The Disability and Aging Collaborative &

CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

Submitted via Regulations.gov

July 31, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-8016

Re: RIN 0938-AV98; CMS-2454-IFC
Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Dr. Oz:

The 53 undersigned members of the Long Term Services and Supports, Health, and Rights Task Forces of the Consortium for Constituents with Disabilities (CCD) and the Disability and Aging Collaborative (DAC) appreciate the opportunity to comment on the Interim Final Rule with comment period "Medicaid Program; Community Engagement Requirement for Certain Individuals" ("Interim Final Rule" or IFC) implementing the Medicaid community engagement requirements under section 1902(xx) of the Social Security Act, as added by section § 71119 of the "One Big Beautiful Bill Act" (OBBBA) (Pub. L. 119-21).[1]

CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. DAC is a coalition of national and state organizations that work together to advance long-term

[1] Pub. L. No. 119-21, § 71119 139 Stat. 72 (2025) (hereinafter P.L. 119-21).

services and supports policy at the federal level. DAC and CCD have a longstanding history of advocating for people with disabilities and aging adults to access needed care in their communities, and supporting the family caregivers and care workers who provide that care.

We write to express our deep concern regarding the impact of the Interim Final Rule with Comment Period (IFC) on individuals with disabilities, older adults, and family caregivers and our strong opposition to several policies in the IFC, including expanded restriction and administrative barriers that will put coverage at risk for our constituencies. These burdens disproportionately impact older adults and people with disabilities who have a harder time finding work and maintaining employment due to functional limitations, changing work or caregiving responsibilities, and fluctuating health. For example, the vast majority of older adults ages 50-64 enrolled in Medicaid expansion who are retired or not working (86%) report having a health condition that prevents them from working.[2]

The provisions of the IFC go far beyond the requirements of section § 71119 of OBBBA in several areas. OBBBA included several exemptions, exclusions, and exceptions from community engagement requirements that the IFC notably narrows, including in ways that exceed the Secretary's authority. Expanded restrictions include new rigid disability standards in relation to community engagement, relationship and residency tests for caregivers, and burdensome verification processes that risk improper terminations of coverage and disrupted access to care for people whom Congress promised to protect, including people with significant disabilities and medical conditions. The consequences of such coverage losses—even temporary losses due to lapses in documentation—can be catastrophic and may result in further disability or death.

Applicable Individuals

OBBBA imposes community engagement requirements on applicable individuals who are either enrolled in Group VIII coverage (also known as Medicaid expansion) or individuals enrolled in a Section 1115(a)(2) demonstration waiver that provides minimum essential coverage (MEC) to adults age 19-64 who are not eligible for Medicare, pregnant, or ineligible for Medicaid under the state plan. The IFC confirms these groups will be subject to the community engagement requirements but also notes that

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[2] Tavares, J., Cohen, M., & LeadingAge LTSS Center @UMass Boston. (2025). *What are Socio-Demographic Characteristics of Medicaid Expansion Population compared to Non-Expansion Medicaid Population age 50 to 64?* [slide 14] https://www.ltsscenter.org/wp-content/uploads/2025/04/Differences-between-Expansion-and-Non-Expansion-Medicaid-Beneficiaries-April-2025.pdf

1115(a)(2) waivers are incredibly broad and commits to a systematic review of 1115 waivers to determine the waiver populations considered applicable individuals.

Some of these section 1115 waivers, like the Georgia Pathways to Coverage or Wisconsin BadgerCare Reform waiver, were established by non-expansion states to cover the same population as Medicaid expansion but with lower income limits or other restrictions. In two instances, it is much clearer to determine that these enrollees are applicable individuals, as the state provided the 1115 as alternatives to expansion. However many other expansion states also have 1115 waivers that, as the IFC noted, include many specified excluded individuals, such as those enrolled in SNAP or TANF who may be subject to those programs' work requirements. There are over 65 approved 1115 waivers across 47 states, with another 35 waivers pending approval.[3] Implementing community engagement requirements for the Group VIII expansion population alone is a massive undertaking for states. Now, it seems most states, including expansion and non-expansion states, will likely have some 1115 populations who may be subject to the community engagement requirements as well. We ask that CMS quickly review all the 1115s and release the results of their review with a plain explanation quickly so states and advocates can be sure those populations are prepared to comply with the requirements. We also urge CMS to grant states good faith exemptions or provide additional time to implement community engagement requirements, particularly for these 1115 populations, given that CMS is providing states with only a few months' notice to determine if those populations are indeed applicable individuals.

The rule makes clear that individuals receiving services solely through a 1915(c) waiver are not applicable individuals. It is our understanding that this extends to other authorities states use to establish HCBS, such as 1915(i), 1915(j), and 1915(k). We further understand that since these individuals are not applicable individuals from the outset, these individuals would be identified as not applicable individuals at application and they would not have to be subject to further processes such as qualifying for a specified exclusion. It would be helpful for CMS to clarify if this is the case and we recommend that CMS require states to implement in this manner.

Populations receiving Medicaid under section 1115 waivers are very broad and include a wide range of services, which adds even more confusion in determining who is subject to the community engagement requirements. Some 1115(a)(2) waivers provide MEC to applicable individuals while those same individuals may receive HCBS through

[3] KFF. (2026, July 14). *Medicaid Waiver Tracker: Approved and pending Section 1115 Waivers by State*. KFF. https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

another 1115 authority. As noted in the preamble, such enrollees may meet the definition of applicable individuals but would be a specified excluded individual due to medical frailty.[4] HCBS enrollees, except for the new 1915(c)(11) authority established by OBBBA, by definition meet an institutional level of care. Thus they have high health and LTSS needs that are only met through Medicaid. If Medicaid were terminated for non-compliance with the community engagement requirements, it would greatly jeopardize their ability to achieve self-sufficiency and live independently, which CMS expressly states is the goal of community engagement.[5] Thus, we urge CMS to provide guidance to states ensuring all HCBS enrollees who do not receive MEC from the expansion or an 1115 do not need to prove an exception or exclusion to prove they are not applicable individuals. We further urge CMS to provide guidance to states ensuring all HCBS enrollees who do receive MEC from the expansion or an 1115 waiver containing applicable individuals, including those receiving both MEC and HCBS through 1115 waivers, are expressly excluded from the community engagement requirements as medically frail individuals.

Qualifying Activities

We appreciate that, as currently written, the IFC sets forward an expansive definition of qualifying activities. Nevertheless, some of the proposed definitions—particularly the proposed definition of "work program"—have caused significant confusion as to whether participation in common programs that promote disability employment, such as supported employment and vocational rehabilitation, will be considered "qualifying activities."

The Vocational Rehabilitation (VR) system is the nation's largest program to promote employment of people with disabilities, serving hundreds of thousands of people each year through a federal-state partnership model. State vocational rehabilitation agencies assist people with disabilities with vocational evaluation, training, education, coaching, exploration of assistive technologies, and job search, among other key services. Although the exact number of VR participants who are enrolled in the Medicaid expansion is unknown, it is undoubtedly high: VR eligibility does not mirror eligibility for SSI or SSDI and includes all people with disabilities who could benefit from vocational rehabilitation.

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[4] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348, 33354 (June 3, 2026) (interim final rule with comment) (hereinafter IFC) .
[5] *Id*. at 33450 ("The community engagement requirement has the potential to empower Medicaid beneficiaries through employment, education, or community service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency and independence").

Yet participation in vocational rehabilitation programs does not fit cleanly under any of the current definitions of qualifying activities outlined in 42 C.F.R. § 435.552(b).[6] Notably, this proposed definition includes work programs authorized under Title I of the Workforce Innovation and Opportunity Act (WIOA), but the VR system is authorized through Title IV of WIOA. While some aspects of these programs may be considered a "program of employment and training operated or supervised by a State or political subdivision of a State that meets standards approved by the Governor of the State," relying on this prong gives rise to unnecessary State-by-State variation and may not encompass all aspects of VR programs (such as vocational evaluations), making it difficult for agencies and Medicaid beneficiaries to understand whether their activities can be counted. CMS should clarify that all hours spent participating in VR programs can be counted as participation in work programs.

The IFC creates similar confusion for those participating in supported employment. Supported employment is a highly effective service that provides individualized supports, including on-the-job coaching and assistance, to help people gain and maintain competitive, integrated employment. People receiving supported employment services are, by definition, engaging in "[w]ork in exchange for money" and therefore should be able to count all such hours toward community engagement requirements. However, explanatory language in the IFC noting that "work programs" do not include supported employment has created significant confusion, leading many stakeholders to question whether supported employment is meant to be a qualifying activity at all. CMS should clarify that hours spent on supported employment are considered "work" under § 435.552(b).

The definition should also be updated to include other job search activities, as well as tasks instrumental to participation in employment such as transportation. Such tasks are necessary in order to find and maintain employment; moreover, people with disabilities are especially likely to spend significant amounts of time on these tasks. For someone with a disability, finding and getting to work may require hours of arranging and waiting for paratransit services. People with disabilities may also take far longer to find employment than people without disabilities, even in localities with a relatively low overall unemployment rate.

While these clarifications will help ensure that people do not unnecessarily lose their Medicaid coverage, any such clarifications *must* be paired with the recognition that engaging in 80 hours of vocational rehabilitation, supported employment, job search and/or job-related activities does not disqualify a person with a disability from later qualifying as an excluded individual. CMS must therefore rescind its explanatory

[6] 42 C.F.R. § 435.552(b).

language stating that someone who is “able to demonstrate community engagement by performing 80 hours per month of qualifying community engagement activities, notwithstanding their physical, mental, or other behavioral health condition,” cannot be considered an excluded individual. Such a position fundamentally ignores the nature of disability and the need for continued service availability in order to facilitate continued engagement, and disincentivizes engagement among people with disabilities.

A disabled person’s ability to participate in work-related activities can vary from month to month; moreover, most of these activities are only possible when the relevant supports are actually available. For example, a person with a disability may spend 80 hours in one month working with their VR agency undergoing vocational evaluations and participating in job counseling; the next month, the same agency may determine that the person is *too disabled* to benefit from VR services. If this person’s ability to participate in 80 hours of vocational rehabilitation is later used to justify a finding that they are not an excluded individual, the result will effectively be punishment for trying to use the VR system to find a job. Similarly, someone who participates in supported employment for 80 hours in one month may be unable to participate in supported employment the next month if they lose access to services or to accessible transportation. Due to the variability of individuals’ disabilities and health conditions and variability in access to supports, we urge CMS to issue guidance that any history of participating in these programs will not be held against individuals seeking the medically frail exclusion.

Specified Excluded Individuals (except for Medically Frail)

Veterans with a Total Disability

OBBBA establishes a veteran with a disability rated as total under section 1155 of title 38,[7] United States Code qualifies for a specified exclusion. The definition at section 1155 of title 38 directs the VA secretary to adopt a disability rating system based upon the average impairments of earning capacity resulting from such injuries in civil occupations. The highest grade is what is known as total disability.[8]

CMS has indicated that it will be entering into a data-sharing agreement with the VA to assess eligibility for this specified exclusion without the need for information from the individual. We ask CMS to enter into this data-sharing agreement as soon as possible and to provide a timeline for how soon this data-sharing agreement will be operational.

As for all the specified exclusions, we ask that CMS and the states minimize the responsibility of individuals to provide information as much and as soon as possible.

[7] 42 C.F.R. § 435.554(c)(4)
[8] 38 U.S. Code § 1155

We also ask CMS and the states to make veterans with disability ratings less than total aware of the other exclusions, exceptions, and exemptions, especially the medically frail exclusion. We would like CMS to confirm that veterans with a disability rating less than total may be eligible for the medically frail exclusion and that processes are put in place to ensure they are properly evaluated.

In Compliance with TANF Work Requirements

OBBBA creates a specified exclusion for individuals in compliance with Temporary Assistance for Needy Families (TANF) work requirements.[9] Because this exclusion is defined by compliance with an entirely separate program, an individual can lose it without any failure related to Medicaid. We ask that any good cause or disability-related exception that preserves an individual's TANF compliance status should automatically preserve their status under this exclusion for Medicaid purposes. We ask that this be done without requiring a separate showing. Furthermore, we ask that a temporary lapse in TANF compliance caused by a disability-related barrier should not result in loss of this exclusion or trigger a notice of noncompliance under the community engagement requirement. We ask that states minimize an individual's responsibility for documentation through the ex parte process as states establish real-time data coordination between TANF and Medicaid eligibility systems. We ask that CMS coordinate with appropriate agencies to ensure TANF recipients are made aware of this exclusion's availability.

Member of a household receiving SNAP and are exempt from SNAP work requirements

OBBBA creates a specified exclusion for individuals who are part of a household receiving Supplemental Nutrition Assistance Program (SNAP) benefits who are "not exempt from a work requirement."[10] Individuals who are exempt from the SNAP work requirements must qualify for a separate specified exclusion such as medically frail. We ask CMS to provide guidance on how SNAP work-requirement exemptions based on disability interact with the medically frail exclusion and urge CMS to presume these individuals will be medically frail based on their exemption from SNAP work requirements. Alternative implementation would allow for disabled SNAP recipients to lose access to healthcare through Medicaid expansion because they will be subject to community engagement requirements many would be unable to meet.

We ask that states minimize an individual's responsibility for documentation through the ex parte process as states establish real-time data coordination between SNAP and Medicaid eligibility systems. Unlike the TANF work requirements, this exclusion does not require individuals to follow SNAP work requirements. We want to ensure that

[9] 42 C.F.R. § 435.554(c)(6)(i)
[10] 42 C.F.R. § 435.554(c)(6)(ii)

individuals not in compliance with the SNAP work requirements do not incorrectly lose their exclusion from Medicaid community engagement during the ex parte process. We ask that CMS coordinate with appropriate agencies to ensure SNAP recipients are made aware of this exclusion's availability.

Family Caregivers

The IFC departs from the statutory language that relies on the RAISE Family Caregivers Act to define family caregivers by limiting the exemption only to caregivers of children age 13 or under and individuals who meet the ADA definition of disability.[11] While the ADA definition of disability is broad, the RAISE Act goes further by explicitly including disabled individuals as well as people with "chronic impairments or functional limitations."[12] The University of Michigan's National Poll on Healthy Aging found that only 19% of adults age 50 and over identified as having a disability even though nearly half of those polled met the ADA definition.[13] The RAISE Act's broad framing is essential to capture the full spectrum of older adults and people with disabilities who need caregiving support. Although the IFC acknowledges that disability has no upper age limit,[14] this narrow interpretation still excludes many older adults whose functional limitations do not neatly align with how "disability" is commonly understood or self-identified by applicants and beneficiaries.[15] This is precisely why Congress incorporated additional language in the RAISE Act—to ensure that caregiving eligibility reflects real-world needs rather than narrow or inconsistent interpretations of disability. CMS must ensure states to use a clear, inclusive, ADA-aligned definition and make explicit that disability does not require receipt of disability-based benefits or a formal medical determination.

The IFC also diverges from HR 1's RAISE Act language that family caregivers have "a significant relationship with" the individual receiving care. Instead of honoring that statutory standard, the IFC further restricts eligibility by requiring caregivers to be related to or live with the individual—criteria that exclude large numbers of caregivers who provide essential support outside of family or household structures. Friends, neighbors, community members, and extended kin often serve as primary caregivers, particularly for older adults and people with disabilities who rely on trusted relationships rather than formal arrangements. Under the IFC, these caregivers must document 80

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[11] P.L. 119-21 § 71119(a)(xx)(9)(A)(ii)(III)
[12] Pub. L, No. 115-119, 132 Stat. 23 (2018).
[13] Meade, M., Kullgren, J., & Univ. of Michigan Institute for Healthcare Policy & Innovation (2025) *Experiences of Disability After Age 50: Poll Looks at Self-Identity and Help in Health Care*. https://ihpi.umich.edu/news-events/news/experiences-disability-after-50-poll-looks-self-identity-and-help-health-care
[14] IFC at 33369.
[15] Leahy, A. (2023, 6 12). Disability Identity in Older Age? - Exploring Social Processes that Influence Disability Identification with Ageing. *Disability Studies Quarterly* 42(3-4) https://doi.org/10.18061/dsq.v42i3-4.7780

hours of caregiving (or a combination of caregiving and community engagement activities) to qualify, imposing an arbitrary burden that fails to reflect the value and necessity of their role. This added requirement not only undermines the statutory objectives of the RAISE Act, but also risks denying protections to caregivers who are indispensable to the health and stability of the individuals they support.

The IFC fails to account for the everyday realities of caregiving. Beginning in January 2028, states will be required to collect documentation or information other than documentation to verify caregiving when no reasonably available data exists. Yet caregivers, especially unpaid family caregivers, rarely have formal records because their support is provided informally and in deeply personal settings. As a result, these unpaid caregivers who deliver essential care to their loved ones risk losing coverage if they are unable to produce documentation that, in practice, often does not exist.

Medically Frail Exclusion

As our coalitions represent the needs of people with disabilities and older adults, we are particularly interested in the specified exclusion of individuals deemed "medically frail." We have three primary concerns to the nature and administration of this exclusion. We are deeply concerned by the criteria the IFC establishes for the medically frail exclusion. We are further concerned that the measures states must take to administer this exclusion appropriately are impractical and administratively burdensome. Finally, we are concerned that individuals who would struggle to comply with the community engagement requirement may nonetheless fail to meet its specific regulatory criteria and lose coverage as a result.

CMS's Requirement that Individuals Demonstrate that their Disability "Significantly Impairs" their Ability to Meet the Community Engagement Requirement Is Inconsistent with the Statute

When Congress enacted the Medicaid community engagement requirement through OBBBA, it exempted individuals who are medically frail, which Congress defined as including—without exception—individuals falling into certain defined categories. Those categories include people who:

- **Are blind or disabled as defined in section 1614 of the Social Security Act**
- Have a "disabling mental disorder"
- Have a "substance use disorder"
- Have a "serious or complex medical condition"

- Have a physical, intellectual, or developmental disability that significantly impairs your ability to do one or more activities of daily living

Numerous members of Congress assured the public that the community engagement requirement would only apply to "able-bodied" people, citing the medically frail exclusion.

Despite this clear language, the IFC departs from the statute and imposes an additional requirement that, to meet the "medically frail" exclusion, a person must not only fall within one of the categories identified but must also demonstrate that their particular condition "significantly impairs" them in meeting the community engagement requirement.[16]

This additional requirement in the IFC is inconsistent with the statute. Congress could have but *did not* say that disabled people would *also* be subject to the requirement unless they could show on an individualized basis that their disability significantly impaired the ability to meet the community engagement requirement. That is simply not the law that Congress wrote.

Indeed, the other specified exclusions confirm that the exclusion categories are not limited to people who could show on an individualized basis that they were significantly impaired in meeting the community engagement requirement. For example, Congress also excluded certain categories of Indians, people who are pregnant or entitled to postpartum medical assistance, and people participating in a drug or alcohol treatment program.[17] As with the "medically frail" category, those categories are not limited exclusively to people who are unable to meet the community engagement requirement; instead Congress categorically exempted everyone in these groups from the community engagement requirement. It is inconsistent with the statute to single out the "medically frail" category for different treatment and limit it in ways that contradict the plain text of the law.

The IFC's "significantly impaired" requirement is also contradicted by the statutory language that already limits physical and intellectual disabilities covered by the "medically frail" exclusion to those that "significantly impair" a person in one activity of daily living, and mental health disabilities covered by the exclusion to those that are "disabling." If the "medically frail" exclusion covers only people who can demonstrate that they are "significantly impaired" in meeting the community engagement requirement, there would be no point to these other statutory limitations. These limitations are the only ones identified in the statute.

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[16] 42 C.F.R. § 435.554.
[17] *Id*.

Criteria for the Medically Frail Exclusion Poses Unique Administrative Challenges for States and Wrongly Impairs Individuals' Ability to Qualify for the Exclusion.

The categories of individuals that could qualify for the medically frail exclusion each pose their own unique challenges for applicants and states. We will share our specific concerns and questions by condition of eligibility.

We are generally concerned how states and CMS plan to verify if an individual meets this criteria to be medically frail. The IFC says states must first rely on ex parte data whenever possible. We urge CMS to work with states to limit the responsibility of applicants and enrollees to provide their own data. Paperwork burden for people with disabilities and chronic health conditions are known contributors to harmful disruptions of coverage, even when they would otherwise be eligible for coverage.

But frankly, the IFC's "significantly impaired" requirement is simply unworkable. The medical professionals who may diagnose or treat someone's disability are typically not in the business of determining how many hours a person's disability may allow them to work. Providers are often reluctant to provide documentation pertaining to the ability to work.[18] Many will likely decline to state whether a person's disability significantly impairs the person in meeting the community engagement requirement, potentially leaving people who are eligible for the exemption unable to provide sufficient documentation to prove it. Even when doctors are willing to sign documentation, they may lack a clear understanding of what information State Medicaid agencies will require them to include.

As noted previously, the "significantly impaired" requirement unnecessarily complicates each condition of eligibility and endangers coverage for individuals with disabilities and older adults. Our critiques on the unworkability of this provision per criterion of medically frail eligibility will be elaborated in each section.

Are blind or disabled as defined by section 1614 of the Social Security Act

Prior to and following the passage of OBBBA, proponents of the bill including members of Congress and the White House claimed one of their aims with the legislation was to

[18] O'Fallon, E., & Hillson, S. (2005). Brief report: Physician discomfort and variability with disability assessments. *Journal of General Internal Medicine*, *20*(9), 852–854. https://doi.org/10.1111/j.1525-1497.2005.0177.x

protect the most vulnerable, including individuals with disabilities.[19,20,21] CMS has similarly emphasized the importance of protecting the most vulnerable.[22] While any of the categories of individuals that could qualify for the medically frail exclusion could be described as vulnerable, individuals who are blind or disabled as defined by section 1614 of the Social Security Act were part of the population described in these accounts.

The IFC's introduction of the "significantly impairs" requirement creates a situation in which individuals who are blind or disabled as defined by the Social Security Act cannot simply be excluded because of their disability. This has created some confusion for recipients of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

As noted in the rule, individuals covered by a Medicaid mandatory eligibility group are not applicable individuals. In 34 states, Washington D.C., and all but one territory, SSI recipients are automatically enrolled in Medicaid and would qualify based on their SSI eligibility. In these states and Washington D.C., individuals who are blind or disabled would not be applicable individuals as long as they remain in compliance with SSI rules. In eight states and one territory (Alaska, Nebraska, Utah, Idaho, Nevada, Northern Mariana Islands, Kansas, Oklahoma, and Oregon), SSI recipients are not automatically enrolled, but are eligible for Medicaid because of their SSI eligibility. In these states, individuals who are blind or disabled would not be applicable individuals as long as they remain in compliance with SSI rules. However, the additional layer of friction and application wait times may result in people not getting coverage when they should have. In eight states (Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia), SSI eligibility does not guarantee Medicaid coverage, as permitted by section 209(b) of the 1972 Amendments of the Social Security Act.[23] These 209(b) states will contain individuals who without doubt would meet the Social Security Act's definition of blind or disabled, but are not covered by a mandatory eligibility group. These individuals may seek health care from the Medicaid expansion instead of meeting the stricter 209(b) requirements, but would be subject to community engagement requirements if they are not approved for a medically frail exclusion. Following the statutory language itself, these individuals would be exempted as medically frail, resulting in consistent outcomes across states. The Secretary's

[19] 171 CONG. REC. S4268 (daily ed. July 9, 2025) https://www.congress.gov/congressional-record/volume-171/issue-118/senate-section/article/S4268-3
[20] Schneider, J. (2025, June 16). *Capitol Hill Touts Benefits of the One Big Beautiful Bill*. The White House. https://www.whitehouse.gov/releases/2025/06/capitol-hill-touts-benefits-of-the-one-big-beautiful-bill/
[21] The White House. (2025). The One Big Beautiful Bill: Fact vs. Myth. In *The White House*. https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf
[22] CMS. (2026). CMS Financial Report for Fiscal Year 2025. In *CMS* (No. 12074). https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2025.pdf
[23] Pub. L. No. 92-603, 86 Stat. 1329 (1972).

additional requirement that their disability "significantly impairs" ability to comply with the engagement requirements poses significant challenges to these individuals to access affordable minimum essential coverage, as the IFC does not provide clear guidance on how to prove significant impairment.

SSI recipients who exceed strict income or asset limits undergo an unscheduled redetermination. If they were receiving Medicaid through the aged, blind, or disabled pathway, they will lose Medicaid coverage through that pathway until the redetermination is settled. Many states in the Medicaid expansion will automatically and temporarily move these individuals into their Medicaid expansion to ensure continuous access to life-saving health care. Our reading of the IFC is such that these individuals would be applicable individuals and have to qualify for an exclusion or comply with community engagement requirements. The majority of these individuals have only temporarily exceeded income or asset limits for reasons unrelated to their actual ability to work—such as through well-intentioned gifts, employer-side accounting errors resulting in a higher than usual paycheck, or a rental payment that is not deposited on time—and their underlying determination of disability remains in effect. People in these situations should not be penalized by losing access to health care. This would be contradictory to states' current efforts to move these individuals into their Medicaid expansion to ensure seamless health care coverage. The statutory language itself would classify these individuals as medically frail. And yet, once again, the Secretary's addition of a "significantly impairs" requirement poses significant challenges to these individuals' ability to access affordable minimum essential coverage as the IFC does not provide a clear path on how to prove significant impairment.

SSDI recipients may eventually be eligible for Medicare Part A and Part B, which would mean they are no longer applicable individuals. However, the majority of SSDI recipients under 65 have to wait 24 months from when they start receiving benefits to become eligible for Medicare. By requirement, these individuals are low-income and many seek health care coverage from the Medicaid expansion as their other options are limited.[24] Individuals who receive SSDI do so because they cannot work at a level sufficient to support themselves. The statutory definition of medical frailty included these individuals, but now the "significantly impairs" requirement poses significant challenges to SSDI recipients' ability to access affordable minimum essential coverage as the IFC does not provide a clear path on how to prove significant impairment.

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[24] Armour, P., Wang, Z., & O'Hanlon, C. (2022, September 1). *Healthcare Cost-Sharing and the Economic Security of Social Security Disability Insurance beneficiaries: Medicaid expansion and the SSDI-Medicare Population*. NBER. https://www.nber.org/programs-projects/projects-and-centers/retirement-and-disability-research-center/center-papers/nb22-04

SSI and SSDI recipients both need to show that they cannot engage in substantial gainful activity (SGA). SGA is defined as the ability to exceed specific earned income limits. In the context of SSI eligibility, the SGA standard is only used for the initial SSI application. SSDI recipients need to remain in compliance with SGA limits for the entire time they receive benefits. The IFC does not weigh in on whether satisfying the SGA standards would also satisfy the "significantly impaired" requirement. If CMS continues to use the significant impairment standard for the medically frail exclusion, we ask CMS to permit the SSA's determination that an individual cannot engage in SGA to satisfy that standard. This would add needed clarity, reduce paperwork burden, and improve States' ability to grant exemptions based on existing records.

The IFC fails to outline a clear pathway to seek the medically frail exclusion for individuals awaiting a decision on their status from the Social Security Administration. This is at a time where the average initial disability determination takes over 6 months, with the average claim that progresses to the hearing stage taking in excess of two years.[25] Upon further appeal and adjudication, disability verification could take years for some individuals. This can be further delayed by the length of time to get a diagnosis. What are these people to do? These individuals are often seeking a disability verification because they are unable to work or can only work very little. There is no reason to bar these individuals from life-saving health coverage—including coverage to see the same doctors that they need to continue seeing in order to document their disabilities. We ask that CMS permit self-attestation for the medically frail exclusion or at minimum a suspension of enforcement for compliance for individuals seeking disability verification until the determination is resolved.

By exceeding its statutory authority, CMS needlessly endangers access to health care for SSI and SSDI recipients. We ask that CMS return to the statutory language and eliminate the significant impairment standard.

Have a "disabling mental disorder"

The IFC does not provide a definition of "disabling mental disorder;" instead it provides a scattershot of potential mental health conditions that could be a "disabling mental disorder." With almost 30% of adults enrolled in Medicaid expansion having a substance use disorder or a mental health condition, we are greatly concerned that the variability of these conditions will still result in coverage losses for those in need of significant care.[26] People with mental health conditions often rely heavily on continued access to

[25] Social Security Administration. (2026, June 9). *Social Security performance*. https://www.ssa.gov/ssa-performance

[26] Maxwell, J., Bourgoin, A., & Lindenfeld, Z. (2020, February 10). Battling The Mental Health Crisis Among The Underserved Through State Medicaid Reforms. *Health Affairs Forefront*.

coverage to promote recovery and avoid significant worsening of symptoms that could result in further limitations in ability to work, adverse health outcomes, loss of housing, and even death. We anticipate the homeless population covered by the Medicaid expansion will especially feel the pain of this barrier.

As in the case of those who meet the SSA definition of disability, the introduction of the "significantly impairs" requirement complicates this criterion; "disabling" already implies some level of functional assessment. The IFC does not contain any guidance on how or by what metrics states can verify what mental health conditions are disabling enough to qualify. As a result, the limitations on self-attestation will be especially felt for this criterion. Please refer to our section "CMS's Requirement that Individuals Demonstrate that their Disability "Significantly Impairs" their Ability to Meet the Community Engagement Requirement Is Inconsistent with the Statute" for our thoughts on this contradiction and the challenges it poses.

Have a "substance use disorder"

The IFC limits this portion of the exclusion by stating it does not apply to those who have been in recovery for five years or more, when there is no language in the statute allowing for this interpretation. A review of the IFC's citations justifying "the risk of SUD recurrence for an individual in stable recovery [5 or more years] is approximately the same as the general population" finds that the studies range from nearly 20 to almost 40 years old, are limited to alcohol use disorder, and define "recovery" as abstinence only. Many of the studies were limited to men; those that were not limited to men found significant gender differences. There does not appear to be an evidence-based justification for this generalization. We are concerned that individuals with nonlinear recoveries will be unable to obtain this exclusion while also being unable to comply with community engagement requirements. This will likely exacerbate individuals substance use disorders.

Medicaid covers 47% of adults under 65 with an opioid use disorder, with the expansion being the primary pathway to coverage for people with substance use disorder.[27] We anticipate this new limitation to result in devastatingly high levels of coverage termination for individuals who need health care to manage their condition. We anticipate the homeless population covered by the Medicaid expansion will especially

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https://www.healthaffairs.org/content/forefront/battling-mental-health-crisis-among-underserved-through-state-medicaid-reforms

[27] Saunders, H., & Rudowitz, R. (2025, August 11). *Implications of potential federal Medicaid reductions for addressing the opioid epidemic*. KFF. https://www.kff.org/medicaid/implications-of-potential-federal-medicaid-reductions-for-addressing-the-opioid-epidemic/

feel the pain of this barrier. The results are likely to be devastating: even now, overdoses account for over 100,000 deaths per year.[28]

There is also a lack of clarity in the statute creating what appears to be a contradiction. The preamble of the IFC states having a "substance use disorder" and "significantly impaired" from fulfilling the community engagement requirement qualifies as medically frail, regardless if the individual is in an active treatment program. However, the requirement of verification at each redetermination, including claims and encounter data, would limit the exclusion to those seeking treatment. We think the former interpretation is the only correct one. The latter goes beyond what OBBBA permits and CMS' interpretation of the statute.

Have a "serious or complex medical condition"

The IFC declines to define "serious or complex medical condition." Instead, it opts to provide a scattershot of conditions that may and may not qualify as medically frail. Notably, the list of conditions not likely to be considered serious or complex in the preamble include: asthma, hypertension, anemia, generalized pain, pre-diabetes, Type I or II diabetes, obesity, psoriasis, headaches, and Attention-Deficit/Hyperactivity Disorder. These are some of the most common conditions reported for a disability and can be incredibly complicated for an individual depending on its severity. This ballpark estimation of conditions that may not apply is wholly inappropriate.

The IFC also uses a new and unusual definition of "serious or complex medical condition" such that an individual's condition must be life-threatening even when receiving treatment. An individual's condition can be serious or complex and even "significantly impair" compliance with the community engagement requirement without being life-threatening with treatment. This is an unnecessary restriction that will especially impact individuals with conditions that are episodic, fluctuating, managed with medication, or approaching remission. These individuals still need health care to survive, and this limitation will be life-threatening.

Prior to the IFC's release, states were developing code lists to anticipate conditions that could be serious or complex. These code lists demonstrate how these community engagement requirements were already unfeasible to administer, but the addition of "significantly impairs" requirement makes it wholly unworkable. Similar to individuals with conditions described in the other potential criteria for medically frail, CMS going beyond the statutory authority and creating another hurdle to coverage for people with

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[28] CDC. (2025, June 9). *Understanding the Opioid Overdose Epidemic*. CDC. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html

serious or complex medical conditions will be devastating for individuals seeking health care.

Consider, for example, a Medicaid beneficiary recently diagnosed with lupus. With treatment, their condition is unlikely to be life-threatening. However, even with treatment, they are likely to experience permanent, irreversible damage to their vital organs. Moreover, even with treatment, their ability to engage in daily activities may vary wildly from day to day and month to month. Under the IFC, even someone experiencing very severe lupus symptoms may not be counted as "medically frail" because their condition is not life-threatening with treatment—resulting in a possible loss of coverage that will be life-threatening. Even if the State recognizes lupus as a serious medical condition, this beneficiary could experience temporary losses of coverage each time she experiences a flare that prevents her from working—resulting in progressively worsening disability and, again, higher risk of death. This outcome is not consistent with Congress's promise to protect vulnerable populations.

Have a physical, intellectual, or developmental disability that significantly impairs your ability to do one or more activities of daily living

We are deeply concerned this exclusion does not cover the full extent of individuals with intellectual or developmental disabilities who require significant functional support. The statute and the IFC only establish that the physical, intellectual, or developmental disability must impair at least one activity of daily living (ADL). This would exclude many people with intellectual and developmental disabilities (IDD) whose disabilities substantially affect their ability to comply with the community engagement requirement but do not significantly impair traditional ADLs.

This approach does not reflect how many intellectual, developmental, cognitive, and related disabilities affect functioning. Many people with IDD can perform basic self-care activities such as eating, dressing, or bathing (ADLs) but have substantial limitations in instrumental activities of daily living (IADLs), adaptive functioning, communication, executive functioning, decision-making, medication management, transportation, and navigating complex paperwork or online systems. Some individuals also require behavioral supports, supervision for safety, or ongoing assistance managing appointments, understanding notices, responding to mail, maintaining records, and interacting with health care providers and public benefit agencies. These limitations are directly relevant to whether an individual can understand and comply with reporting and verification requirements.

Available data demonstrate that an ADL-only standard would fail to identify many Medicaid beneficiaries with disabilities who face significant barriers to compliance. KFF found that, among more than 15 million Medicaid enrollees with disabilities, 53 percent

reported cognitive difficulty and 44 percent reported difficulty living independently, while only 24 percent reported self-care difficulty such as difficulty dressing or bathing.[29] The limitations most relevant to complying with a complex reporting requirement—such as understanding notices, using online portals, keeping records, managing appointments, and responding to agency requests—are therefore often not reflected in traditional ADL measures.

Furthermore, we urge CMS to establish a strong presumption of medical frailty for individuals with diagnoses or records demonstrating a lifelong developmental disability. This presumption should include, but not be limited to, people with intellectual disability, autism, cerebral palsy, Down syndrome, Fragile X syndrome, Prader-Willi syndrome, traumatic brain injury, and related developmental disabilities.

The IFC already identifies several of these conditions as examples that may fall within the serious or complex medical condition category, but it continues to require individuals to demonstrate that their condition impairs their ability to comply with the community engagement requirement. Requiring people with lifelong and well-documented disabilities to repeatedly establish their functional limitations will not meaningfully advance program integrity. Instead, it will impose unnecessary administrative burdens, create barriers for individuals and their families, and increase the risk that eligible people will lose Medicaid coverage because they could not successfully complete the exemption process.

CMS should adopt a medical frailty standard that reflects the full range of functional limitations experienced by people with disabilities and ensures that individuals are not denied an exclusion simply because they can perform basic self-care activities.

Additional impacted populations not adequately covered by the medically frail exclusion

While the medically frail exclusion only contains 5 different categories that an individual could be considered medically frail, not enough attention was paid to atypical manifestations or overlapping populations that may struggle to meet the criteria for this exclusion.

We briefly mentioned the lack of accommodations for episodic and fluctuating conditions. These conditions will struggle to meet the requirements in the given time frames for verification laid out in the IFC. This could be remedied through a few different approaches, such as verification looking at impairment and the condition over a period

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[29] Burns, A., & Cervantes, S. (2025, August 12). *5 Key Facts About Medicaid Coverage for People with Disabilities*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-disabilities/

of time or in a set lookback period as opposed to the snapshot determination that is currently in place.

Individuals with conditions that do not have a single diagnostic test, require multiple tests or visits, or are treated by specialists that may take months or years to see are at a particular disadvantage. Flexibility beyond specific code lists, permitted self-attestation, and functional assessments will not fully resolve this issue, but could mitigate the worst impacts.

Older adults with conditions that work jobs that are limited by their condition, forcing them to retire early, are also put in an impossible situation. Their health conditions may make it dangerous or impossible to continue their current job while they lack the education and experience to find another job. We are especially concerned about older adults that work physically demanding jobs.

The IFC references the lack of an exclusion for individuals who are homeless and we note the overlap this population has with individuals with mental health conditions and substance use disorders. We urge CMS to work with states to establish processes to improve engagement with homeless individuals who may qualify for any of the specified exclusions.

Short-term Hardship Exceptions

As has been stated throughout, people with disabilities or chronic conditions often experience serious, fluctuating, or progressive health needs potentially leading to coverage loss if they are unable to comply with the community-engagement requirements. Many older adults and individuals managing complex conditions regularly rely on inpatient hospital stays, nursing-facility care, intermediate care facility (ICF) services, or similar forms of treatments. These periods of care are medically necessary and often unavoidable, yet they directly limit a person's ability to meet community engagement requirements. Without these short-term hardship exceptions, older adults and people with disabilities would be disproportionately penalized for needing the very services Medicaid is designed to provide. Individuals recovering from surgery, managing acute episodes of chronic illness, or receiving facility-based care could lose coverage simply because their health needs prevent them from meeting community-engagement standards. Thus, states should be strongly encouraged to adopt these optional hardship exceptions to ensure that people are protected from losing coverage due to their health care needs.

As crucial as this exception is for older adults and people with disabilities, it poses a challenge to implement for real world situations given how the exception is triggered.

Under the statute and the IFC, individuals receiving a short-term hardship are "applicable individuals" who must determine their compliance with the community engagement requirements retrospectively, either one to three consecutive months immediately preceding the month of application or for at least once month during their review period for renewals.[30] This means an applicable individual with a review date in July must show they complied with the community engagement requirements for at least one month during their prior review period. Because applicable individuals are subject to both mandatory and short-term hardship exceptions, they must also show they qualified for the exception at least one month prior to application or at least one month in the review period.[31] Yet the IFC states that a person qualifies for a hardship exception if during all or part of a month, the individual experiences a hardship event including receiving inpatient hospital, nursing facility, ICF services and other treatments of similar acuity.[32] This language suggests the exception applies during the month the person is receiving the inpatient services, while the applicable individual language (being retrospective) indicates the exception only applies for the months following the inpatient services. The two standards conflict with the purpose of the exception which is to ensure individuals receiving intensive medical care are not required to engage in qualifying activities while hospitalized. This contradiction creates significant confusion, and we ask CMS to provide guidance to better align the short-term hardship exception with the realities of inpatient care, particularly for older adults and people with disabilities who disproportionately rely on these services.

Verification and Self-attestation

CMS's Limitations on Self-Attestation of Medical Frailty are Inconsistent with the Statute

Congress clearly stated in OBBBA that states "may elect to not require an individual to verify" that they meet an exemption to the community engagement requirement.[33] Contrary to this plain language, the IFC does *not* allow states to elect this option for individuals who are excluded due to medical frailty after January 1, 2028. Beginning on that date, according to the IFC, states can only allow individuals to provide a statement or other information showing they meet the medically frail exclusion *one time*, for as long as they remain continuously enrolled.[34] After that one time, states can no longer

[30] P.L. 119-21 § 71119(a)(xx)(1); IFC at 33353.
[31] IFC at 33364 ("... compliance with community engagement is assessed for a time period that predates an individuals' application or renewal date…").
[32] 42 C.F.R. § 435.555.
[33] P.L. 119-21, § 71119(a).
[34] 42 C.F.R. § 435.557(f)(ii).

“elect to not require an individual to verify” that they are medically frail and thus excluded, despite Congress’s mandate, and must instead require documentation.

The IFC is thus squarely at odds with the plain language of the statute and must be modified to conform to what Congress directed.

CMS Imposes a Significant Burden on States through its Requirements for States Building Systems for Data Verification

In OBBBA, Congress instructs the states to “establish processes and use reliable information available to the State . . . without requiring, where possible, the applicable individual to submit additional information.” States have been building their systems for months in order to comply with the general implementation deadline of January 1, 2027. Compliance with this requirement was already incredibly difficult for several of the specified exclusions. As mentioned, there is no data source to identify most caregivers. Even when the data does exist, such as if veterans have a total disability rating, putting the responsibility on the individual to prove their exclusion while CMS and the Department of Veteran Affairs establish appropriate data sharing is incredibly burdensome to the individual. The IFC adds to this burden by imposing the new “significantly impairs” requirement to qualify for the medically frail exclusion because data sources to verify this requirement would not exist. CMS also institutes a new limitation on applicable information for the medically frail exclusion to a 12-month lookback window. Similarly, the IFC also introduces a 12-month reverification period after medically frail status is established. Neither of these are specified in statute and are especially unreasonable for medically frail individuals with lifelong conditions. These individuals may also not have relevant data within the past 12 months. To mitigate these burdens, we believe that CMS should permit states to utilize self-attestation to its fullest extent as permitted by OBBBA. We believe this is reasonable as similar attestation are typical to the Medicaid eligibility screening process.

Further Impact on Applicants and Enrollees

Ensuring applicants and enrollees understand the purpose and function of self-attestation in the application and redetermination process is essential. This includes the fact that states are required to provide reasonable modification and effective communication as discussed below. Threat of perjury and incomplete understanding of the process will have a chilling effect on applications for individuals who should be eligible for coverage and an exclusion. The limitation on states’ ability to not require an individual to verify their information will require individuals to provide more information than the statute required. This paperwork burden will further churn or prevent individuals from accessing coverage when they should be eligible.

Compliance with Civil Rights Laws

CMS Should Address States' Need to Comply with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act

States participating in the Medicaid program are also required to comply with applicable civil rights laws, including the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. These laws require state and local governments to provide people with disabilities equal opportunity in state Medicaid programs.[35] They also require state and local governments to make reasonable modifications to avoid discriminating based on disability.[36] Further, they require effective communication.[37]

While CMS does not enforce the ADA or Section 504, it is critically important that CMS make clear to both state Medicaid officials and applicants and enrollees with disabilities that these laws provide protections in Medicaid application, enrollment, and redetermination processes as community engagement requirements take effect. It is predictable that people with disabilities will be wrongly denied or disenrolled from Medicaid coverage if they do not receive—and are not aware they can request—reasonable modifications or effective communication. Further, as Congress recognized in enacting the "medically frail" exemption, some disabilities may affect a person's ability to meet these requirements.

Indeed, CMS provided guidance on the application of the ADA and Section 504 in 2018 when it provided direction on Medicaid community requirements in Medicaid demonstration programs. In State Medicaid Director Letter #18-002, CMS stated:

> States are required, in the design and administration of Medicaid demonstration projects, to comply with all applicable federal civil rights laws, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, the Age Discrimination Act, and other applicable statutes.

The federal disability rights laws are of particular importance, given the broad scope of protection under these laws and the fact that disabilities can affect an individual's ability to participate in work and community engagement activities. States may not impose such requirements on individuals classified as "disabled" for Medicaid eligibility purposes.

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[35] 42 U.S.C. §§ 12132, 12134, 28 C.F.R. § 35.130(b)(1) (ADA Title II); 29 U.S.C. § 794, 45 C.F.R. § 84.68(b)(1) (Section 504).
[36] 42 U.S.C. §§ 12132, 12134, 28 C.F.R. § 35.130(b)(7) (ADA Title II); 29 U.S.C. § 794, 45 C.F.R. Section 84.68(b)(7) (Section 504).
[37] 42 U.S.C. § 12132, 12134, 28 C.F.R. § 35.160 (ADA Title II); 29 U.S.C. § 794, 45 C.F.R. § 84.77 (Section 504).

> CMS recognizes that individuals who are eligible for Medicaid on a basis other than disability (and are therefore classified for Medicaid purposes as "non-disabled") may have a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or section 1557 of the Affordable Care Act. States should include, in their proposals, information regarding their plans for compliance with these requirements, including provision of reasonable modifications in work or community engagement requirements. . . .[38]

CMS should include reference to the application of federal disability rights laws in guidance concerning the community engagement requirements rule. It should provide examples of reasonable modifications and effective communication to which people with disabilities may be entitled—for example:

- An enrollee whose disability makes it difficult for them to navigate the process of showing that they are exempt from community engagement requirements may be entitled to a reasonable modification of additional assistance in collecting, producing, and submitting documents.
- An applicant whose disability impacts their ability to secure and maintain employment, but who is nonetheless found not exempt from the community engagement requirement, may be entitled to a reasonable modification of the state providing supported employment services to help the person secure and maintain employment.
- An applicant with an intellectual disability may be entitled to have Medicaid officials communicate with them in plain language.
- An enrollee who is deaf or hard of hearing may be entitled to have Medicaid officials communicate with them in a format that is accessible to the person, such as American Sign Language, and to ensure that online information is accessible.

Conclusion

We thank you for reviewing these comments. As stated, we are deeply concerned with the additional restrictions imposed by the IFC and the impact it will have on our constituencies. For questions, please contact John Poulos at jpoulos@autisticadvocacy.org.

Sincerely,
Access Ready, Inc.
AFT: Education, Healthcare, Public Services
American Association on Heath and Disability
American Network of Community Options and Resources (ANCOR)

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[38] Centers for Medicare & Medicaid Services, State Medicaid Director Letter No. 18-002, *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries* (January 11, 2018).

American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of Assistive Technology Act Programs
Association of People Supporting Employment First (APSE)
Autism Society of America
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network
Bazelon Center for Mental Health Law
CalPACE
Care in Action
Caring Across Generations
Center for Medicare Advocacy
Center for Pubic Representation
CommunicationFIRST
Cure SMA
Deaf Equality
Disability Rights Education and Defense Fund (DREDF)
Diverse Elders Coalition
Easterseals, Inc.
Epilepsy Foundation of America
Family Voices National
Huntington's Disease Society of America
Justice in Aging
Lakeshore Foundation
Little Lobbyists
Medicare Rights Center
Muscular Dystrophy Association
National Academy of Elder Law Attorneys (NAELA)
National Association of Councils on Developmental Disabilities
National Committee to Preserve Social Security and Medicare
National Disability Rights Network (NDRN)
National Domestic Workers Alliance
National Down Syndrome Congress
National Multiple Sclerosis Society
National PLACE
National PLAN Alliance (NPA)
New Disabled South
Paralyzed Veterans of America
PHI

Society for Developmental & Behavioral Pediatrics
Special Needs Alliance
TASH
TDIforAccess
The Arc of the United States
The Partnership for Inclusive Disaster Strategies
Triage Cancer
United Spinal Association
Well Spouse Association