UCLA School of Law
Collective for Racial & Disability Justice

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Attn: Collective for Racial & Disability Justice
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7/13/2026

Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz,

The Collective for Racial and Disability Justice (CRDJ) submits this comment in response to the Centers for Medicare & Medicaid Services' (CMS) interim final rule, Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC, RIN 0938-AV98). CRDJ urges CMS to withdraw the rule in full.

CRDJ is a research center, committed to advancing racial and disability justice through legal analysis, policy research, public education, community-centered knowledge production, and action-oriented tools. We are commenting on this rule because Medicaid is not merely a health insurance program. For many disabled people, Medicaid is the infrastructure that makes community living possible. It funds personal care services, home and community-based services (HCBS), behavioral health care, substance use treatment, durable medical equipment, prescription medications, transportation, long-term services and supports (LTSS), and other forms of care that support health, autonomy, work, education, caregiving, and community participation.

Although CMS frames the rule as a "community engagement" requirement, the rule would function in practice as a Medicaid coverage termination system. It would condition health coverage on whether individuals can repeatedly prove work, education, community service, income, disability, medical frailty, caregiving, hardship, or other exception status through complex administrative systems. That structure will predictably terminate coverage for eligible people—not because they are ineligible for Medicaid, and not because they refuse to work, but because they cannot navigate or survive an inaccessible paperwork regime.

CRDJ is especially concerned that the rule will harm disabled people and other multiply marginalized communities by making health care contingent on state-recognized productivity, documentation, and impairment. The rule would force people to prove their worthiness for health care through systems that have historically excluded, surveilled, and punished poor,

disabled, racialized, unhoused, criminalized, immigrant, and medically underserved communities.

CRDJ's main concerns are that:

- The rule is a Medicaid termination framework, not a work-support policy.
- The rule's disability-related exclusions and exceptions are inadequate and administratively fragile, and likely to produce exemption churn.
- The rule will cause eligible people to lose coverage through paperwork, misclassification, and inaccessible systems.
- The rule threatens disabled people's health, community living, caregiving networks, presumptive eligibility, and access to crisis care.
- The rule will deepen inequity through surveillance, data matching, managed care involvement, and uneven implementation.
- CMS should withdraw the rule because mitigation cannot fix its fundamental failures.

On June 29, 2026, CMS issued a correction replacing the regulatory text for §§ 435.557 and 435.558, governing verification and noncompliance procedures. The correction clarifies that states must check all reliable information available before requesting information from individuals, must apply exclusions when sufficient information exists, and must provide a 30-day noncompliance response period. These corrections do not substantively alter the rule's fundamental flaws. Rather, they confirm that the rule depends on complex data matching, documentation, medical frailty verification, notices, and state eligibility systems—precisely the systems most likely to produce wrongful terminations for disabled and multiply marginalized people.

BACKGROUND

This interim final rule implements a Medicaid community engagement requirement enacted as part of H.R. 1, the 2025 budget reconciliation law also known as the One Big Beautiful Bill Act (OBBBA) and codified as Public Law 119-21. Section 71119 of that law amended section 1902 of the Social Security Act to add a new subsection, section 1902(xx), requiring states to condition Medicaid eligibility for certain individuals on demonstrating "community engagement." The rule is therefore part of a broader set of Medicaid and health coverage changes that the disability community strongly opposed because of their expected impact on Medicaid coverage, HCBS, direct care, health access, and disabled people's ability to live in their communities. Disability advocates warned that the legislation would not merely reduce federal spending, it would shift costs and administrative burdens onto states, providers, families, caregivers, and disabled people themselves [1-11]. Those concerns are directly implicated by this rule.

Under the interim final rule, the community engagement requirement applies primarily to adults ages 19 through 64 who are eligible for or enrolled in Medicaid through the Affordable

Care Act (ACA) adult group, as well as certain individuals covered through section 1115 demonstrations that provide minimum essential coverage. An applicable individual may satisfy the monthly requirement by working at least 80 hours, completing at least 80 hours of qualifying community service, participating in a qualifying work program for at least 80 hours, enrolling in an educational program at least half time, combining qualifying activities for at least 80 hours, or meeting certain income-based standards.

The rule identifies several categories of "specified excluded individuals" who are not subject to the requirement, including certain former foster youth; American Indians and Alaska Natives; parents, guardians, caretaker relatives, and family caregivers of certain dependent children or disabled individuals; veterans with total disability ratings; medically frail individuals or individuals with special medical needs; people participating in certain drug or alcohol treatment programs; inmates of public institutions; and pregnant or postpartum individuals. CMS also recognizes mandatory exceptions for certain individuals and allows states to adopt short-term hardship exceptions.

Although these exclusions and exceptions are important, they do not eliminate the rule's risk of harm. People must still be identified, verified, classified, and documented correctly in order to benefit from those protections. Disabled people who should be excluded or excepted may still lose coverage if the state cannot identify them through available data, if they miss a notice, if they cannot obtain documentation, if their disability is non-apparent or underdiagnosed, if their condition fluctuates, or if they cannot navigate the reporting process. This structure also creates the risk of **exemption churn**, where a person may be excluded or excepted in one month, subject to the requirement in another, and required to prove exclusion again later because of changes in disability, health status, caregiving, treatment status, housing, work hours, or documentation [12-19]. For people with fluctuating disabilities, episodic illness, caregiving responsibilities, unstable work, or unstable housing, this churn is not a minor administrative inconvenience. It is a recurring threat to coverage, care continuity, and health stability.

The rule requires states to use "reliable information available to the State" before requesting documentation directly from individuals. This may include eligibility records, payroll data, claims and encounter data, state agency records, federal data sources, and other available information. If the state cannot verify compliance, exclusion, or exception status through available data, it must request additional information from the individual. The rule also contemplates a role for **managed care** plans in outreach, education, referrals, and data sharing related to community engagement, raising concerns about privacy, surveillance, conflicts of interest, and the blurring of care coordination with eligibility enforcement.

If the state determines that an individual has not satisfied the requirement and does not qualify for an exclusion or exception, the state must issue a notice of noncompliance and give the individual a limited opportunity to respond. If the individual does not make a satisfactory showing and does not qualify for Medicaid on another basis, the state must deny or terminate Medicaid eligibility. The rule is unusually punitive as individuals denied or terminated for failure

to satisfy the community engagement requirement may also be precluded from receiving advance premium tax credits or premium tax credits for Marketplace coverage, creating the risk of a **coverage dead zone**: no Medicaid, no affordable Marketplace coverage, and no realistic private insurance option.

Moreover, CMS applies the community engagement framework to **presumptive eligibility** and hospital presumptive eligibility, even though those processes often serve as urgent access points for people experiencing sudden illness, injury, psychiatric crisis, substance use crisis, homelessness, domestic violence, pregnancy-related complications, or newly disabling events. The rule also does not treat Medicaid-covered **supported employment** services, including services provided through HCBS waivers or section 1915(i) state plan services, as independently satisfying the work-program pathway, even though many disabled people rely on supported employment, job coaching, habilitation, peer support, and other Medicaid-funded employment services as part of their path toward work and community participation [20-24].

Finally, the implementation timeline magnifies the rule's risks. States must implement complex eligibility changes on a compressed timeline, even though doing so will require major updates to eligibility systems, applications, renewal forms, notices, data-sharing infrastructure, presumptive eligibility processes, provider workflows, managed care coordination, appeals systems, call center scripts, outreach materials, staff training, and reasonable modification processes. States must also ensure that these systems are accessible, multilingual, understandable, and compliant with federal disability civil rights law.

CMS itself acknowledges that implementation of the community engagement requirement will require major system, policy, and operational changes to state Medicaid programs. That acknowledgment underscores the concern that states are being pushed to redesign eligibility systems, verification processes, notices, data-sharing infrastructure, managed care coordination, appeals systems, and accessibility procedures on a compressed timeline. This pushes states to implement changes before many will be ready to do so safely, accurately, or accessibly.

For disabled people, the consequences are especially severe. Medicaid coverage is often the source of the services and supports that make work, education, caregiving, and community life possible. Medicaid funds personal care services, HCBS, behavioral health care, substance use treatment, prescription medications, durable medical equipment, transportation, LTSS, and other care infrastructure [24-28]. Terminating Medicaid coverage because a person cannot prove compliance or exemption status may destabilize health, interrupt treatment, eliminate personal care, prevent them from living in their home or the community, and increase the risk of institutionalization [12, 24, 29-31].

For these reasons, this rule should be understood not as a narrow administrative implementation of a work-related eligibility requirement, but as a major restructuring of Medicaid eligibility. It creates a new system of documentation, verification, surveillance,

managed care coordination, state implementation pressure, and termination that will predictably harm disabled people and other communities already facing structural barriers to health care and public benefits.

THE RULE IS A MEDICAID TERMINATION FRAMEWORK, NOT A WORK-SUPPORT POLICY

CMS describes the rule as a community engagement requirement. That framing obscures the rule's actual operation. The rule does not create jobs, improve wages, expand access to education, provide childcare, fund personal assistance, increase transportation, or remove barriers to employment. Instead, it makes Medicaid eligibility contingent on whether individuals can prove that they have met state-recognized activity requirements or qualify for state-recognized exclusions or exceptions. That is a termination framework.

For disabled people, this distinction is critical. Many disabled people want to work, do work, or would work if provided the necessary supports, accommodations, transportation, personal assistance, flexible scheduling, and protection against discrimination [32-35]. Medicaid can be one of the most important supports that allows disabled people to work [20, 36, 37]. It provides access to medications, personal care attendants, behavioral health care, durable medical equipment, HCBS, and other supports that make employment possible [24, 27, 28, 37].

The rule reverses that relationship. Instead of recognizing Medicaid as infrastructure that supports work and community participation, it conditions Medicaid on work or work-like activity. This creates a harmful cycle where people may lose Medicaid because they cannot work or cannot prove work. After losing Medicaid, they may become less able to work because they lose the care and supports that made work possible.

The rule's treatment of supported employment and Medicaid-funded employment services illustrates why this is not a true work-support policy. Many disabled people participate in supported employment, job coaching, habilitation, peer support, benefits counseling, vocational supports, or other Medicaid-funded services as part of their path toward work and community participation [20, 21, 24, 37-39]. These services are often essential for disabled people who want to work but need individualized support, accommodations, and disability-specific employment infrastructure.

Yet the rule does not treat Medicaid-covered supported employment services as independently satisfying the work-program pathway. That distinction is harmful and counterproductive. It means disabled people may be doing exactly what disability employment policy encourages—building skills, receiving job coaching, preparing for work, or participating in supported employment—but still be treated as not satisfying the community engagement requirement.

A policy that fails to count disability-specific employment supports as meaningful work-related activity does not promote employment. It penalizes disabled people for using the very supports

that make employment possible. This is not a work-support policy. It is a health care termination policy.

> CMS should withdraw the rule because Medicaid should not be transformed into a productivity test. Public health coverage should not be conditioned on whether a person can satisfy or document state-recognized work, education, service, income, disability, caregiving, or hardship status.

THE RULE'S DISABILITY-RELATED EXCLUSIONS AND EXCEPTIONS ARE INADEQUATE, ADMINISTRATIVELY FRAGILE, AND LIKELY TO PRODUCE EXEMPTION CHURN

CMS appears to rely on disability-related exclusions and exceptions to protect disabled people from harm. However, exemptions on paper do not guarantee protection in practice. Many disabled people will still have to prove, re-prove, or document disability, medical frailty, caregiving, treatment status, or hardship in order to keep coverage.

That burden is especially dangerous as many disabled Medicaid beneficiaries do not receive Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare, or a formal disability determination [40]. Others have disabilities that are non-apparent, episodic, fluctuating, contested, newly acquired, or underdiagnosed [41-44]. People with psychiatric disabilities, cognitive disabilities, intellectual and developmental disabilities (I/DD), substance use disabilities, Long COVID, ME/CFS, chronic pain, autoimmune conditions, cancer, HIV, diabetes, traumatic brain injuries (TBI), and other serious or complex conditions may not be readily identifiable through state data systems [40-42, 45].

The rule therefore creates a "prove your disability" regime wherein disabled people would be forced to repeatedly establish that their disabilities are real, serious, and sufficiently recognized by the state. This change creates barriers to care, not meaningful protection.

The rule's treatment of medical frailty is especially concerning. By tying medical frailty to whether a condition impairs a person's ability to satisfy the community engagement requirement, CMS risks denying protection to disabled people precisely because they are working or participating in community life with Medicaid supports. A person may work because Medicaid provides medications, personal care, behavioral health care, transportation, durable medical equipment, or other supports [28, 36, 37, 46]. Treating that work as evidence against medical frailty or disability would punish disabled people for working while disabled.

Policy analyses of the interim final rule have emphasized that CMS's medical frailty framework requires states to consider not only whether a person has a qualifying condition, but also whether that condition significantly impairs the person's ability to work or engage in other qualifying activities [9, 47, 48]. That additional work-capacity inquiry makes medical frailty harder to verify automatically and increases the likelihood that disabled people with serious,

complex, behavioral health, functional, fluctuating, or underdiagnosed conditions will be missed.

The rule's reliance on claims and encounter data also creates predictable gaps. Claims data may show diagnoses, prescriptions, hospitalizations, or service use, but they often will not show whether a person can reliably work, sustain hours, navigate reporting systems, or comply with community engagement requirements. When data are incomplete, states may turn to provider documentation, individualized review, or additional requests for information from the beneficiary. That process increases administrative burden on disabled people, providers, and states, and creates new opportunities for wrongful denial or termination.

Disability is not the absence of work. Many disabled people work part time, intermittently, seasonally, with accommodations, or during periods of relative stability [32, 49, 50]. Others experience flares, relapses, treatment periods, crises, hospitalization, caregiving emergencies, or fluctuating capacity [43, 51]. A rigid monthly requirement does not reflect the realities of disabled workers or disabled people seeking work [40, 49, 52].

The rule will create exemption churn. Disabled people's lives often do not fit into stable, static eligibility categories. Under this rule, ordinary life changes can become repeated threats to Medicaid coverage. A person may be excluded one month, subject to the requirement the next month, and required to prove exclusion again later [14, 18, 53]. This churn will be especially harmful for people with episodic disabilities, chronic illness, mental health disabilities, substance use disabilities, fluctuating work capacity, caregiving responsibilities, or unstable housing [12, 13, 40, 51, 54].

Exemption churn is itself a health harm. It creates instability, anxiety, treatment interruptions, administrative burden, and recurring risk of wrongful termination [14, 53, 55]. For people who rely on Medicaid-funded medications, personal care, behavioral health care, durable medical equipment, or home- and community-based services, even temporary coverage instability can have serious consequences [12, 13, 24, 29, 56].

While the June 29th correction limits some between-renewal reverification of specified excluded status absent information that the status has changed, churn remains a serious concern. People may still move between compliance, exception, exclusion, and noncompliance categories as disability, medical frailty, caregiving, treatment, housing, work hours, or documentation change. Additionally, medical frailty must still be reverified at least every 12 months once verified through reliable information or documentation.

CMS should withdraw the rule because its disability-related protections are too narrow, too burdensome, and too dependent on state recognition. At minimum, CMS would need to require broad self-attestation, prohibit repeated proof of permanent or long-term disabilities, prevent states from using work or wages as evidence against disability, and require broad recognition of non-apparent, episodic, psychiatric, cognitive,

developmental, chronic, and complex conditions. But even these mitigations would not fix the rule's fundamental faults.

THE RULE WILL CAUSE ELIGIBLE PEOPLE TO LOSE COVERAGE THROUGH PAPERWORK, MISCLASSIFICATION, AND INACCESSIBLE SYSTEMS

The rule will predictably terminate coverage for eligible people through paperwork burden, misclassification, and administrative failure. This appears to be built into the rule's very structure.

The rule requires states to verify compliance, exclusion, or exception status. When the state cannot verify that information through available data, individuals must provide additional information. If they do not respond adequately and within the required timeframe, they risk denial or termination of Medicaid coverage.

For many disabled people, this process will be inaccessible. People may miss notices because they are hospitalized, institutionalized, unhoused, incarcerated, in psychiatric crisis, fleeing violence, without stable mail, or dependent on a caregiver to manage paperwork [14, 57, 58]. Others may be unable to use online portals because of inaccessible design, lack of broadband, lack of assistive technology, limited digital literacy, or cognitive and communication disabilities [59-62]. Some may be unable to obtain medical documentation quickly because they lack a regular provider, face specialist shortages, cannot afford transportation, or have been denied appropriate diagnosis or care [63-65]. Such administrative burden often functions as an access barrier [14, 53, 57].

The rule's reliance on data matching also creates risks. Claims and encounter data only reflect what the health system has already diagnosed, coded, and recorded. Payroll data may not capture informal, gig-based, seasonal, self-employed, or fluctuating work. Eligibility records may be outdated. Automated systems may reject documents, misread uploads, mismatch names, or fail to capture complex circumstances. These failures will disproportionately harm people who already face barriers to diagnosis, documentation, employment, and state systems.

The existence of notice and fair hearing rights does not fix this problem. A disabled person who loses access to medications, personal care, behavioral health treatment, durable medical equipment, or HCBS may experience serious harm before an appeal is resolved [13, 29, 55, 56]. Fair hearing rights are meaningful only if people can access them, understand them, obtain assistance, request accommodations, and maintain coverage while the dispute is pending [14, 57, 66, 67].

CMS should withdraw the rule because it knowingly creates procedural disenrollment at scale. No Medicaid rule should be implemented when the agency anticipates that eligible people will lose coverage because of paperwork and administrative barriers.

THE RULE THREATENS DISABLED PEOPLE'S HEALTH, COMMUNITY LIVING, CAREGIVING NETWORKS, PRESUMPTIVE ELIGIBILITY, AND ACCESS TO CRISIS CARE

Medicaid is the foundation of community living for many disabled people. It funds services and supports that private insurance often does not cover, including LTSS, personal care, HCBS, behavioral health care, substance use treatment, supported employment, durable medical equipment, and transportation [24, 27, 28, 68].

Loss of Medicaid can therefore mean far more than loss of a doctor's visit. It can mean loss of attendant care, interruption of psychiatric medication, inability to access substance use treatment, loss of durable medical equipment, inability to remain housed, loss of transportation to work or treatment, hospitalization, crisis, or institutionalization [13, 24, 29, 55, 56, 69].

For disabled people, this rule risks undermining the very infrastructure that supports autonomy and community participation. A person who loses Medicaid may be forced into a nursing facility, psychiatric institution, hospital, shelter, jail, or family home without adequate support. That is tantamount to avoidable segregation and abandonment, not community engagement [24, 29, 31, 70, 71].

Presumptive eligibility is designed to provide temporary access to Medicaid coverage when people appear eligible and need care quickly. It has been used to initiate temporary coverage in time-sensitive settings, including pregnancy, hospital care, emergency care, disaster-related health-system disruption, and reentry or justice-involved transitions [72-75]. These are the kinds of circumstances in which people may need immediate access to coverage because of sudden illness, injury, psychiatric crisis, substance use crisis, homelessness, domestic violence, pregnancy-related complications, cancer diagnosis, or newly disabling events.

Adding community engagement screening or exemption assessment to presumptive eligibility risks delaying or denying coverage at the point when immediate access matters most. People seeking hospital presumptive eligibility may be in pain, crisis, withdrawal, psychiatric distress, trauma, or medical instability. They may not be able to answer complex questions, produce documentation, explain disability status, or prove exemption eligibility in that moment. CMS should not require work, exemption, or community engagement screening at crisis access points. Doing so undermines the purpose of presumptive eligibility and increases the likelihood that people with urgent medical needs will go without care.

The rule also threatens caregiving networks. Although the rule includes a caregiver exclusion, that exclusion is too narrow and administratively vulnerable. Caregiving is often informal, reciprocal, chosen-family based, culturally specific, non-cohabiting, intermittent, and undocumented [76-79]. Many people provide essential care without formal records, fixed hours, or state-recognized caregiver status [76, 80]. Requiring caregivers to prove hours, relationship status, dependency, or disability status will exclude many people who provide essential care [14, 53, 57, 81].

The rule may also worsen the direct care workforce crisis [82-84]. Many direct care workers, home care workers, personal care attendants, peer support workers, and family caregivers are low-paid and may rely on Medicaid themselves. Their work hours may be split across clients, unstable, poorly documented, or difficult to verify [84-87]. If these workers lose Medicaid, disabled people who rely on them may experience disrupted care, missed shifts, hospitalization, or institutionalization risk [24, 29, 88].

> CMS should withdraw the rule because it threatens disabled people's health, care, autonomy, employment, family stability, and ability to live in the community. Further, the rule would likely deepen the direct care crisis by destabilizing the care workforce and the disabled people whose independence depends on that workforce.

THE RULE WILL DEEPEN INEQUITY THROUGH SURVEILLANCE, DATA MATCHING, MANAGED CARE INVOLVEMENT, AND UNEVEN IMPLEMENTATION

The rule's harms will not fall evenly. They will fall hardest on disabled people who are also Black, Indigenous, Latine, Asian American and Pacific Islander, poor, unhoused, immigrant, criminalized, rural, LGBTQ+, limited-English proficient, medically underserved, or otherwise multiply marginalized.

The rule relies on state systems that already reproduce inequity: health care documentation, diagnosis, provider certification, payroll records, claims data, data matching, mail notices, online portals, call centers, eligibility workers, managed care systems, and appeals processes [14, 53, 57, 89]. These systems have demonstrated racial disparities in diagnosis and treatment, ableism in medical systems, language access failures, digital exclusion, employment discrimination, housing instability, transportation barriers, and histories of surveillance and punishment [58, 59, 61, 90-94]. A person's ability to keep Medicaid under this rule will depend not only on whether they are working, disabled, caregiving, or experiencing hardship, but whether those facts are legible to the state.

The rule also raises serious privacy and surveillance concerns. Medicaid data collected for care should not be repurposed into an eligibility policing system. Disabled people and other marginalized communities may reasonably fear that sensitive information about disability, substance use treatment, behavioral health, immigration-related household circumstances, caregiving, employment, or incarceration will be used against them. That fear may chill enrollment, renewal, treatment, disclosure of disability, or requests for help.

Technology and vendor systems deepen these concerns. States may rely on automated tools, data matching, eligibility vendors, document upload portals, optical character recognition, call center scripts, and electronic verification tools to implement the rule. These systems can become hidden disability gatekeepers when they are inaccessible, unaudited, inaccurate, or too rigid to capture complex lives.

Managed care involvement raises additional concerns. The rule allows managed care plans to assist with outreach, education, referrals, and data sharing related to community engagement. Even if managed care entities are not making final compliance determinations, their involvement may blur the line between care coordination and eligibility enforcement.

Managed care plans may already control or influence access to services, prior authorization, care coordination, provider networks, HCBS, and utilization management. If those same entities are involved in gathering or transmitting information related to work, disability, medical frailty, treatment, caregiving, or compliance, beneficiaries may experience care systems as surveillance systems.

This is especially concerning for people with psychiatric disabilities, substance use disabilities, HIV, chronic illness, immigration-related fears, criminal legal system involvement, or prior experiences of medical discrimination. People may avoid disclosing disability, treatment needs, caregiving arrangements, or hardship if they fear that information could be used to terminate coverage. Medicaid data collected for care should not be repurposed into eligibility policing. CMS should not create a system in which the entities involved in managing disabled people's care also help feed data into processes that can result in loss of coverage.

> CMS should withdraw the rule because it creates a surveillance and verification infrastructure that will deepen racialized disability inequities and expose marginalized communities to new forms of administrative harm.

CMS SHOULD WITHDRAW THE RULE BECAUSE MITIGATION CANNOT FIX ITS FUNDAMENTAL FAILURES

CRDJ urges CMS to withdraw the rule in full. If CMS declines to withdraw the rule, it must at minimum delay implementation and adopt extensive safeguards. These would need to include:

- Broad self-attestation
- Continued coverage during appeals, accommodation requests, documentation efforts, exemption reviews, and hardship determinations
- Accessible and multilingual notices
- Human review of automated decisions
- Privacy protections
- Broad caregiver protections
- Recognition of non-apparent and episodic disabilities
- Protections for disabled workers
- Recognition of supported employment and disability-specific employment services
- Robust public reporting
- Prohibition on repeated proof of long-term disabilities.

However, these safeguards would not correct the core problem. The rule's fundamental failing is that it makes Medicaid coverage contingent on productivity, documentation, and state recognition. It creates a system in which low-income people must repeatedly prove that they

are working, too disabled to work, caring for someone, medically fragile enough, in crisis enough, or otherwise deserving enough to keep health care. That is inconsistent with the principle that health care should support life, autonomy, and community, not function as a reward for administrative compliance.

> CMS should withdraw the rule.

CONCLUSION

The impact of this rule on the disability community would be profound. Disabled people would lose coverage not only because they fail to meet an 80-hour monthly requirement, but because they cannot prove compliance, cannot obtain documentation, miss a notice, cannot access an online portal, lack a formal diagnosis, experience fluctuating capacity, rely on informal caregiving, or are misclassified by data systems that do not understand their lives.

The consequences would be immediate and serious. People could lose medications, personal care services, HCBS, behavioral health care, substance use treatment, durable medical equipment, transportation, and access to providers. Some would lose the supports that make work possible. Some would lose the care that allows them to live in their homes and in the community. Some would become uninsured altogether, especially if termination also prevents access to subsidized Marketplace coverage.

The rule would not just affect individual beneficiaries. It would destabilize families, caregivers, direct care workers, community-based providers, hospitals, behavioral health systems, and the disability community writ large. It would deepen existing inequities by placing the heaviest burdens on those least able to navigate complex administrative systems and those most likely to be underdiagnosed, undocumented, surveilled, or excluded.

Medicaid should not be transformed into a health care termination system. Disabled people and other multiply marginalized communities should not have to prove their productivity, impairment, caregiving, crisis, or deservingness to keep the care they need to live. For these reasons, CRDJ respectfully urges CMS to withdraw the interim final rule in full. If you have any questions, please feel free to contact Dr. Kate Caldwell at caldwell@law.ucla.edu.

Sincerely,

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