American Association on Health & Disability

110 N. Washington Street Suite 407 Rockville, MD 20850
T. 301-545-6140 **F.** 301-545-6144 www.aahd.us

AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

July 30, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 2454-IFC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **Comments in Response to Interim Final Rule on Medicaid Community Engagement Requirements (CMS-2454-IFC)**

Dear Dr. Mehmet Oz:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments on the CMS's interim final rule on the community engagement requirement for Medicaid. Set forth below are our concerns regarding this proposed final rule and we would encourage CMS to delay these rules and not adopt them in their current form and make significant revisions to them.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research

program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

1. **Definition of Medical Frailty**.

The proposed definition for medical frailty under these rules would add an additional layer beyond the statutory language and provisions to what was originally envisioned when the concept of medical frailty was originally adopted as part of the creation of Alternate Benefit Plans in 2005. Previous federal law gave individual states a lot of discretion to define what it means to be "medically frail," but it established a floor of individuals that must be covered. Medically frail persons include individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living. "Activities of daily living" are common tasks that people perform as part of their day and include things like eating, dressing, bathing, walking and transferring, and hygiene.

The proposed rule would provide an exemption for individuals who have a specific health condition (such as a disability, blindness, substance use disorder, mental health condition, etc.) and are unable to work. The additional requirement that the individual needs to prove that they are unable to work is what makes this proposal especially problematic. It is entirely possible that an individual with a disability would be able to work in some part-time capacity but would still be medically frail. If this part-time employment only provided limited hours (i.e. 5 hours per week), it would leave that individual unable to meet the work reporting requirements. As written, this definition imposes on people with disabilities a high standard that is only required of those seeking Social Security disability benefits – demonstrating their inability to maintain gainful employment.

The rule's definition of medical frailty is particularly troubling because it narrows a statutory protection into a case-by-case test of one's ability to work. That approach is inconsistent with the realities of disability, fluctuating health conditions, limited access to specialists, and the administrative barriers many Medicaid beneficiaries already face. CMS should not define medical frailty primarily by whether a person can satisfy the community engagement requirement. The statute identifies categories of people who must be protected, including people who are blind or disabled, people with physical, intellectual, or developmental disabilities that limit activities of daily living, people with substance use disorders, people with disabling mental disorders, and people with serious or complex medical conditions. The proposed approach risks turning those categorical protections into a narrow inquiry about whether a person can work or perform qualifying activities in a given month. This is the wrong lens. Disability and medical frailty should not be reduced to a binary judgment about one's ability to work. A person may be capable of some activity on some days while still needing protection from a reporting requirement that is incompatible with episodic symptoms, treatment schedules, cognitive limitations, communication barriers, or the cumulative burden of managing a serious health condition.

Additionally, the administrative burden of qualifying for this exemption will most certainly lead to people losing coverage. A medical frailty exemption that depends on individualized documentation will be difficult for beneficiaries to navigate. Many Medicaid beneficiaries do

not have a regular primary care provider, cannot quickly obtain medical records, or face long waits for appointments. People with cognitive disabilities, serious mental illness, traumatic brain injury, limited literacy, or communication disabilities may be least able to complete repeated forms and deadlines, even when they are most clearly within the protected population. People with vision disabilities may need accessible formats. People with mobility disabilities may not be able to visit offices. People with psychiatric disabilities or chronic illnesses may have fluctuating capacity to respond to paperwork within short deadlines. People who rely on home and community-based services may face catastrophic consequences if Medicaid coverage is interrupted, including loss of personal care, medications, behavioral health services, transportation, durable medical equipment, or community-based supports that make daily life possible.

CMS should presume exemption wherever existing data indicate disability, serious illness, functional limitation, receipt of disability-related services, use of long-term services and supports, behavioral health treatment, substance use disorder treatment, or other markers of special medical needs. Beneficiaries should not be required to repeatedly prove what the state already knows or can reasonably identify through existing records.

Ironically, an individual with a disability may be able to do some work (although not meet the requirement of 80 hours per month), but this could cause them to not qualify for the exemption under this definition meaning that they would lose their coverage. This could then result in poorer health outcomes and affect their ability to work even in a limited capacity they were doing. Subsequent interruptions in their health care due to a paperwork error alone could impact their access to care and actually lead to an inability to work at all. In other words, these requirements that are meant to ensure that people who are able to work are working could have the exact opposite outcome of making it so that someone who is able to work but unable to meet the paperwork requirements would then lose their coverage and their health will suffer meaning that they would no longer be able to work.

Overall, it has been estimated that between 5-10 million people will lose Medicaid coverage as a result of the new requirements.[1] Given the fact that many people with disabilities rely on Medicaid for their coverage, a great number of these individuals who lose coverage will be people with disabilities. We would encourage CMS to delay implementation of the community engagement requirements. CMS should not implement a policy that predictably causes eligible people, including people with disabilities, to lose health coverage because of administrative complexity. Instead, we would recommend that CMS reevaluate the definition of medical frailty so that it includes, at minimum, people with functional limitations, episodic conditions, serious behavioral health conditions, substance use disorders, and complex chronic conditions and does not add an additional test for someone's inability to work.

2. **<u>Additional Burden on Providers</u>**.

The administrative burden will not only be on Medicaid beneficiaries. Requiring that individuals demonstrate their health condition prevents them from working will also require medical documentation from providers to back up that claim. Many providers are already limited on the

[1] https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html (accessed July 27, 2026).

amount of time that they can spend with patients and for people with disabilities who have complex medical needs, this time is precious and needs to be focused on the healthcare of the individual and not on meeting administrative paperwork so that individual can maintain their coverage. Last month, the American Medical Association stated that the exemption for medical frailty "must reflect clinical realities and protect vulnerable patients while avoiding burdensome administrative requirements that can interfere with care."[2] Simply put, healthcare providers are not vocational experts and they should not be asked to make a determination of whether patient can and cannot do. Once again, we encourage CMS to reevaluate its definition and not add an additional test which would require a healthcare provider to attest that their patient is unable to work.

3. **Family Caregivers Risk Losing Coverage**.

When the One Big Beautiful Bill Act (OBBBA) was passed, it was supposed to exempt family caregivers from the community engagement requirements. Unfortunately, under the proposed rules, family caregivers are still at risk for losing coverage. While they are allowed to claim an exemption, the proposed rules do not offer guidance as to the adequate documentation needed to verify that a person is meeting the requirements in order to meet the exemption. Caregivers of people with disabilities should be exempt from the community engagement requirement, but the exemption, as described, is not sufficient unless CMS requires states to implement it broadly and without burdensome proof requirements. Family caregiving is work. It includes medication management, transportation, communication support, behavioral support, assistance with activities of daily living, help navigating benefits and health care systems, crisis response, and support that prevents institutionalization. These responsibilities are often unpredictable and cannot be reduced to a standard monthly schedule.

Many people with disabilities rely on unpaid family caregivers because paid home and community based services are unavailable, underfunded, or delayed by waiting lists and workforce shortages. Penalizing caregivers for not meeting an additional work requirement ignores the economic and social value of the care they already provide. If caregivers lose Medicaid coverage, the people with disabilities who depend on them are also harmed. The result may be avoidable health crises, caregiver burnout, loss of community stability, and increased risk of institutional placement.

CMS should also clarify that the family caregiver exemption includes any adult family member, chosen family member, friend, neighbor, or other person with a significant relationship to an individual with a disability, chronic condition, serious illness, or functional limitation who provides ongoing or intermittent assistance. The exemption should not be limited to legally responsible relatives, people living in the same household, parents of minor children, or caregivers providing a minimum number of hours each month. Disability support often depends on informal networks that do not fit narrow family definitions. A sibling may coordinate appointments from another home. A grandparent may provide daily supervision. A neighbor may provide transportation and communication assistance. A friend may support a person with psychiatric, intellectual, developmental, sensory, or physical disabilities during periods of crisis. These forms of support are real caregiving and should qualify.

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[2] https://www.ama-assn.org/press-center/ama-press-releases/ama-adopts-policy-calling-exemptions-medicaid-work-requirements (accessed July 27, 2026).

We would encourage CMS to withdraw the proposed rule and reevaluate it to make changes making it clear who qualifies for the caregiver exemption. The rule should require that states define "family caregiver" broadly to include relatives, chosen family, friends, neighbors, and other trusted supporters. The rule should also permit ongoing self-attestation of caregiver status and prohibit coverage determination while any exemption or verification is pending.

4. **State Agencies Are Not Ready for the Administrative Burden**.

The proposed rules are being released with minimal time for states to understand and integrate new processes in time for the January 1, 2027 implementation deadline, including complying with detailed federal expectations for verification, outreach, communication, noncompliance procedures, and reporting. This timeline is unrealistic. State Medicaid agencies are still managing the consequences of recent eligibility redetermination challenges, workforce shortages and outdated eligibility systems. Adding a new work requirement process will divert staff and technology resources away from core Medicaid functions such as timely application processing, renewals, appeals, home and community-based services administration, and disability-related eligibility determinations. Enrollment and eligibility workers are responsible for the day-to-day workload of processing paperwork and may not fully understand how to implement work requirements on time. This could result in harmful processing errors that impact coverage for the people who need it most, including those with disabilities.

Opportunities to automate processing of work requirement exemptions are no longer available as the timeline no longer allows for it. For instance, as discussed above, the medical frailty definition differs from what was in the OBBBA. Originally, the medical frailty exemption could have been based on simply having a relevant diagnosis of blindness, substance use disorder, mental disorder, or disability. Physical, intellectual or developmental conditions affecting daily living would also qualify, as well as serious or complex medical conditions. With this changing definition and depending on the disability, CMS has left states to determine whether an enrollee meets the new criteria. Now, a person having one of these conditions or disabilities would also be required to prove that they are unable to work in order to seek the exemption. There is no standard medical assessment that can prove someone's inability to work, and states are left to interpret what constitutes adequate proof. With just a few months until these regulations need to be implemented, states do not have adequate time to set up automation and will struggle with reviewing all the applications for exemptions with the staffing they have.

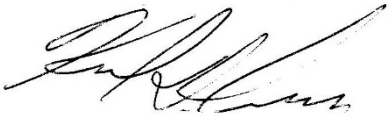
Although the rule recognizes exemptions for certain people with disabilities, disabled people are still at significant risk of losing Medicaid because exemptions must be identified, documented, verified, and maintained through state administrative systems which are not ready to process them. People with disabilities are not a single, easily identifiable group. Many have functional limitations, intellectual or developmental disabilities, communication disabilities, behavioral health conditions, chronic illnesses or invisible disabilities that do not fit neatly into automated data matches. The risk is not theoretical. A work requirement system depends on beneficiaries successfully completing administrative steps, and disability can make those steps harder and not having state systems which are prepared for this onslaught of work will only make it more likely that people with disabilities will fall through the cracks and lose their access to coverage.

We would encourage CMS to delay implementation of these regulations and allow states more time to prepare for these regulations. Many states would welcome this delay and would be able to use that additional time as an opportunity to allow for some automation to be added to the process. Additionally, CMS should not prohibit states from adopting broader, more protective criteria. States need flexibility to recognize conditions and functional limitations that may not fit neatly into a diagnosis list but clearly interfere with compliance. A federal floor should not become a federal ceiling.

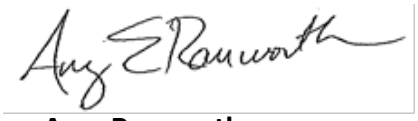
Conclusion

For the reasons stated above, we have significant reservations about the proposed rules and strongly encourage CMS to reconsider them. We suggest that they be withdrawn and revised with a focus on ensuring that those that need the exemptions from the community engagement requirements are protected and not at risk for losing their Medicaid coverage. We would welcome an opportunity to discuss further how this could be accomplished. Thank you for the opportunity to comment. If you have any questions, please contact Karl Cooper at kcooper@aahd.us.

Sincerely,



Karl D. Cooper, Esq.
Executive Director
American Association on Health and Disability
110 N. Washington Street, Suite 407
Rockville, MD 20850
301-545-6140 ext. 204
301 545-6144 (fax)
kcooper@aahd.us



Amy Rauworth
Chief Research and Innovation Officer
Lakeshore Foundation (www.lakeshore.org)
4000 Ridgeway Drive
Birmingham, Alabama 35209
205.313.7487
amyr@lakeshore.org