted from work but should wear source control from the day of first exposure through at least the fifth day after exposure. Healthcare personnel with a suspected or confirmed viral respiratory infection should be restricted from work until all four conditions are met:

- At least three days have passed since symptom onset (or first positive test, for asymptomatic infections),
- The individual is fever-free for at least 24 hours without the use of fever-reducing medications,
- Symptoms are improving, and
- The individual feels well enough to return to work.

Testing to determine the specific respiratory illness is not required; however, CDC recommends following guidance specific to the respiratory pathogen should the individual opt for testing. LeadingAge is very pleased to see this updated guidance after years of advocacy and urges CDC to similarly update transmission-based precautions for healthcare settings and retire outdated guidance for SARS-CoV-2 infections among patients in healthcare settings, including residents in nursing homes.

LeadingAge Submits Comments on the CY2027 Physician Fee Schedule. LeadingAge submitted [comments](#) on September 14, 2026, on a number of proposals and requests for information contained in the CY2027 proposed rule concerning payment policies under the physician fee schedule (PFS) and other changes to Part B payment and coverage policies. In our comments, we supported CMS' proposal to equalize the rate for nursing facility visits and CMS' proposed transition timeline for Fast Healthcare Interoperability Resources-based quality reporting that would account for variations across programs. However, we expressed concerns over CMS' proposal to only allow payment for remote patient monitoring services when they are furnished by employees of the practice rather than third party contractors, as that could result in reduced access to care. Additionally, we provided a number of recommendations relating to how CMS could reconfigure care management codes for longitudinal care management of senior living residents, including not making it contingent upon physical employment of or primary care practitioner ownership of the workforce. With respect to palliative care, we emphasized the need for CMS to provide a sustainable billing pathway – in particular, the creation of a distinct code that identifies specialty palliative care and is paid for through a monthly bundle that sustains the non-billing members of the interdisciplinary team. Lastly, with respect to the Medicare Shared Savings Program Accountable Care Organizations (SSP ACOs), we provided recommendations that would help to expand partnerships between SSP ACOs and aging service providers including how residents could be aligned to the ACO and opportunities for aging services providers to receive financial incentives for participating in these ACOs.

Last Weekly: [Medicaid, HCBS, and PACE Weeklies](#)