Submitted via Regulations.gov
July 31, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-8016

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

Dear Administrator Oz:

The Consortium for Constituents with Disabilities Emergency Management Task Force (CCD EMTF) appreciates the opportunity to comment on the Interim Final Rule with Comment Period, *Medicaid Program; Community Engagement Requirement for Certain Individuals*.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. The Emergency Management Task Force advocates for the rights of persons with disabilities as it relates to policies and services before, during, and after disasters to ensure everyone has access to needed supports and services.

We are deeply concerned that the Interim Final Rule will increase the risk that eligible people with disabilities lose Medicaid because of administrative barriers, especially during disasters and public health emergencies. For many people with disabilities, it is the foundation that makes it possible to live safely and independently in the community. Medicaid supports medications, health care, behavioral health treatment, home- and community-based services, personal assistance, durable medical equipment, assistive technology, transportation, and other services necessary to maintain health and independence.

A disruption in Medicaid coverage can quickly become life-threatening during a disaster. The loss of these essential services may lead to preventable hospitalization, institutionalization, homelessness, deterioration of health, or death. CMS must therefore evaluate this rule as an emergency preparedness, continuity of care, civil rights, and community resilience issue.

Disasters disrupt every part of the Medicaid eligibility and renewal process. People may be displaced from their homes. Mail may be delayed, destroyed, or sent to an address where no one resides at the time. Electricity, phone service, internet access, transportation, and government offices are frequently interrupted during disasters. Medical records may be inaccessible, and health care providers may be closed, or the workers may be displaced or overwhelmed.

Under these conditions, requirements that depend on timely notices, online portals, repeated documentation, provider verification, or rapid responses to state agencies will likely cause eligible people to lose coverage.

People with disabilities may also face additional barriers understanding notices, using inaccessible websites, obtaining documents, communicating with agencies, or navigating complex exemption processes. These barriers become more severe during emergencies, when everyday supports and routines have been disrupted.

CMS should not create a system in which people lose health coverage because a hurricane destroyed their paperwork, a wildfire displaced them, a flood closed their provider's office, or a power outage prevented access to an online portal.

The rule's disaster-related hardship protections are inadequate if they are optional, limited to narrow geographic areas, or tied only to the formal incident period. The effects of a disaster often continue long after the hazard has passed or a declaration has ended. Disabled survivors may lose accessible housing, transportation, employment, caregivers, medical providers, equipment, or community-based services for months or years. A person may be displaced outside the declared area while still experiencing the direct effects of the disaster. Others may be evacuated before a formal declaration is issued.

Disaster protections should therefore apply automatically to people living in, evacuated from, displaced from, or otherwise directly affected by a declared emergency or disaster. These protections should remain in place through the actual response and recovery period, not only during the official incident period.

820 First Street, NE Suite 740 • Washington, DC 20002 • PH 202-567-3516 •
FAX 202-408-9520 • Info@c-c-d.org • www.c-c-d.org

CMS should require states to:

- suspend community engagement requirements and related adverse actions during disasters and recovery;
- automatically extend deadlines for applications, renewals, redeterminations, reporting, and verification;
- Place an automatic temporary hold on requiring electronic visit verification
- continue Medicaid coverage without interruption when communications, transportation, health care, housing, or government systems are disrupted;
- accept self-attestation of disaster-related hardship;
- use available government data rather than requiring survivors to prove disaster impacts;
- reinstate coverage retroactively, without gaps, when disaster conditions contributed to noncompliance or procedural termination; and
- Continue providing services for people displaced outside a declared county or state.

The medical frailty process is too burdensome for disaster conditions. The rule's medical frailty process is overly complex. Requiring people first to prove that they have a qualifying condition and then to prove that the condition significantly impairs their ability to satisfy the community engagement requirement places an unreasonable burden on applicants, enrollees, clinicians, and states.

Clinicians diagnose and treat health conditions. They may not be prepared to determine whether a person can complete a specific number of hours of work, education, or volunteer activity every month. During a disaster, a person may be receiving care from an unfamiliar provider at a shelter, noncongregate place like a hotel, or another temporary setting. Their regular provider may be unavailable, and records may not be accessible.

A survivor should not lose Medicaid because an emergency clinician cannot complete a separate functional or work-capacity assessment.

CMS should:

- eliminate the additional "significantly impairs" test;
- allow ongoing self-attestation;
- prohibit repeated verification of permanent or lifelong disabilities;

- accept previous disability and functional determinations made by other federal or state programs;
- recognize episodic, fluctuating, progressive, and disaster-exacerbated conditions;
- consider limitations in communication, executive functioning, adaptive functioning, transportation, and navigating complex systems, not only basic activities of daily living; and
- maintain coverage while an exclusion decision is pending.

Medicaid is essential to preparedness and continuity of care

When Medicaid coverage is lost, due to paperwork or due to displacement across state lines, people may delay care, ration medications, lose attendant services, or be unable to repair or replace essential equipment. They enter the next hurricane, wildfire, flood, extreme heat event, winter storm, power outage, or public health emergency with fewer resources and greater risk.

During response, even a short coverage interruption can prevent a pharmacy from filling medication, interrupt attendant services, delay replacement of a wheelchair or oxygen equipment, stop access to behavioral health and substance use disorder treatment, or even stop dialysis treatments altogether. These disruptions can force people into emergency rooms, hospitals, shelters, or institutions, or could possibly lead to death.

Coverage loss increases the risk of institutionalization

Medicaid coverage is often what allows people with disabilities to remain in their homes and communities. After a disaster, survivors may need personal assistance, replacement equipment, home modifications, accessible transportation, medication management, etc.

When these supports are unavailable, disabled people may be discharged from hospitals to nursing facilities, psychiatric facilities, assisted living facilities, or other congregate settings because no community-based alternative has been arranged. Once institutionalized, people lose their house, employment, possessions, relationships, and access to their community networks. Returning to the community once institutionalized can be extremely difficult. Efforts should be made towards rebalancing and increasing home- and community-based services

Medicaid coverage is life-sustaining disaster infrastructure. It supports health, independence, preparedness, continuity of care, and the right of people with disabilities to remain in their homes and communities. Medicaid means much more than health insurance to many people; it's a lifeline to independence.

A disabled person should not lose Medicaid because a disaster interrupted their mail, transportation, internet, medical care, records, employment, or access to government systems. A person awaiting a disability determination should not lose the health coverage needed to manage and document that disability. A survivor should not be institutionalized because an administrative coverage loss interrupted the services that made community living possible.

CMS must ensure that implementation of the community engagement requirement does not increase preventable harm, institutionalization, or death during disasters and emergencies.

Thank you for the opportunity to comment.

Respectfully submitted,

Marcie Roth, Germán Parodi, and Shaylin Sluzalis
Co-Chairs
Consortium for Constituents with Disabilities
Emergency Management Task Force