July 31, 2026

Submitted Electronically via *www.regulations.gov*

Re: Comments on CMS Interim Final Rule: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC; RIN 0938-AV98)[1]

Dear Administrator Oz:

Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members serve millions of Medicaid beneficiaries who depend on home medical equipment and supplies — including oxygen therapy, ventilators, enteral nutrition, wheelchairs, complex rehabilitation technology, and other life-sustaining devices — to live safely and independently in their communities.

AAHomecare is submitting comments on the above-captioned interim final rule with comment period (the "Rule"), which implements the community engagement requirement under section 1902(xx) of the Social Security Act (the "Act") for certain Medicaid expansion adults. While we recognize that Congress mandated these requirements in H.R. 1, we are deeply concerned that the Rule's implementation framework — particularly its restrictive medical frailty definition, verification burdens, and disenrollment procedures — will predictably disrupt access to medically necessary DMEPOS services for vulnerable patients who should remain eligible for Medicaid.

CMS's own Regulatory Impact Analysis projects that between 3.1 and 3.3 million individuals will lose Medicaid coverage under the Rule, while the Congressional Budget Office and Urban Institute project coverage losses of 5.2 to 7 million.[2] CMS further estimates that approximately 7 percent of individuals who are working or otherwise meeting the requirement will nonetheless lose coverage due to administrative or procedural reasons.[3] Many of these individuals depend on ongoing home medical equipment and supplies that cannot be safely interrupted. For patients on continuous oxygen therapy, home ventilation, or enteral nutrition, even brief coverage lapses can be immediately life-threatening.

We urge CMS to address the following concerns to protect patient access to medically necessary DMEPOS and to minimize the harmful unintended consequences of community engagement implementation.

I. Protect Continuity of Care for DMEPOS Services

[1] 91 Fed. Reg. 33,348 (June 3, 2026).
[2] See 91 Fed. Reg. at 33,471 (Table 41); CBO, *Estimated Budgetary Effects of H.R. 1* (June 4, 2025).
[3] See 91 Fed. Reg. at 33,470.

CMS should encourage and, where its authority permits, require states to implement the community engagement requirement in ways that minimize interruptions in medically necessary DMEPOS services, particularly for patients with ongoing rental equipment and continuous-use supplies.

The Rule provides that states must continue to furnish Medicaid to enrolled beneficiaries until they are determined ineligible, consistent with 42 C.F.R. § 435.930(b).[4] In addition, the Rule prohibits states from imposing any "waiting period" or "lock-out period" following disenrollment for noncompliance with the community engagement requirement.[5] These are important protections, but they do not by themselves ensure continuity of care for patients on ongoing rental DME.

AAHomecare recommends:

- CMS should clarify that state noncompliance and disenrollment procedures must account for patients with ongoing DMEPOS rental arrangements (e.g., oxygen concentrators, ventilators, CPAP devices, wheelchairs) so that equipment is not repossessed during the 30-day cure period or reconsideration period while a beneficiary's eligibility remains unresolved.
- CMS should require that when a beneficiary is reinstated after a coverage lapse — whether through reapplication, reconsideration, or a corrected exclusion determination — retroactive coverage includes continuous authorization for ongoing rental equipment and supplies without requiring new prior authorization, new physician orders, or resetting the capped rental clock.
- CMS should encourage states to establish operational processes to notify ongoing DMEPOS rental providers when a beneficiary's eligibility status changes, so that suppliers can proactively manage equipment continuity and coordinate with patients rather than learning about eligibility lapses only when claims are denied at the point of service.

Medicaid's longstanding requirement of "reasonably prompt" eligibility determinations (section 1902(a)(8) of the Act) and the provision for retroactive eligibility (section 1902(a)(34) of the Act) support these protections. If coverage is ultimately restored — as it predictably will be for beneficiaries who are in fact working, exempt, or medically frail — there is no rational basis for requiring patients to go without life-sustaining equipment during a procedural lapse.

II. Monitor and React Quickly to Patient Care Impacts

Patients with chronic conditions requiring the following DMEPOS items and services are particularly vulnerable to treatment disruptions if Medicaid eligibility lapses:

- Oxygen therapy
- Ventilators
- CPAP/BiPAP
- Enteral nutrition
- Wheelchairs

[4]See also section 1902(xx)(6)(A)(ii)(II) of the Act; 91 *Fed. Reg.* at 33,451.
[5]See 42 C.F.R. § 435.558(e); 91 *Fed. Reg.* at 33,454.

- Complex rehabilitation technology (CRT)
- Ostomy and urological supplies
- Insulin pumps and continuous glucose monitors (where covered under Medicaid)

Many of these patients should qualify as medically frail under the Rule's definition of a "serious or complex medical condition" at 42 C.F.R. § 435.554(c)(5)(i)(E), which includes conditions that are "life threatening," "requiring frequent monitoring," "affecting multiple organ systems," or "requiring adjustment in non-medical environments."[6] However, as demonstrated by prior state experience with work requirements, administrative burdens and procedural errors predictably cause eligible individuals, including those who qualify for medical frailty exclusions, to lose coverage. In Arkansas, for example, an estimated 95 percent of those who lost Medicaid coverage during the state's work requirement program had in fact met the requirement or qualified for an exemption.[7]

AAHomecare recommends:

- CMS should not move forward with requirements for proving that someone is medically frail or with a serious or complex medical condition that are more restrictive than the statute requires. Any administrative burdens imposed by the Rule that are not strictly required by statute are likely to result in unnecessary coverage loss for people who Congress sought to exempt from the work requirement, leading to disruptions in critical care.
- CMS should require states, as part of the monitoring data required under 42 C.F.R. § 435.562(d), to report on coverage disruptions affecting beneficiaries with active DMEPOS claims or rental authorizations, so that CMS can identify and respond to patient care impacts quickly.
- CMS should use its authority under § 435.562(d)(5) ("any other data specified by CMS") to add data elements tracking DME/HME utilization changes, supply disruptions, and associated emergency department or hospital admissions among beneficiaries subject to the community engagement requirement.
- CMS should establish rapid-response procedures for states to report, and CMS to act upon, early warning signals that DME-dependent patients are losing access to equipment and services, consistent with the corrective action authority at § 435.562(e).
- CMS should require states and managed care plans to include ongoing DMEPOS rental providers in their communication and notification processes when a beneficiary's eligibility status changes, so that suppliers can coordinate care transitions rather than experiencing coverage status changes as unexpected claim denials.

III. Preserve Access to Life-Sustaining Equipment

Coverage disruptions for DMEPOS patients are qualitatively different from interruptions in other Medicaid services because of the time-sensitive and life-sustaining nature of the equipment involved. A patient whose oxygen concentrator is removed due to an eligibility lapse may not be able to wait 30 days for a noncompliance cure period, plus the additional time for reinstatement, before resuming therapy. For ventilator-dependent patients, even overnight interruption of equipment access can be fatal.

[6] 91 Fed. Reg. at 33,472.
[7] Sommers et al., "Medicaid Work Requirements In Arkansas: Two-Year Impacts," *Health Affairs* 39(9) (2020).

AAHomecare urges CMS to recognize this reality in implementing the Rule:

- CMS should issue sub-regulatory guidance explicitly identifying DMEPOS items such as oxygen therapy, ventilators, enteral nutrition, insulin pumps/CGMs, wheelchairs, and complex rehabilitation technology as services for which states must take affirmative steps to prevent interruptions during the community engagement verification process.
- CMS should encourage states that elect the short-term hardship exception under § 435.555(a) to recognize that patients receiving home-based services of "similar acuity" to institutional care — such as home ventilation or continuous enteral nutrition — qualify for the short-term hardship exception under § 435.555(d)(1)(ii)(E), which permits states to identify noninstitutional services that match the acuity of inpatient care.
- CMS should supplement the Regulatory Impact Analysis to account for the costs of DMEPOS disruption, including increased hospitalizations, emergency department visits, and equipment reissuance costs that will result from coverage lapses among DME-dependent patients. The current RIA quantifies costs only for the Federal government, States, and beneficiaries, and does not account for provider-side costs or health system spillover effects.

The Rule itself recognizes that coverage loss can cause "negative benefits" for some individuals.[8] CMS has a duty under the APA to reasonably consider this important aspect of the problem.[9] For DME-dependent patients, the predictable consequence of even procedural coverage loss is not merely inconvenience. It is measurable clinical harm, including increased hospitalizations and preventable deaths. Researchers estimate that Medicaid work requirements could cause 7,000 to 9,200 preventable deaths per year across the affected population.[10] The DMEPOS-dependent subset of that population faces among the most acute risk.

IV. Reduce Administrative Burden on Beneficiaries, Providers, and Plans

CMS should encourage streamlined eligibility verification and rapid reinstatement processes to reduce unnecessary administrative burden on all parties.

- CMS should clarify that ongoing DMEPOS utilization data — such as rental claims, encounter records for oxygen equipment, ventilator use, and wheelchair delivery — constitutes "reliable information available to the State" under 42 C.F.R. § 435.557(a) and should be used to support *ex parte* verification of medical frailty exclusions under § 435.557(f)(1). Patients who are continuously receiving oxygen therapy, ventilator services, or enteral nutrition through Medicaid claims plainly have "serious or complex medical conditions" that "significantly impair" their ability to comply with an 80-hour monthly work requirement. Using existing DMEPOS claims data for this purpose would reduce the need for burdensome individualized assessments, additional provider documentation, and patient self-attestation — consistent with the statute's directive that states use "reliable information available to the State" and avoid, "where possible," requiring the individual to submit additional information. (Section 1902(xx)(5) of the Act.)
- CMS should require that reinstatement following a coverage lapse includes automatic restoration of prior DMEPOS authorizations, so that patients and providers do not bear

[8]See 91 Fed. Reg. at 33,459.
[9] *See Motor Vehicle Manufacturers Ass'n v. State Farm*, 463 U.S. 29, 43 (1983).
[10]Woolhandler et al., *JAMA Internal Medicine* (2026).

the burden of re-obtaining prior authorizations, physician orders, and documentation that were valid before the coverage gap.

- CMS should ensure that the six-month (or, where elected, 12-month) redetermination cycle for the community engagement requirement does not create duplicative prior authorization renewal obligations for DMEPOS items whose authorization cycles do not align with the community engagement verification schedule. The Rule should not add prior-authorization burden on top of already-complex DME authorization requirements.

The administrative burden imposed on DMEPOS suppliers by eligibility verification, re-authorization, and coverage-gap management is not accounted for in the Rule's Paperwork Reduction Act analysis or Regulatory Impact Analysis. CMS acknowledged in its RIA that cost estimates "are not expected to be uniform" and that "additional cost implications may be identified that are not fully captured in this analysis."[11] AAHomecare submits that provider-side administrative costs of managing eligibility disruptions for DMEPOS patients constitute such an additional cost implication and should be quantified and addressed.

V. Monitor Access by Product Category and Geographic Area

CMS should require states to monitor whether implementation of the community engagement requirement results in measurable changes in:

- DME/HME utilization (by HCPCS code and product category)
- DMEPOS supplier participation in Medicaid and Medicaid managed care networks
- Rural DMEPOS provider access
- Service delays for medically necessary equipment and supplies
- Hospitalizations, emergency department visits, and urgent care visits associated with interruptions in home-based DME care

Access should be monitored by geographic area and by DMEPOS product category (e.g., respiratory, mobility/seating, enteral, prosthetics/orthotics, diabetes management). This monitoring is critical because the DMEPOS supplier network in many states — particularly rural states — is already fragile. Medicaid reimbursement rates for DME are frequently below cost, and many suppliers operate on razor-thin margins. If the community engagement requirement causes significant eligibility churn, some suppliers may exit the Medicaid market entirely, reducing access for all beneficiaries — not just those subject to the requirement.

AAHomecare has previously recommended that CMS require clear network adequacy criteria by DMEPOS product category and geographic area for both fee-for-service and managed care programs.[12] We renew that recommendation here. The community engagement requirement creates new risks to DMEPOS network adequacy that CMS must monitor and address proactively.

CMS has explicit authority to require such monitoring under § 435.562(d)(5) ("any other data specified by CMS to monitor State implementation") and to take corrective action under § 435.562(e) when data indicate access problems.

VI. Coordinate with Medicaid Managed Care

[11] 91 Fed. Reg. at 33,461.
[12] See AAHomecare, Comments on CMS-2442-P (June 30, 2023).

Because over 80 percent of Medicaid beneficiaries receive services through managed care plans, CMS should encourage states and MCOs to establish clear procedures for handling DMEPOS authorizations, rentals, and ongoing services when beneficiary eligibility changes occur due to the community engagement requirement.

The Rule permits states to utilize managed care plans to assist with outreach and communication activities.[13] However, the Rule prohibits MCOs from determining beneficiary compliance with the community engagement requirement.[14] AAHomecare does not seek to involve MCOs in compliance determinations but instead urges CMS to ensure that MCOs are required to:

- Maintain transition-of-care and continuity-of-care protocols for ongoing DMEPOS authorizations and rentals when a beneficiary's eligibility status is in flux (pending noncompliance cure, pending reapplication, or pending medical frailty determination).
- Notify contracted DMEPOS suppliers when a member's eligibility status changes or is under review for community engagement compliance, so that suppliers can plan for potential coverage gaps and coordinate patient outreach.
- Ensure that capitation and Medical Loss Ratio (MLR) rules (42 C.F.R. §§ 438.4, 438.5, 438.8) are applied in a manner that permits MCOs to continue paying claims for medically necessary DMEPOS services during the 30-day cure period and reconsideration period — which is a covered-service cost for an enrolled member, not an administrative community-engagement activity.
- Establish clear processes for rapid re-authorization of DMEPOS items and services upon beneficiary reinstatement, without requiring new physician orders or new prior authorization for services that were previously authorized.

VII. CMS Should Account for DMEPOS in its Regulatory Impact Analysis

Finally, AAHomecare notes that the Rule's Regulatory Impact Analysis (RIA) does not account for the impact of coverage disruptions on DMEPOS suppliers, homecare service providers, or the health care system costs associated with interruption of home-based equipment services. The RIA focuses exclusively on costs to "Medicaid applicants and beneficiaries subject to the community engagement requirement, States, and the Federal government."[15] It does not quantify uncompensated care, emergency utilization, or provider costs related to eligibility churn — despite CMS's acknowledgment elsewhere in the Rule that coverage losses will occur for procedural reasons even among individuals who are in fact meeting the requirement or qualify for exclusion.

We urge CMS to supplement the RIA to account for: (1) the cost to DMEPOS suppliers of managing eligibility disruptions, including equipment retrieval, storage, redelivery, and re-authorization costs; (2) the downstream health system costs of DME interruptions, including hospitalizations, emergency department visits, and skilled nursing facility admissions that are avoidable when patients maintain access to home oxygen, ventilators, and other equipment; and (3) the cost to state Medicaid programs of these avoidable institutional admissions.

[13] See 42 C.F.R. § 435.561(e)(2); 91 *Fed. Reg.* at 33,478–79.
[14] See 42 C.F.R. § 438.58(b).
[15] 91 Fed. Reg. at 33,459.

Conclusion

AAHomecare supports the goal of promoting employment and self-sufficiency among Medicaid beneficiaries. However, implementation of the community engagement requirement must not come at the cost of life-sustaining home medical equipment access for the most medically vulnerable populations. Many of the individuals most affected by this Rule (i.e., those with chronic respiratory failure, neuromuscular disease, mobility impairments, and other conditions requiring ongoing DMEPOS) are precisely the population Congress intended to protect through the medically frail exclusion.

We urge CMS to issue guidance addressing continuity of care for DMEPOS patients, to require states to monitor DMEPOS access as part of community engagement implementation, to leverage existing DME utilization data for *ex parte* medical frailty verification, and to coordinate with managed care plans to ensure DMEPOS authorizations and rental arrangements are not disrupted during eligibility transitions.Thank you for the opportunity to submit comments. Please contact us if you would like additional information or if we can be of further assistance.

Sincerely,

Tom Ryan
President and CEO
American Association for Homecare