JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 2454-IFC
7500 Security Boulevard
Baltimore, Maryland 21244-8016

Submitted via Regulations.gov

Re: Medicaid Program: Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)

Justice in Aging appreciates the opportunity to comment on the Interim Final Rule with comment (IFC) regarding implementation of the new Medicaid community engagement requirements (CE). Justice in Aging is a national legal organization whose mission is to improve the lives of low-income older adults. We fight senior poverty through law by securing access to affordable health care, economic security, housing, and the courts for older adults with limited resources. We focus our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have expertise in Medicaid, including for older adults ages 50 to 64 eligible through Medicaid expansion.

We are deeply concerned about the impact of the IFC on older adults, people with disabilities, and the caregivers they rely on for crucial support. Although the community engagement requirements apply to those under age 65**,** they have a significant impact on aging adults. More than 40% of Medicaid enrollees aged 50-64 are enrolled in Medicaid expansion and likely subject to the community engagement requirements.[1] Moreover, many of the age 50+ population report difficulty working due to employment discrimination, caregiving responsibility, or health conditions.[2] It is crucial the community engagement requirements are implemented in a manner that minimizes improper termination or denials, particularly since 1.8 million more people are expected to lose Medicaid than originally projected due to the restrictions in the IFC.[3]

Automatically Excluding Older Adults and People with Disabilities Who Are Never Subject to Community Engagement Requirements

The Centers for Medicare and Medicaid Services (CMS) should ensure states establish clear processes for identifying individuals who should never be subject to community engagement requirements using

[1] Tobey Oliver, *Data Visualization: Older Adults Ages 50–64 Who Rely on Medicaid Expansion*, AARP Pub. Pol'y Inst. (Oct. 2, 2025), https://www.aarp.org/pri/topics/health/coverage-access/older-adults-rely-medicaid-expansion/.
[2] Annette M. Gaudino, *Medicaid Cuts, Including Work Documentation Requirements, Harm Older Adults*, U.C. Berkeley Lab. Ctr. (July 25, 2024), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults/.
[3] Patti M. Boozang, Avi Herring, Adam D. Striar & Elizabeth A. Scott, *CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027–2034, Vital Signs: 50-State Tracking* (Manatt Health July 2026), https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034.

ex parte data to prevent improper disruptions in coverage and unnecessary burdensome paperwork for these individuals.

CMS should require states to automatically and permanently exempt individuals who are categorically excluded under the Budget Reconciliation Act of 2025 (H.R. 1),[4] including older adults age 65 and over, people dually enrolled in Medicare and Medicaid, and those eligible through disability based or other mandatory state plan pathways. State Medicaid agencies are frequently understaffed and operate under significant strain, which could lead to offices sending out CE requirement information and screening forms to all enrollees instead of only those in the expansion and relevant section 1115 waiver programs. To prevent confusion, administrative burden and wrongful termination, CMS should direct states to rely on ex parte systems to identify and exclude people in these groups who are never "applicable individuals" without imposing additional documentation obligations on the applicants or new enrollees.

We also urge CMS to encourage states to identify the Medicaid group that individuals are enrolled in on their Medicaid cards, similar to Connecticut's Husky Health cards.[5] This can help eliminate confusion when it comes to determining the population subject to community engagement. In addition, CMS should require states to clearly indicate whether new applicants are subject to CE requirements, including on paper applications, so applicants receive accurate information at the outset and are not confused or misled during enrollment.

Challenges Determining Who Are "Applicable Individuals"

Under H.R. 1, Medicaid community engagement requirements apply to "applicable individuals" enrolled in two Medicaid categories. The first is the Affordable Care Act Medicaid expansion population (also known as Group VIII) while the second applies to certain section 1115(a)(2) demonstration waivers that provide Minimum Essential Coverage (MEC) to adults age 19-64 who are not pregnant or ineligible for Medicare or Medicaid under the state plan. Identifying "applicable individuals" under Group VIII Medicaid expansion is relatively straightforward, while determining who qualifies across the wide range of section 1115 waiver populations is far more complex. CMS has acknowledged that Section 1115(a)(2) authorities are quite broad and that demonstration waivers vary widely in structure, purpose, and populations served.[6] CMS has committed to conducting a comprehensive review of all approved waivers to determine which demonstration enrollees meet the definition of "applicable individuals" for purposes of community engagement.[7]

We are concerned that several 1115 populations will be subject to the CE requirements with little notice, particularly for non-expansion states. Some 1115 waivers are very similar to expansion. For example, Georgia and Wisconsin implemented 1115 waivers in lieu of traditional Medicaid expansion. These demonstrations clearly include "applicable individuals" given they are almost identical to the expansion population aside from greater income restrictions and work requirements. However, several

[4] 42 U.S.C § 1396a(xx)(9)(A); 42 C.F.R § 435.551.
[5] HUSKY Health Program, *Member ID Cards*, https://www.huskyhealthct.org/members/member_id_cards.html.
[6] Ctr., for Medicaid and CHIP Servs., (CMCS), *All-State Webinar on Medicaid Community Engagement Requirements* (June 9, 2026).
[7] Id.

states, including non-expansion states, operate 1115 waivers that include groups subject to exclusions, such as parent/caretakers and those enrolled in SNAP or TANF who may be subject to those programs' work requirements.[8] Moreover, non-expansion states were not expected to have to comply with the CE requirements, giving them less time to prepare to implement for their 1115 populations. Although CMS has stated it will conduct a systematic review to identify which 1115 demonstrations include individuals subject to community engagement, we remain concerned that states will not have sufficient time to prepare for implementation once those determinations are made.

Implementing community engagement for the expansion population is already a massive burden for states. With the addition of various 1115 waivers, many states will need to account for several distinct populations subject to the requirements, while some non-expansion states may also need to develop new systems to comply with the CE requirements within a matter of months. Since determining whether someone is an "applicable individual" is a threshold question which states must be able to answer beginning in January 2027, we urge CMS to complete its review of section 1115 waivers quickly to maximize states' preparation time. We also recommend that CMS provide good faith exemptions or additional flexibility, particularly for states with 1115 populations subject to community engagement, to prevent enrollees from being penalized while states work to implement the rules.

We are also concerned about potential confusion for older adults and people with disabilities who may be enrolled in applicable 1115 waivers and also receiving home- and community-based services (HCBS) under another waiver authority. Under the IFC, enrollees receiving services solely through 1915(c) waivers are not considered applicable individuals. However, it is less clear for 1115 waiver enrollees, who may receive Minimum Essential Coverage under one 1115 while also receiving HCBS under another waiver. CMS' stated purpose for these community engagement requirements is 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."[9] Since older adults and people with disabilities who receive HCBS rely on Medicaid to live safely and independently, terminating Medicaid due to the confusion regarding these section 1115 waivers undermines CMS' own goals. We strongly urge CMS to clarify that HCBS enrollees are not "applicable individuals" and thus not subject to these requirements.

Family Caregiver Exclusion Is Narrowed Beyond the Statute

The IFC narrows the caregiver exclusion beyond the statute. H.R. 1 explicitly uses the RAISE Family Caregiver Act (RAISE Act) to define family caregiver as a family member "or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[10] Meanwhile, the IFC limits the exclusion only to caregivers of children age 13 or under and disabled individuals under the Americans

[8] Ctrs. for Medicare & Medicaid Servs., *Demonstration and Waiver List: Section 1115 Demonstrations*, Ctrs. for Medicare & Medicaid Servs., *Demonstration and Waiver List: Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demonstrations.
[9] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348, 33354 (June 3, 2026) (hereinafter IFC).
[10] Pub. L. No. 115-119, 132 Stat. 23 (2018).

with Disabilities Act (ADA) definition.[11] The RAISE Act's language is broader and covers individuals with disabilities, as well as those with chronic conditions or functional limitations so as to accurately reflect all individuals who need caregiving. Though CMS notes there is no upper age limit for disabled individuals, many older adults do not identify as disabled despite otherwise meeting the criteria, in which case their caregivers would have difficulty showing they qualify for the exclusion.[12] Consequently, the IFC's narrower definition risks excluding caregivers for many older adults.

CMS should clarify that states must use an inclusive, ADA-aligned definition that does not require unnecessary or burdensome documentation such as a showing that the care recipient has a disability determination, or receives disability benefits. This approach would help identify caregivers of older adults while minimizing personal information sharing and burden on the care recipient.

The IFC also deviates from the statutory language in H.R. 1 which uses the RAISE Act definition of a caregiver as someone having a "significant relationship" with the individual receiving care. Instead, the IFC arbitrarily requires caregivers to be relatives or household members to qualify for the exclusion. With 60% of caregivers residing outside of the care recipient's home, and another 11% providing care to non-relatives,[13] this leaves out many trusted and valued friends, neighbors, and community members who provide essential care outside of traditional familial relationships or households to older adults and people with disabilities. To be excluded from community engagement, the IFC once again deviates from H.R. 1 by requiring these non-relative caregivers who do not reside with the care recipient to provide at least 80 hours of care, without combining other qualifying activities, despite providing the same support as other caregivers.

The application of the IFC's relative or household member requirement is arbitrary, as evidenced by the example of Cassandra. Cassandra is enrolled in Medicaid expansion coverage and is the primary caregiver to her godfather with Alzheimer's, whom she's known her entire life and who lives several miles away. Given the fluctuating nature of caregiving, she spends as few as ten hours and as many as twenty hours weekly caring for her godfather depending on his care needs and the availability of his neighbors who help out. Since Cassandra is not providing care to a relative or household member, she only qualifies for the exclusion if she provides 80 hours of care each month; if she cannot meet the 80-hour threshold, she must find other qualifying work or community engagement opportunities to meet the community engagement requirements—opportunities which may afford her less availability to care for her godfather. Moreover, to qualify for the exclusion, Cassandra must provide 80 hours of caregiving to her godfather and cannot combine 80 hours of caregiving with other qualifying activities, making the exclusion potentially more burdensome than demonstrating compliance with the community engagement requirement. If Cassandra were providing the same care to an aunt, [14] even if she has little

[11] 42 C.F.R § 435.554.
[12] See Molly Meade & Jeffrey Kullgren, *Experiences of Disability After Age 50: Poll Looks at Self-Identity and Help in Health Care*, Univ. of Mich. Inst. for Healthcare Pol'y & Innovation (2025) (Report finding that only 19% of adults age 50+ self-identified as disabled despite half meeting the ADA definition of disabled).
[13] AARP Pub. Pol'y Inst., *Caregiving in the U.S. 2025* (2025), https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/caregiving-in-us-2025.doi.10.26419-2fppi.00373.001.pdf.
[14] 42 C.F.R § 435.554(a)(ii) defines relative as the disabled individual's husband, wife, son, daughter, stepson, stepdaughter, grandson, or granddaughter; 42 C.F.R § 435.553(a)(iii) gives states the option to expand this

relationship with that aunt, she would qualify for the exclusion without needing to provide a set number of care hours. This distinction is arbitrary and significantly undermines the exclusion for family caregivers included in H.R. 1. and could force older adults and people with disabilities to go to institutions or other costly forms of care.

We also express concern that the verification process may place a substantial administrative burden on family caregivers and create an insurmountable administrative barrier for eligible individuals. Beginning in 2028, states must require Medicaid enrollees to provide information to verify they are eligible for the caregiving exclusion even when no formal records exist, a process that will harm unpaid caregivers. Requiring documentation is excessively burdensome where such care is not captured by state systems. States do not have the infrastructure for unpaid caregivers to register as such, nor the requirement to set up a caregiving database. States that require extensive verification risk excluding caregivers who perform essential work but cannot produce documentation that does not exist, thereby systematically denying Medicaid coverage to eligible individuals. Without accessible verification pathways, many eligible individuals will experience coverage loss simply because their caregiving is not documented in official systems.

Medically Frail Exclusion Significantly Burdens Older Adults and People with Disabilities.

Congress established the Medicaid community engagement requirement in H.R. 1 with a clear, categorical exclusion for "medically frail" individuals.[15] However, the IFC deviates from the statutory language by adding a new requirement: individuals must not only fall within one of the listed categories, but must also prove that their condition “significantly impairs” their ability to meet the community engagement requirement. This additional requirement contradicts the statute, which provides that individuals meeting one of the five listed categories are excluded as medically frail, full stop.[16]

The added “significantly impairs” requirement poses substantial challenges for older adults with serious health conditions and people with disabilities. For one, the IFC introduces substantial complications for individuals who qualify as blind or disabled under section 1614 of the Social Security Act. Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) recipients are eligible for Medicaid through SSI or other disability-based pathways. However, some are enrolled in expansion coverage (or relevant section 1115 waiver) for a variety of reasons. For example, an SSI recipient may go over the low asset limit and thus lose eligibility for Medicaid on that basis, but remain eligible for Medicaid coverage under expansion eligibility criteria. People with disabilities who are SSDI beneficiaries must wait for two years to be eligible for Medicare. During that waiting period, they often enroll in Medicaid expansion for

definition to other relatives based on blood, adoption, or marriage. This means that in some states, caring for a cousin could make someone exempt but in other states not, regardless of the actual caregiving relationship.

[15] P.L. 119-21 § 71119(a)(xx)(9)(A)(ii)(IV).

[16] The five medically frail categories under H.R. 1 require the individual 1) meet the blind or disabled as defined in section 1614 of the Social Security Act; 2) have a disabling mental disorder; 3) have a substance use disorder; 4) have a serious or complex medical condition; 5) have a physical, intellectual, or developmental disability that significantly impairs your ability to do one or more activities of daily living.

health coverage. These examples are in addition to many people with disabilities who enroll in Medicaid expansion while applying for SSI or SSDI, or while waiting for prolonged disability determinations.[17]

The IFC's arbitrary addition of the "significantly impairs" standard creates an additional burden for SSDI recipients. Under H.R. 1, individuals found disabled under Social Security rules, such as SSDI recipients, are excluded as medically frail by virtue of their SSDI alone. The statute does not impose any other restrictions for the medically frail exclusion. However, the IFC now requires all medically frail individuals to also show their condition or disability significantly impairs their ability to meet the community engagement requirements, meaning they must not be able to engage in the qualifying activities.[18] Thus, the IFC is effectively requiring states to conduct a separate evaluation to determine if an individual who is medically frail, including individuals on SSDI, can engage in the qualifying activities.

The IFC does not state that an SSDI determination satisfies the significantly impairs standard for the medically frail exclusion. This means a state Medicaid agency could make their own determination that an individual can engage in qualifying activities like completing 80 hours of work, volunteer, or attend school half-time, even if they have SSDI, and thus not grant them the exclusion. This contradicts the statute which finds a Social Security disability determination alone is enough for the exclusion and creates an excessive burden for both states and SSDI recipients to demonstrate their disability "significantly impairs" their ability to comply with community engagement.

For example, Carl, age 60, hurt his back while working in construction, forcing him to stop working the job he had his entire life. He gets approved for SSDI in February 2028. Since his SSDI income is over the limit for disability-based Medicaid, he enrolls in Medicaid expansion so he can be covered during his 24-month Medicare waiting period. At renewal, the state finds that although he is on SSDI and satisfies the first prong for determining medical frailty, his disability does not significantly impair his ability to attend school half-time, volunteer, or participate in a combination of qualifying activities. He subsequently loses the health coverage that helps him manage his condition.

The added "significantly impairs" standard also restricts states' ability to use ex parte data for medically frail exclusions. Although the IFC requires states to rely on ex parte data whenever possible, it offers little guidance on how to operationalize this process when it comes to the "significantly impairs" standard. For example, CMS requires states to use relevant claims data as ex parte data sources for verifying medical frailty.[19] However, claims data rarely include more than services provided for purposes of reimbursement or diagnoses. Claims data does not show whether an individual can work or volunteer for 80 hours, or attend school half-time. In other words, the IFC alters medical frailty into a determination that cannot be made through existing data sources, including Social Security disability data for the reasons stated above, effectively negating ex parte review. Given these challenges in ex parte review, individuals who should qualify for the medically frail exclusion will instead face additional

[17] See KFF, *What Could Medicaid Work Requirements Mean for SSI Applicants?* (2026), https://www.kff.org/medicaid/what-could-medicaid-work-requirements-mean-for-ssi-applicants/; See also Rachel Vanneman, *Cuts to Medicaid Expansion Harm People with Mental Health Disabilities* (Nat'l Health L. Prog. Apr. 16, 2025), https://healthlaw.org/wp-content/uploads/2025/04/Vanneman_NHeLP_Cuts-to-Medicaid-Expansion-Harm-People-with-Mental-Health-Disabilities_041625.pdf.
[18] P.L. 119-21 § 71119(a)(xx)(2); 42 C.F.R § 435.552(a).
[19] IFC at 33394.

verification steps, provider forms, and paperwork. These administrative burdens increase the likelihood that eligible older adults and people with disabilities will experience wrongful adverse actions, not because they fail to meet statutory criteria, but because the IFC imposes an additional requirement that cannot be satisfied through ex parte review.

The IFC also increases administrative burden by significantly limiting self-attestations for medically frail individuals after 2027, despite the statute having no such restriction.[20] This limitation harms older adults and people with disabilities, populations that rely on Medicaid to help with their disabilities and manage their chronic health conditions. Consider an individual with Multiple Sclerosis (MS) which greatly limits their mobility due to muscle weakness and nerve pain. They could qualify for a medically frail exemption through self-attestation because their condition impairs at least one activity of daily living (ADL). Yet their Medicaid claims may reflect only routine encounters, such as primary care visits or prescription refills, which offer no insight into whether they can complete the qualifying activities. Moreover, certain conditions like MS often take years to diagnose due to complex diagnostic criteria and the lack of a singular accurate diagnostic test.[21] In such case, claims data would not show a particular condition or diagnosis. Additionally, MS flare-ups can be very sporadic, resulting in someone potentially going months with minimal symptoms while experiencing debilitating pain in other months. Without self-attestation, they will have to undergo a burdensome verification process to demonstrate they cannot meet the community engagement requirement, which might not fully capture the fluctuations of their condition.

The significantly impairs standard and limitations on self-attestation are without statutory authority and will force states to require overly burdensome documentation and extensive verification leading to loss of coverage for eligible individuals. We recommend CMS remove the significantly impairs standard for determining medical frailty and allow self-attestations during all review periods after 2027.

Challenges in Implementing Short-term Hardship Exceptions

Older adults and people with disabilities frequently experience periods of intensive medical care such as in-patient hospitalizations, nursing facility stays, and similar treatments to manage complex or chronic conditions. Receiving this care naturally inhibits an individual from meeting community engagement requirements. Without this hardship exception, people who rely on these medically necessary services could lose coverage while they are using Medicaid for its intended purpose. Thus, states should be strongly encouraged to adopt the optional hardship exceptions to prevent enrollees from being penalized for unavoidable health-related interruptions.

We are also concerned the short-term hardship exceptions may be difficult to implement. Short-term hardships apply only to "applicable individuals," who must demonstrate compliance, a mandatory exception, or short-term hardship retroactively in the one to three months prior to application or renewal.[22] At the same time, the IFC states that a hardship exists during any month in which a person

[20] See 42 U.S.C 1396a(xx)(5).
[21] Habiba Atta, *MS Diagnostic Delays Persist, Especially in Under-Resourced Areas*, Am. J. Managed Care (July 22, 2026), https://www.ajmc.com/view/ms-diagnostic-delays-persist-especially-in-under-resourced-areas.
[22] IFC at 33364 ("... compliance with community engagement is assessed for a time period that predates an individuals' application or renewal date…").

receives inpatient or comparable care.[23] One standard treats the hardship as protection during the period of intensive treatment, the other applies it only after the fact. This mismatch creates operational confusion for enrollees and undermines the purpose of the exception. CMS should clarify how the hardship exception should function for individuals who rely on inpatient care or residential care, particularly older adults and people with disabilities who experience these episodes most often.

Ensuring Accessibility and Other Safeguards

As we expressed, we are very concerned that these community engagement requirements will lead to improper coverage loss for groups that rely on Medicaid, particularly given the quick timeline for implementation. Thus, CMS should ensure states provide accessible information in multiple languages and through multiple formats. The information should include reporting requirements, details on the exclusion processes and documentation requirements, processes for requesting accommodations, and a contact for additional questions and assistance with completing forms and submitting information.

Accessibility also extends to the systems people use to apply, report, and renew coverage. States should thoroughly test online portals, mobile tools, and paper processes for user ability to ensure they are accessible to older adults and people with disabilities. Clear guidance on appeal rights is equally important. Enrollees need straightforward explanations of how to keep coverage during an appeal, the deadlines for requesting review, and the timelines for state decisions, along with practical assistance completing forms or securing representation.

Finally, CMS must make explicit that coverage cannot be terminated when a state fails to provide adequate notice or meet basic due process standards. To ensure transparency, states should also be required to report regular, publicly available data to CMS on disenrollments, exemptions, and potential coverage losses associated with community engagement implementation. Ensuring strong communication protections is critical to preventing avoidable loss of coverage for eligible individuals and maintaining fairness across the program.

Conclusion

We appreciate your consideration of our comments on this IFC. As previously stated, our concerns are rooted in the barriers imposed by community engagement requirements, particularly for older adults and people with disabilities. We encourage CMS to issue further guidance to limit improper coverage loss. For additional questions, please reach out to Gelila Selassie at gselassie@justiceinaging.org.

Sincerely,

Natalie Kean
Managing Director, Health Advocacy
Justice in Aging

[23] 42 C.F.R. § 435.555.