MEDICARE RIGHTS CENTER
Getting Medicare right

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VIA ELECTRONIC SUBMISSION

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Baltimore, MD 21244

Re: RIN 0938-AV98 Medicaid Program; Community Engagement Requirement for Certain Individuals [CMS-2454-IFC]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Medicaid Community Engagement** interim final rule with comment period. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals. Our mission is to support people with Medicare and to advance policies that improve coverage and the enrollee experience.

These comments are informed by decades helping older adults and people with disabilities enroll into Medicare for the first time, access high-quality care, and navigate complex benefits.

The Medicare population is not statutorily affected by HR 1's Medicaid work and reporting requirements. But we have deep concerns that the administrative and bureaucratic challenges of this law, exacerbated by this flawed interim final rule, will result in many people—including caregivers and those who are dually eligible for Medicare and Medicaid—losing coverage and being unable to get the help they need to resolve administrative eligibility issues.

We urge CMS to make clear to states that people with Medicare must not have their Medicaid coverage interrupted. This population is not eligible for adult group Medicaid and is also statutorily exempted from HR 1's Medicaid community engagement.

We also urge CMS to work with states to develop clear communications for all people with Medicaid—both populations that are impacted by HR 1's changes and those that are not—to reduce confusion, ensure people understand what they must do to get and keep coverage, ease fears for populations that are not affected, and provide information about appeals or other resources where there are cases of administrative error.

To facilitate this outreach and education, we encourage increased funding to and support of State Health Insurance Assistance Programs (SHIPs). Additional resources are needed to meet the growing demands for one-on-one counseling and information that HR 1 and demographic changes are expected to yield.

Value of Medicaid Coverage

People with dual eligibility for Medicare and Medicaid rely on Medicaid for wraparound coverage and financial support. This includes reduced costs, care in the home and community, other health benefits not covered by Medicare, and Medicare premium payment through Medicare Savings Programs (MSPs). When eligible beneficiaries lose access to Medicaid coverage and financial assistance, they may delay care or skip it altogether, as well as face impossible choices, like whether to pay monthly Medicare premiums or monthly rent.

This Interim Final Rule is Deeply Flawed

At a minimum, for the reasons outlined below, portions of the rule that address medical frailty should be withdrawn or revised. This should also trigger state implementation extensions upon request to minimize care disruptions and preserve eligibility for millions of beneficiaries.

1. The final rule makes it harder for states to appropriately exempt people with serious and complex health conditions from the work requirement

The text of HR 1 creates categories of people who are not subject to the new eligibility requirements. One such exclusion is for people who are "medically frail or otherwise ha[ve] special medical needs."[1]

The rule attempts to define medical frailty by adding a requirement, not in the statute, that for such medical frailty or special medical needs to count, they must impair "an individual's ability to engage in community engagement activities."[2] This addition departs from the plain language of the statute, creating an arbitrary process for determining frailty that runs counter to congressional intent, as it would ultimately result in medically frail people not receiving the

[1] 2 U.S.C. 1396a § (xx)(9)(A)(i).
[2] 91 Fed. Reg. 33348, 33373.

statutorily required exemption. In addition, it puts people with serious health conditions at risk if they can only work *because* they have Medicaid coverage.

2. These added barriers will tax state resources and burden state systems even further

We know from our experience, including during the post-pandemic Medicaid unwinding, that even individuals whose circumstances are not directly affected by a law or procedural change can fall through the cracks and lose coverage when state Medicaid programs are made more complex or resources are diverted. Independent analysts agree. For example, one study shows that nearly one in seven low-income Medicare beneficiaries lost coverage for at least one month from April 2023 to September 2024 during unwinding, and fewer than one-third re-enrolled within six months despite the likelihood they were still eligible.[3]

3. The rule will overburden providers and interfere with access to care

Determinations of an inability to engage in community engagement activities will also overburden medical and other providers who will be called upon to make determinations about work ability that are beyond the scope of their licenses or expertise.[4] This will unnecessarily clog the health system and take time and attention away from delivering needed health care, therapy, or other services.

Combined, these factors will lead to a worsening health system for everyone and many individuals losing coverage despite statutory protections.

For these reasons, we urge CMS to change course and withdraw or revise portions of this rule that address medical frailty. In the meantime, CMS should grant states implementation extensions to ensure Medicaid disruptions are as limited as possible.

Conclusion

Thank you again for the opportunity to provide comments. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

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[3] Eric T Roberts, *et al.*, "Disenrollment Rate For Dual-Eligible Beneficiaries During Medicaid Unwinding, 2023–24" (March 2, 2026) https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.01209?journalCode=hlthaff. https://ihpi.umich.edu/news-events/news/medicaid-unwindings-effects-dual-eligible-individuals-mapped.

[4] American Medical Association & Massachusetts Medical Society, "Brief of Amici Curiae in Support of Plaintiff's Motion for a Preliminary Injunction" (July 21, 2026), https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/07/Massachusetts_2026.07.21_AMICUS-BREIF-AMERICAN-MEDICAL-ASSOCIATION-ET-AL.pdf.

Sincerely,

Fred Riccardi
President
Medicare Rights Center