July 31, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2454-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

[CMS-2454-IFC] Medicaid Program; Community Engagement Requirement for Certain Individuals

Submitted electronically via: https://www.regulations.gov/commenton/CMS-2026-2047-0002

Dear Administrator Oz,

We appreciate the opportunity to comment on the interim final rule with comment period, [CMS-2454-IFC], Medicaid Program; Community Engagement Requirement for Certain Individuals. We recognize that the rule takes effect on July 31, 2026, the same day this comment period closes. We nonetheless urge CMS to address the issues identified below through subsequent rulemaking, sub-regulatory guidance, or both. Several are matters CMS can resolve quickly and at little cost, and resolving them would reduce administrative burden on states while protecting coverage for the older adults our members serve.

LeadingAge, together with our state partners, represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with state partners whose members are active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care.

Summary of Recommendations
Our comments and recommendations address six areas of the IFC. In brief, we urge CMS to:

1. Apply the medically frail exclusion using the five categories of qualifying conditions Congress enacted, without the additional requirement at 42 C.F.R. § 435.554(c)(5)(i) that the condition also significantly impair the individual's ability to comply;
2. Confirm that states may consider instrumental activities of daily living—including transportation, medication management, communication, and money management—

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alongside activities of daily living when assessing whether a condition impairs the ability to comply;

3. CMS should confirm in guidance that states may partner with trusted community organizations—including HUD- and Treasury-assisted senior housing providers, service coordinators, and Area Agencies on Aging—to deliver the outreach required by 42 C.F.R. § 435.561, and should publish model notice and outreach language that states can share with those partners.
4. Confirm that election of the Medicaid hospice and palliative care benefit establishes status as a specified excluded individual, and direct states to verify hospice and palliative care election on an ex parte basis;
5. Expand the definition of "disabled individual" to reach individuals with chronic impairments or functional limitations, consistent with the RAISE Family Caregivers Act, and retain in regulatory text that no disability-based benefit or formal medical determination is required;
6. Issue a model verification standard for unpaid family caregiving that states may adopt as presumptively sufficient where documentation does not exist;
7. Clarify that a short-term hardship event occurring in the month of application, renewal, or verification qualifies an individual for the exception for that period; and
8. Permit states to adopt one or more short-term hardship exceptions rather than requiring adoption of all four.

CMS Should Not Condition the Medical Frailty Exclusion on a Separate Finding That the Individual's Condition Significantly Impairs Their Ability to Comply.

Section 1902(xx)(9)(A)(ii)(V) of the Social Security Act excludes from the community engagement requirement any individual who is medically frail or otherwise has special medical needs, and identifies five categories of qualifying conditions. The IFC adds a condition Congress did not write. Under 42 C.F.R. § 435.554(c)(5)(i), an individual is medically frail only if a physical, mental, or other behavioral health condition "significantly impairs the individual's ability to comply with the community engagement requirement" *and* the individual falls within one of the five statutory categories.[1] As drafted, this impairment test is not limited to the fifth category, serious or complex medical conditions. It applies to individuals who are blind or disabled as defined in section 1614 of the Act and individuals with a physical, intellectual, or developmental disability that already significantly impairs the ability to perform one or more activities of daily living. The statute conditions the exclusion on the individual's condition, not on a separate finding about the individual's capacity to complete qualifying activity.

The practical consequence is a second eligibility test that the IFC does not explain how to administer. CMS does not define "significantly impairs," establish a threshold, or identify who is qualified to apply it. States must build auditable lists of diseases, diagnoses, disorders, and conditions to identify potentially medically frail individuals,[2] but a diagnosis code speaks to clinical acuity, not to whether a person can complete required community engagement activity in a month. Claims and encounter data cannot close that gap. States will therefore have to seek documentation

1 42 C.F.R. § 435.554(c)(5)(i).

2 42 C.F.R. § 435.554(c)(5)(ii).

from treating clinicians, and clinicians will be asked to render what amount to occupational capacity opinions—assessments most practitioners are neither trained nor equipped to make, and that eligibility staff are not positioned to evaluate.

The verification rules compound the problem. Beginning January 1, 2028, a state may accept a statement made under penalty of perjury only once during an individual's period of enrollment; thereafter the state must require documentation whenever documentation is reasonably available, and must reverify medical frailty at least every twelve months.[3] The exclusion exists to spare people whose conditions make participation infeasible from the burden of demonstrating participation. Requiring those same individuals to make repeated trips to clinicians and eligibility offices in order to document that their condition prevents participation inverts that purpose. For an older adult with limited mobility, no reliable transportation, or a condition that fluctuates week to week, the documentation burden may exceed what the condition allows. Proving they are unable to comply with community engagement requirements becomes nearly as onerous as actually complying, making the exclusion impractical and a farse.

States have very little time to develop reasoned policy guidance on a standard this consequential before January 1, 2027. The predictable results are inconsistent determinations across and within states, avoidable appeals, and coverage losses among people the statute plainly protects which are most at risk for catastrophic outcomes when they lose coverage.

Recommendation. CMS should revise § 435.554(c)(5)(i) to apply the five statutory categories as Congress enacted them, without an additional impairment finding. If CMS retains an impairment standard, it should define that standard in regulatory text, specify the evidence sufficient to satisfy it, and confirm that the presence of a qualifying condition on the state's list under § 435.554(c)(5)(ii) is by itself sufficient.

CMS Should Not Limit the Impairment Analysis to Activities of Daily Living.
The IFC compounds the problem described above by narrowing the functional vocabulary states may use to apply it. Congress referred to activities of daily living once, and in one place only: in describing a single category of qualifying condition, a physical, intellectual, or developmental disability that significantly impairs the ability to perform one or more activities of daily living.[4] CMS has extended that framing well beyond its statutory place. In explaining the general impairment standard, CMS states that it considers conditions significantly impairing the ability to meet the community engagement requirement to be conditions impairing the ability to perform one or more activities of daily living (ADLs), and that instrumental activities of daily living (IADLs) do not count.[5]

That is the wrong measure for the question CMS is asking. ADLs are the basic tasks of self-care: bathing, dressing, toileting, transferring, continence, and eating. IADLs are the tasks that determine whether a person can hold a job: arranging transportation, managing medications, handling

3 42 C.F.R. § 435.557(f)(1)(i)–(iii).
4 42 C.F.R. § 435.554(c)(5)(i)(D) (implementing § 1902(xx)(9)(A)(ii)(V) of the Social Security Act).
5 IFC at 33373–33376.

money, shopping, preparing meals, keeping a schedule, and communicating by telephone. Capacity for employment tracks the second list far more closely than the first. ADL dependence is a strong indicator that a person needs personal care or institutional services; IADL dependence is the better indicator of whether a person can sustain eighty hours of work, schooling, or community service in a month. CMS has selected the measure less related to the question it is answering.

The resulting gaps are not marginal. An older adult (still under 65) in the early stages of dementia may bathe, dress, and eat without assistance while being unable to keep a schedule, navigate an unfamiliar route, or manage a paycheck. An adult with a seizure disorder who cannot legally drive may have no ADL limitation whatsoever and no means of reaching a job in a rural county. A person recovering from a stroke with expressive aphasia may be entirely independent in self-care and still unable to take direction or communicate with coworkers. Each of these individuals is plainly unable to complete eighty hours of qualifying activity in a month. Under an ADL-only screen, none of them meets the impairment threshold.

The ADL-only screen also departs from how Medicaid measures function everywhere else in the program. Nursing facility level-of-care determinations, functional eligibility for home and community-based services under sections 1915(c) and 1915(i) of the Act, and the assessment instruments states already administer routinely account for IADLs. The IFC asks state eligibility staff to apply an undefined impairment standard using a narrower functional vocabulary than the one embedded in their already familiar assessment tools, and to reach conclusions about employment capacity that those tools were never designed to support. That is a recipe for inconsistent determinations and for denials that will not survive appeal. If states were to adapt those tools for this purpose, extensive testing, training, and outcome verification would need to be conducted to ensure the instruments are reliable in determining the standard for which they are used.

Recommendation. CMS should confirm that, in assessing whether a condition significantly impairs an individual's ability to comply with the community engagement requirement, states may consider instrumental activities of daily living alongside activities of daily living. The statutory reference to activities of daily living governs the single category at § 435.554(c)(5)(i)(D); it does not constrain the broader impairment analysis CMS has adopted, and reading it to do so excludes precisely those individuals whose functional limitations bear most directly on their ability to work.

Older Adults in Affordable Senior Housing Will Be Required to Demonstrate Compliance or Establish an Exclusion, Placing Their Coverage at Risk.

Older adults living in federally assisted senior housing are exposed to losing their Medicaid coverage. The Department of Housing and Urban Development's Section 202 Supportive Housing for the Elderly program serves residents beginning at age 62 and the U.S. Treasury's Low Income Housing Tax Credit's senior buildings serve residents 55+; residents of these and other federal affordable housing programs, including the U.S. Department of Agriculture's Rural Housing Service, are targeted to meet the needs of older adults with low incomes and fall squarely within the adult group and will be applicable individuals unless they receive an exclusion or exception. Our

members are already fielding questions from residents and preparing staff for the new requirements.

Housing providers and, where they exist, service coordinators are being asked to help residents find work, work programs, or volunteer placements, or to assemble documentation for an exclusion. Service coordinators are funded to connect residents to community services, not to navigate Medicaid eligibility, and many properties have no coordinator at all. Residents in this age band are among the least likely to complete a paperwork exchange successfully and among the most likely to have a qualifying condition.

Eliminating the requirement to link medical frailty to an inability to comply, as described above, would allow far more of these residents to be identified as excluded on an ex parte basis and to retain coverage without any beneficiary contact at all.

Recommendation. CMS should confirm in guidance that states may partner with trusted community organizations—including HUD- and Treasury-assisted senior housing providers, service coordinators, and Area Agencies on Aging—to deliver the outreach required by 42 C.F.R. § 435.561, and should publish model notice and outreach language that states can share with those partners.

CMS Should Confirm That Election of the Medicaid Hospice Benefit Establishes Status as a Specified Excluded Individual.

The IFC does not address hospice. As a result, it is unclear whether an individual who has elected the Medicaid hospice benefit qualifies as a specified excluded individual, and states are left to resolve the question on their own. Although most hospice patients are enrolled in Medicare and therefore outside the adult group, adults under 65 who elect the Medicaid hospice benefit are applicable individuals unless an exclusion applies or are accessing Medicaid through another eligibility group.

This gap should be straightforward for CMS to close. Election of hospice requires physician certification that the individual is terminally ill, with a life expectancy of six months or less if the illness runs its normal course. That certification is a documented, auditable clinical determination that already exists in the patient's record. It satisfies the definition of a serious or complex medical condition at § 435.554(c)(5)(i)(E)—a condition that is life threatening—under any reading of the impairment standard CMS ultimately adopts. Hospice election is also visible in the adjudicated claims and encounter data that states must already review for the preceding twelve months when verifying medical frailty,[6] so no new data connection and no contact with the beneficiary is required.

Absent that clarification, individuals in the final months and days of life could be required to obtain additional documentation to maintain their coverage. If they cannot, they risk losing Medicaid eligibility and, with it, the hospice benefit itself—an outcome that serves no one and that shifts costs onto the beneficiary, onto hospices if they choose to continue to serve the beneficiary with

6 42 C.F.R. § 435.557(f)(1)(i)–(iii).

charity care, and onto states or hospitals if these terminally ill beneficiaries seek uncompensated care in hospitals.

Similarly, the proposed rule is silent on how states could add exclusion for individuals that have elected palliative care. States have developed service codes and taken steps to advance palliative care availability. CMS should include current receipt of palliative care services as an automatic qualification for the medical frailty exclusion.

Recommendation. CMS should state in guidance, and confirm in the final rule, that election of the Medicaid hospice or palliative care benefit establishes status as a specified excluded individual, and should direct states to include hospice election among the indicators on the list required by § 435.554(c)(5)(ii) and to verify it ex parte.

CMS Should Broaden the Definition of "Disabled Individual" to Reflect the Full Breadth of Caregiving Responsibilities.

Section 1902(xx)(9)(A)(ii)(III) of the Act draws on the RAISE Family Caregivers Act in excluding family caregivers from the community engagement requirement.[7] The IFC limits that exclusion to caregivers of a dependent child 13 years of age or under or of a disabled individual, and defines "disabled individual" by reference to the Americans with Disabilities Act definition at 28 C.F.R. § 35.108. We appreciate two choices CMS made here. The ADA definition is broad, and the IFC provides that an individual need not be eligible for Medicaid or other federal programs on the basis of disability in order to be a disabled individual. We urge CMS to preserve both in the final rule.

The definition nonetheless falls short of the RAISE Act, which reaches individuals with "chronic impairments or functional limitations" in addition to those who are disabled.[8] That difference matters a great deal for older adults. The University of Michigan's National Poll on Healthy Aging found that only 19 percent of adults age 50 and over identified as having a disability, even though nearly half of those polled met the ADA definition.[9] Although the IFC acknowledges that disability has no upper age limit,[10] a caregiver will not claim an exclusion that rests on a term the care recipient does not apply to themselves.[11] Congress incorporated the RAISE Act's additional language precisely so that caregiving eligibility would track real-world need rather than self-identification or the presence of a formal determination.

Recommendation. CMS should amend the definition of "disabled individual" at § 435.554(a) to include individuals with chronic impairments or functional limitations, consistent with the RAISE

7 Pub. L. No. 119-21, § 71119(a) (adding § 1902(xx)(9)(A)(ii)(III) of the Social Security Act).

8 RAISE Family Caregivers Act, Pub. L. No. 115-119, 132 Stat. 23 (2018).

9 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

10 IFC at 33369.

11 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

Act, and should retain in regulatory text the clarification that no disability-based benefit or formal medical determination is required.

The IFC's Verification Rules Sit Uneasily with How Caregiving Actually Happens.
Beginning January 1, 2028, when data available to the state are insufficient, states must require documentation whenever documentation is reasonably available. Unpaid family caregiving generates almost no records. There is no employer, no timesheet, and no agency file for the daughter who checks on her father each morning, or for the neighbor who manages a friend's medications and drives her to appointments.

We appreciate that the IFC requires states to accept information other than documentation where documentation does not exist or is not reasonably available, prohibits denial or termination on that basis alone, and identifies family caregivers as a circumstance in which documentation is likely unavailable.[12] That protection, however, currently depends on each state's discretion to determine what information is "sufficient," with no federal floor. Caregivers in identical circumstances will be treated differently depending on where they live, and states facing audit exposure have every incentive to demand more rather than less, in spite of the statute's intent to protect these caregivers.

Recommendation. CMS should publish a model standard. For example, a signed statement from the caregiver describing the relationship, the assistance provided, and its frequency, corroborated where available by a statement from the care recipient or another household member, that a state may adopt as presumptively sufficient. A federal safe harbor would reduce state administrative burden and audit exposure while preventing arbitrary coverage loss among caregivers.

CMS Should Align the Short-Term Hardship Exception with the Realities of Acute Medical Care and Allow States to Adopt Exceptions Individually.
People with serious or chronic conditions often experience fluctuating or progressive health needs. Inpatient hospital stays, nursing facility stays, and rehabilitative episodes are medically necessary and frequently unavoidable, and they directly limit a person's ability to complete community engagement-qualifying activity. Without a functioning short-term hardship exception, individuals recovering from surgery, managing an acute episode of a chronic illness, or receiving facility-based care could lose coverage precisely because they needed the services Medicaid exists to provide. We strongly support the exception and encourage CMS to urge states to adopt it.

The Exception is Triggered at the Wrong Time.
Compliance is assessed retrospectively. Applicants must demonstrate compliance for one to three consecutive months immediately preceding the month of application, and enrolled beneficiaries for at least one month during the review period.[13] Because a hardship exception substitutes for compliance, the individual must also qualify for the exception during that same retrospective

12 42 C.F.R. § 435.557(b)(3)–(4); IFC at 33395.
13 Pub. L. No. 119-21, § 71119(a) (adding § 1902(xx)(1) of the Social Security Act); IFC at 33353.

period.[14] Yet the exception is written to apply where, during all or part of a month, the individual experiences a hardship event, including receipt of inpatient hospital, nursing facility, or intermediate care facility services, or other services of similar acuity.[15]

The result is a mismatch that is counter to the exception's purpose. An uninsured adult hospitalized in March cannot apply in March and rely on the exception, because the March stay falls outside the February lookback. If she applies in April, the exception applies—but her March hospital bill goes unpaid unless she happened to comply with the requirement in February. An enrolled beneficiary hospitalized during her renewal month faces the same problem. As drafted, the exception protects people in the month after intensive medical care rather than during it, which must be the opposite of what it was designed to do.

Recommendation. To the fullest extent its authority permits, CMS should clarify that a short-term hardship event occurring during the month of application, renewal, or a more frequent verification qualifies the individual for the exception for that review period.

States Should be Permitted to Adopt Hardship Exceptions Individually.

The IFC provides that a state electing the short-term hardship exception must adopt all four hardship events.[16] Nothing in the statute requires that. States differ, and the work of building policy, verification processes, and eligibility system logic for each event is substantial. A state with persistently low unemployment or limited exposure to federally declared disasters may reasonably prefer to concentrate its implementation capacity on the two medically driven events—inpatient and institutional care, and extended travel for medical services—where it expects meaningful volume and where the coverage stakes for older adults are highest. Under an all-or-nothing rule, a state short on time and staff may then adopt nothing. Older adults **will** lose protections not because the state opposed it, but because the package was too large to build by January 1.

Recommendation. CMS should permit states to elect one or more short-term hardship exceptions through the state plan amendment process rather than requiring adoption of all four. Modular adoption would reduce administrative burden while supporting program integrity, a goal CMS and the states share.

Conclusion

We close with a word about state capacity. Where states are stretched, their ability to administer efficient programs with high standards for program integrity will suffer. States must stand up the community engagement requirement by January 1, 2027, while simultaneously managing, among other responsibilities:

14 IFC at 33364 ("... compliance with community engagement is assessed for a time period that predates an individuals' application or renewal date…").

15 42 C.F.R. § 435.555.

16 IFC at 33380.

- Policy and information technology changes related to provider tax and state directed payment development and changes;
- Compliance with CMS directives on program integrity, including plans for off-cycle revalidations and assessments of the effectiveness of their Medicaid Fraud Control Units (MFCUs);
- Rolling out the Rural Health Transformation Fund;
- Ensuring alignment across agencies related to new requirements in Medicaid and the Supplemental Nutrition Assistance Program (SNAP);
- For some states, re-examining their section 1115 waivers or filing renewals in light of new guidance from CMS;
- For some states, evaluating their provider tax arrangements to ensure compliance;
- The regular daily work of administering the Medicaid program; and
- Preparing for or managing decreased budgets to do all of this work.

The good faith effort exemption offers only limited relief. The IFC caps an initial exemption at six months and requires quarterly updates to sustain it, and CMS anticipates receiving roughly ten requests while expecting to approve two.[17] CMS should consider the comprehensive changes to states' systems and programs and provide lenient granting of good faith exemptions.
CMS's own regulatory impact analysis projects that this rule will reduce Medicaid enrollment by approximately 2.3 million people in FY 2027 and by 3.1 to 3.3 million in later years.[18] Each additional definitional ambiguity, verification step, and documentation demand the IFC layers on top of the statute increases the share of that reduction borne by people who are, in fact, eligible and excluded from the requirement.

As advocates for high-quality long-term services and supports across the aging services continuum, LeadingAge members will continue to serve the Medicaid population wherever they can. We support CMS's efforts to maintain Medicaid as a viable and vibrant program for older adults, wherever they call home, and we believe the recommendations above would advance that goal while reducing administrative burden on states. Please contact Georgia Goodman (ggoodman@leadingage.org) with any questions.

Sincerely,

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17 42 C.F.R. § 435.560(c); IFC at 33430.
18 IFC at 33461.