American Disability and Aging Alliance

July 31, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator, Centers for Medicare &Medicaid Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Re: Public Comments on the Centers for Medicare & Medicaid Services Proposed Interim Final Rule Implementing Medicaid Community Engagement Requirements (RIN 0938-AV98; Docket No. CMS-2026-2047)

Dear Administrator Oz:

The American Disability & Aging Alliance (ADAA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) Interim Final Rule (IFR) implementing Medicaid community engagement requirements for certain Medicaid beneficiaries.

ADAA is a national coalition of aging and disability organizations committed to protecting access to Medicaid, home- and community-based services (HCBS), civil rights protections, and community living for older adults, people with disabilities, family caregivers, and individuals with chronic, complex, behavioral health, and long-term support needs. Our coalition represents organizations that work directly with millions of Americans who rely on Medicaid not only for health care, but also for the long-term services and supports that allow them to live independently, participate in their communities, obtain employment, pursue education, care for family members, volunteer, and avoid unnecessary institutionalization.

Our members represent individuals with physical disabilities, intellectual and developmental disabilities, sensory disabilities, chronic illnesses, behavioral health conditions, substance use disorders, traumatic brain injuries, neurological conditions, rare diseases, and other disabilities who depend on Medicaid to maintain their health, independence, and full participation in community life.

We recognize that CMS is implementing statutory requirements enacted by Congress. Congress has directed the agency to establish a framework for community engagement requirements, and CMS must carry out that directive. At the same time, Congress has entrusted CMS with broad responsibility to determine how those requirements are implemented. The manner in which CMS exercises that discretion will determine whether the new requirements are administered in a way that promotes the objectives of the Medicaid Act while remaining consistent with longstanding federal disability rights laws.

For millions of Americans, Medicaid is the foundation that makes employment, education, caregiving, volunteering, and independent living possible by financing the health care, home- and community-based services, behavioral health treatment, transportation, assistive technology, and other supports needed to live safely in the community.

The greatest risk presented by the Interim Final Rule is not that eligible beneficiaries will refuse to work or participate in their communities, but that they will lose Medicaid because of inaccessible systems, complicated reporting requirements, documentation burdens, state administrative errors, or overly restrictive interpretations of disability-related protections.

Community engagement requirements must not become paperwork requirements. Administrative complexity should never operate as an eligibility barrier. Beneficiaries who qualify for Medicaid under federal law should not lose access to essential health care and long-term services because of inaccessible technology, provider delays, documentation burdens, state errors, or overly narrow interpretations of statutory protections.

CMS has both the authority and responsibility to implement the statute in a manner that protects eligible beneficiaries from avoidable coverage loss while advancing the objectives of the Medicaid Act. These comments therefore focus on how CMS can administer community engagement requirements in a manner that minimizes unnecessary burden, promotes continuity of coverage, and ensures full compliance with federal disability rights laws.

The recommendations that follow are intended to assist CMS in developing a regulatory framework that supports employment and community participation without creating unnecessary barriers to health care, long-term services and supports, or community living for the millions of Americans who rely on Medicaid every day.

I. The Interim Final Rule Misunderstands Disability and Community Participation

The Interim Final Rule rests on an assumption inconsistent with modern disability policy: that an individual's ability to consistently complete eighty hours of work or other qualifying community engagement activities each month is an appropriate measure of disability or functional capacity. Although the rule recognizes that some individuals should be excluded from the requirement, its overall structure reflects an outdated understanding of disability that does not align with current medical knowledge, federal civil rights law, or the lived experiences of people with disabilities and chronic health conditions.

Disability is rarely static. Individuals often experience fluctuating health conditions that change from day to day, week to week, or month to month. Many disabilities and chronic illnesses are episodic, meaning a person may function well for extended periods before experiencing significant symptom flare-ups, medical complications, hospitalizations, treatment-related side effects, mental health crises, or interruptions in caregiving and support services. Conditions such as multiple sclerosis, lupus, Crohn's disease, epilepsy, sickle cell disease, migraine disorders, bipolar disorder, major depressive disorder, cancer, HIV, autoimmune diseases, traumatic brain injury, and many behavioral health conditions frequently involve periods of relative stability followed by periods of substantial functional limitation.

Similarly, individuals with autism, intellectual and developmental disabilities, ADHD, fetal alcohol spectrum disorders, dementia, schizophrenia, Parkinson's disease, stroke-related disabilities, and other neurological or cognitive disabilities may have stable physical health while simultaneously experiencing significant challenges with executive functioning, communication,

decision-making, organization, memory, processing speed, sensory regulation, or adapting to changes in routine. These disabilities may not prevent employment altogether, but they often make rigid monthly reporting requirements particularly difficult to navigate.

The Interim Final Rule implicitly divides beneficiaries into two categories: those who can engage in qualifying activities and those who cannot. Disability rarely functions in such binary terms. Functional capacity exists on a continuum and is influenced by numerous factors beyond an individual's diagnosis. Whether someone can work, volunteer, attend school, or participate in community life depends on the interaction between their health condition and the accessibility of the surrounding environment. Transportation, workplace accommodations, caregiver availability, accessible housing, assistive technology, behavioral health services, home- and community-based services, and the availability of direct support professionals often determine whether an individual can participate successfully in community life.

Federal disability policy has spent more than fifty years moving away from simplistic questions of whether an individual is "disabled enough" or "able to work." Instead, Congress and the courts have consistently recognized that barriers within society—not disability alone—often prevent participation. The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Workforce Innovation and Opportunity Act, and the Supreme Court's decision in *Olmstead v. L.C.* all embrace a social and civil rights model of disability. These laws seek to remove barriers, expand opportunities, and provide reasonable modifications so that people with disabilities can participate fully in society alongside their nondisabled peers.

The Interim Final Rule should reflect this modern understanding. The purpose of disability policy is not to determine whether someone is capable of working every month without interruption. Rather, it is to identify and remove barriers that unnecessarily limit participation. A beneficiary who misses work because a personal care attendant does not arrive, because a wheelchair is awaiting repair, because transportation is unavailable, because behavioral health symptoms worsen, or because a chronic illness unexpectedly flares has not failed to engage with their community. They have encountered barriers that disability policy is specifically designed to address.

The rule also fails to recognize that disability and community participation are not mutually exclusive. Millions of Americans with disabilities are employed, volunteer in their communities, raise children, care for aging parents, pursue higher education, operate businesses, participate in civic organizations, and contribute meaningfully to society while simultaneously relying on Medicaid-funded services and support. Their participation is made possible because barriers have been reduced—not because their disabilities have disappeared.

Equating intermittent employment or periods of medical stability with an ability to consistently satisfy an eighty-hour monthly requirement ignores the realities of disability and risks excluding precisely the individuals Congress intended to protect. Such an approach is inconsistent with the objectives of the Medicaid Act and decades of bipartisan disability policy promoting employment, independence, and community integration.

Recommendations

CMS should revise the Interim Final Rule to reflect contemporary disability policy to:

- Recognize that disability is dynamic rather than static and that functional capacity frequently fluctuates over time.
- Clarify that the ability to work intermittently or during periods of medical stability should not be interpreted as evidence that an individual can consistently satisfy monthly community engagement requirements.
- Direct states to evaluate disability using individualized functional assessments rather than simplistic assumptions based on work history or diagnosis alone.
- Explicitly acknowledge that environmental barriers, access to supports, and reasonable accommodations substantially influence an individual's ability to participate in community life.
- Ensure that implementation of community engagement requirements advances, rather than undermines, the principles embodied in the ADA, Section 504, Section 1557, and *Olmstead*.

II. The Definition of "Medically Frail" and Special Medical Needs Is Too Narrow and Relies on Outdated Disability Concepts

The Interim Final Rule's implementation of the statutory exclusion for individuals who are "medically frail or otherwise have special medical needs" is among the most significant concerns presented by the regulation. While Congress recognized that certain individuals require protection from community engagement requirements because of disability, chronic illness, or other serious health conditions, the Interim Final Rule interprets those protections far more narrowly than necessary.

Under the rule, individuals must demonstrate not only that they have a qualifying disability, chronic medical condition, behavioral health condition, substance use disorder, functional limitation, or other special medical need, but also that the condition significantly impairs their ability to satisfy the monthly community engagement requirement. These standard risks excluding many individuals Congress intended to protect.

The additional requirement fundamentally changes the nature of the exclusion. Rather than recognizing disability itself as the basis for protection, the rule requires beneficiaries to prove that their disability renders them sufficiently incapable of consistently meeting an eighty-hour monthly requirement. Modern disability policy has deliberately moved away from requiring individuals to demonstrate profound incapacity before receiving civil rights protections or reasonable accommodations. The Interim Final Rule risks reviving precisely the type of binary disability determination that federal disability law has spent decades rejecting.

The terminology itself also warrants reconsideration. The phrase "medically frail" reflects an outdated medical model of disability that defines people according to perceived weakness, dependency, or vulnerability. Many individuals with disabilities do not identify as frail and would reject that characterization entirely. A person with a spinal cord injury, cerebral palsy, blindness, deafness, autism, an intellectual disability, multiple sclerosis, epilepsy, or a psychiatric disability may be highly independent, employed, raising a family, serving as a

caregiver, volunteering, and participating actively in community life while still relying upon Medicaid-funded supports to maintain that independence. Describing these individuals as "frail" is inaccurate, stigmatizing, and inconsistent with the person-centered principles that have guided disability policy for decades.

Equally concerning is the rule's apparent reliance on medical diagnoses and documentation as proxies for functional capacity. Diagnosis codes alone cannot capture the complexity of disability. Two individuals with the same diagnosis may experience vastly different functional limitations, treatment needs, support requirements, and ability to participate in work or other community activities. Conversely, many disabilities, particularly behavioral health conditions, neurological disorders, rare diseases, and chronic illnesses, may not be fully reflected in claims data despite substantially affecting daily functioning.

The rule also fails to recognize that many disabilities fluctuate over time. Individuals may successfully maintain employment for months before experiencing disease progression, hospitalization, medication changes, behavioral health crises, treatment schedules, caregiver disruptions, or other events that temporarily prevent them from satisfying rigid monthly requirements. Employment should never be interpreted as evidence that an individual no longer requires disability-related protections. For many beneficiaries, Medicaid-funded personal assistance services, assistive technology, behavioral health treatment, transportation, home- and community-based services, prescription medications, and durable medical equipment are precisely what make employment possible. Removing those supports because someone has successfully worked creates a self-defeating cycle that undermines both employment and independence.

The rule also imposes substantial administrative burdens by requiring beneficiaries to continually demonstrate that they remain "medically frail enough" to qualify for protection. This approach unnecessarily delays access to care, increases documentation burdens, creates inconsistent determinations across states, and places individuals at risk of losing coverage despite continuing to meet the underlying statutory criteria.

CMS possesses broad discretion to interpret the statutory exclusion in a manner that is faithful to congressional intent while remaining consistent with modern disability policy. A broader, functional interpretation would better protect beneficiaries with disabilities, chronic illnesses, behavioral health conditions, substance use disorders, neurological conditions, and other special medical needs without expanding the statute beyond its intended scope.

Recommendations

CMS should:

- Interpret the statutory exclusion broadly to encompass individuals whose disabilities, chronic illnesses, behavioral health conditions, or functional limitations place them at substantial risk of losing coverage under community engagement requirements.
- Eliminate the additional requirement that beneficiaries separately prove their condition significantly impairs their ability to satisfy the monthly engagement requirement.

- Clarify that current, recent, intermittent, or part-time employment does not disqualify an individual from disability-related protections.
- Require individualized assessments that consider functional limitations, fluctuating health conditions, treatment needs, environmental barriers, caregiving responsibilities, and available support rather than relying primarily on diagnosis codes or work history.
- Reconsider the continued use of the term "medically frail" and adopt terminology that better reflects contemporary disability rights principles and person-centered policy.
- Require states to evaluate all applicable disability-related categories before determining that a beneficiary is subject to community engagement requirements.

III. Administrative Burden Will Become the Primary Cause of Coverage Loss

The greatest threat posed by the Interim Final Rule is not that eligible beneficiaries will refuse to work or participate in their communities, but that they will lose Medicaid because they cannot successfully navigate complicated administrative processes. Experience from previous Medicaid work requirement demonstrations shows that coverage losses resulted primarily from paperwork failures, reporting errors, inaccessible systems, and procedural barriers—not from a failure to meet substantive eligibility requirements.

The Interim Final Rule requires beneficiaries to understand complex eligibility rules, determine whether they qualify for an exclusion or exemption, collect supporting documentation, monitor deadlines, respond to notices, navigate online reporting systems, and appeal adverse decisions.

Each of these steps creates an opportunity for otherwise eligible individuals to lose coverage for reasons unrelated to their actual eligibility.

These burdens disproportionately affect people with disabilities, older adults, individuals with limited health literacy, people experiencing housing instability, those living in rural communities, and beneficiaries with limited internet access. For many disabled individuals, the reporting process itself becomes a disability-related barrier. Executive functioning disabilities, cognitive disabilities, mental health conditions, communication disabilities, and sensory disabilities can make recurring administrative requirements far more difficult than the underlying work or volunteer activities themselves.

CMS should recognize that unnecessary administrative complexity functions as a barrier to coverage and should minimize reporting requirements wherever possible. States should be required to maximize the use of existing eligibility information, broadly accept self-attestation when appropriate, provide multiple methods for reporting, and prohibit termination when delays result from provider, system, or administrative failures rather than beneficiary noncompliance.

Recommendations

- Require states to use existing eligibility data before requesting additional documentation.
- Broadly accept self-attestation whenever information cannot reasonably be verified through existing records.
- Provide multiple accessible methods for reporting compliance.
- Prohibit termination when delays result from provider or administrative error.

- Publicly report procedural terminations separately from eligibility-based disenrollments.

IV. Provider Verification Requirements Create an Impossible Standard

The Interim Final Rule assumes that health care providers can readily certify whether a beneficiary is capable of satisfying an eighty-hour monthly community engagement requirement. In practice, no standardized medical determination exists for this purpose.

Physicians, psychologists, behavioral health providers, therapists, home- and community-based service providers, and community organizations are trained to evaluate diagnoses, treatment needs, and functional limitations—not to determine whether an individual can reliably satisfy a Medicaid community engagement requirement. Many providers will not know what documentation is required, how CMS expects functional capacity to be evaluated, or whether they are being asked to make a medical, vocational, or legal determination.

Beneficiaries may therefore face lengthy appointment delays, provider fees, incomplete documentation, inconsistent medical opinions, or outright refusals to complete unfamiliar forms. Rural provider shortages and workforce shortages further increase these barriers.

CMS should not allow provider verification to become an unintended eligibility barrier. Beneficiaries should not lose Medicaid simply because no standardized documentation process exists or because providers are unable to complete unfamiliar paperwork within state deadlines.

Recommendations

- Do not require providers to make vocational or Medicaid eligibility determinations.
- Require states to accept existing medical documentation whenever possible.
- Accept beneficiary self-attestation when provider verification cannot reasonably be obtained.
- Clarify that failure to obtain provider documentation alone may never justify termination of coverage.

V. Medicaid Community Engagement Requirements Must Be Accessible, Fair, and Consistent with Federal Disability Rights Laws

Although Congress enacted Medicaid community engagement requirements through statute, CMS retains broad discretion over how those requirements are implemented. That discretion carries an independent responsibility to administer the program in a manner consistent with federal civil rights laws.

The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and the Supreme Court's decision in *Olmstead v. L.C.* all require public programs to provide equal access, reasonable modifications, effective communication, and meaningful opportunities for participation by individuals with disabilities.

Implementation of the Interim Final Rule must therefore extend beyond simply providing accessible notices. States must ensure that every aspect of the eligibility process—including

online portals, call centers, identity verification systems, documentation requests, appeals, hearings, and reporting mechanisms—is fully accessible to individuals with physical, sensory, cognitive, intellectual, developmental, and communication disabilities.

Administrative procedures that appear neutral may nevertheless have a discriminatory effect when they disproportionately prevent people with disabilities from maintaining health coverage. Beneficiaries who lose Medicaid because they cannot navigate inaccessible reporting systems, obtain unfamiliar documentation, or comply with unnecessarily burdensome administrative procedures are not merely losing insurance coverage—they are losing access to the very services that allow them to exercise their civil rights, remain employed, raise families, and participate in community life.

CMS should therefore require states to implement community engagement requirements in full compliance with federal disability rights laws by ensuring accessible technology and communications, providing reasonable modifications, offering multiple reporting and exclusion-request pathways, and maintaining meaningful due process protections before coverage is terminated.

Recommendations

- Require full compliance with the ADA, Section 504, Section 1557, and *Olmstead* across eligibility, reporting, verification, notices, appeals, and hearings.
- Require reasonable modifications and effective communication at every stage of implementation.
- Ensure beneficiaries have multiple accessible methods to report compliance, request exclusions, submit documentation, and file appeals.
- Continue Medicaid coverage during reasonable modification requests, disability determinations, good-cause reviews, and appeals.
- Monitor accessibility barriers, disparities, procedural terminations, and corrective actions affecting beneficiaries with disabilities.

VI. States Must Demonstrate Operational Readiness Before Implementation

Successful implementation of community engagement requirements depends not only on federal policy, but also on each state's ability to administer the program accurately, consistently, and accessibly. The Interim Final Rule assumes that states will be prepared to identify individuals who qualify for statutory exclusions, administer reporting systems, process documentation, evaluate good-cause requests, and protect beneficiaries' civil rights. Many state Medicaid agencies, however, face staffing shortages, aging eligibility systems, provider shortages, and limited accessibility infrastructure.

Experience from previous Medicaid eligibility initiatives demonstrates that even well-intentioned policies can result in widespread procedural disenrollments when implementation systems are not fully prepared. Incorrect notices, delayed processing, inaccessible online portals, incomplete data matching, technology failures, provider verification delays, and staffing shortages have all contributed to eligible individuals losing coverage despite remaining eligible for Medicaid.

The complexity of the Interim Final Rule substantially increases these risks. States will be responsible for determining whether beneficiaries qualify for disability-related exclusions, evaluating medical frailty determinations, processing caregiver exemptions, reviewing good-cause requests, coordinating information from multiple agencies, maintaining accessible communication systems, and administering appeals while ensuring compliance with federal disability rights laws. These responsibilities require significant operational capacity that cannot be assumed.

Before states begin terminating Medicaid coverage based on community engagement requirements, CMS should require them to demonstrate that their systems are capable of accurately identifying protected individuals and preventing wrongful terminations. The burden of implementation should not fall upon beneficiaries who may lose essential health care because of administrative shortcomings beyond their control.

Operational readiness should include more than simply launching an online reporting portal. States should demonstrate that eligibility workers are trained on disability rights obligations, reasonable modifications, accessibility requirements, medical frailty determinations, caregiver protections, and good-cause exceptions. Systems should be tested with individuals who have disabilities to ensure they are usable by people with a wide range of physical, sensory, cognitive, communication, and behavioral health disabilities.

CMS should also establish robust federal oversight to monitor implementation and identify disparities. Public reporting on procedural disenrollments, appeals, reinstatements, and coverage losses among people with disabilities would improve transparency and allow CMS to intervene when systemic problems emerge. Continuous monitoring is particularly important during the early stages of implementation, when administrative errors are most likely to occur.

Successful implementation should be measured not by the number of beneficiaries removed from Medicaid, but by whether eligible individuals maintain uninterrupted access to coverage while states accurately administer statutory requirements.

Recommendations

CMS should:

- Require each state to demonstrate operational readiness before implementing community engagement requirements.
- Verify that states have accessible reporting systems, trained staff, and adequate procedures for identifying exclusions and good-cause exceptions.
- Require states to demonstrate compliance with the ADA, Section 504, and Section 1557 before approving implementation.
- Establish federal oversight and public reporting on procedural terminations, appeals, reinstatements, and disparities affecting people with disabilities.
- Delay implementation in any state that cannot demonstrate that eligible beneficiaries will be protected from wrongful loss of coverage due to administrative failures.

VII. Recommendations and Conclusion

The American Disability & Aging Alliance supports policies that expand opportunities for employment, education, caregiving, volunteerism, and community participation. These goals are central to the disability rights movement and are shared by people with disabilities, advocates, providers, employers, and policymakers.

For millions of Americans with disabilities, Medicaid is not a barrier to employment—it is the foundation that makes employment, education, caregiving, volunteering, and independent living possible. Policies intended to encourage community engagement should strengthen that foundation, not place it at risk.

Although Congress established Medicaid community engagement requirements by statute, CMS retains significant discretion over implementation. That discretion should be exercised in a manner that promotes the objectives of the Medicaid Act, ensures full compliance with federal disability rights laws, minimizes unnecessary administrative burden, protects eligible beneficiaries from avoidable coverage loss, and reflects the realities of disability, chronic illness, and caregiving responsibilities.

Accordingly, ADAA respectfully urges CMS to revise the Interim Final Rule to:

- Adopt a modern, functional understanding of disability that recognizes fluctuating conditions, environmental barriers, and the support that make community participation possible.
- Interpret statutory protections broadly for people with disabilities, chronic illnesses, behavioral health conditions, substance use disorders, and other special medical needs, including individuals who work intermittently or part time.
- Reduce administrative burden by relying on existing eligibility information, accepting self-attestation when appropriate, preventing provider-verification barriers, and protecting coverage when delays are outside a beneficiary's control.
- Require accessible systems, reasonable modifications, effective communication, continuation of coverage during reviews and appeals, and full compliance with the ADA, Section 504, Section 1557, and *Olmstead*.
- Require states to demonstrate operational readiness before implementation and establish federal oversight to monitor procedural disenrollments, appeals, reinstatements, and disparities affecting people with disabilities.

By adopting these recommendations, CMS can implement the statute in a manner that advances employment, independence, and community integration while protecting the health, coverage, and civil rights of the people who rely on Medicaid.

Thank you for the opportunity to submit these comments. ADAA appreciates CMS's consideration of these recommendations and its commitment to implementing the statute in a manner that protects beneficiaries while advancing the objectives of the Medicaid program.

American Disability and Aging Alliance