ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

November 10, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

The Association for Behavioral Health and Wellness (ABHW) respectfully requests that the Centers for Medicare & Medicaid Services (CMS) consider the following comments in your work to develop regulations to implement the provisions of the One Big Beautiful Bill Act (OBBBA) of 2025 related to the community engagement requirements. In particular, ABHW would like to offer insights and recommendations regarding the implementation of the statutory exemptions from the community engagement requirements for individuals with mental health (MH) and substance use disorder (SUD) conditions.

ABHW is the national voice for payers managing behavioral health insurance benefits. Our member companies provide coverage to 200 million people in both the public and private sectors to treat MH, SUDs, and other behaviors that impact health and wellness. Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes.

Furthermore, our policy work aims to ensure that physical and behavioral health care is integrated and coordinated. ABHW is committed to ensuring better outcomes for whole-person care for all individuals and communities. We believe access to comprehensive, evidence-based MH and SUD services is critical to enhancing patients' health and overall well-being.

Subject matter experts within our membership met repeatedly to provide recommendations on how to operationalize the behavioral health provisions of the OBBBA. We also sought input from other experts and organizations, and continue to do so. We share our initial key recommendations below and look forward to continuing to solicit ideas and work with you and your staff to ensure the regulations are workable and efficient.

1) REGULATORY RECOMMENDATIONS FOR BEHAVIORAL HEALTH

I. Definitions for Exemptions

Definition for "medically frail"

The OBBBA statute defines several specific categories of individuals to be excluded from the new Medicaid community engagement. Specifically, it defines the term "specified excluded individual" to include an individual "who is ***medically frail*** or otherwise has special medical needs (as defined by the Secretary)," including individuals with a substance use disorder or a "disabling mental disorder."[1] We believe that the phrase "disabling mental disorder" as part of the definition for "medically frail" requires regulatory interpretation.

Other federal agencies have defined Serious Mental Illness "SMI), including, most notably, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The ISMICC was first convened by the Secretary of Health and Human Services under President Trump in 2017 and includes the Secretaries of Veterans Affairs, Defense, Housing and Urban Development, Labor, and Education, as well as the Attorney General and the Commissioner of the Social Security Administration.

The definition for "an adult with SMI" used by ISMICC is:

> **"a person over the age of 18 who currently or at any time in the past year has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities."**[2]

CMS has also adopted this definition for the Serious Mental Illness Section 1115 Demonstration Opportunity.[3]

Definition for "disabling mental disorder" for health care provider determinations

ABHW recommends CMS interpret "disabling mental disorder" to include, at a minimum, the ISMICC definition for "SMI" for the purposes of exemptions from Medicaid community engagement that are based on a clinical evaluation by a qualified health care provider. Licensed clinicians should be able to make individualized determinations consistent with the ISMICC standard. At a minimum, the fact that the phrase "disabling mental disorder" has been defined to *include* adults with a SMI implies that regulations to implement this definition should be no more restrictive than the ISMICC definition for SMI.

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[1] OBBBA Sec. 71119(a), amending 42 U.S.C. 1396a to add new subsection (xx)(9)(A)(ii).

[2] See, e.g., The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). Building on Progress: Federal Action for a System that Works for All People Living with SMI and SED and Their Families and Caregivers, Report to Congress: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2024, p. 11.

[3] SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, p. 1.

We note that OBBBA also requires states to undertake *ex parte* verifications to determine whether an individual is a "specified excluded individual"—i.e., whether they qualify for an exemption to the community engagement. These *ex parte* verifications will include a range of data-matching strategies, and we recognize that the ISMICC definition for SMI will require further interpretation for the purposes of defining specific data queries to apply to existing data sets to identify applicable individuals.

Definition of "disabling mental disorder" for ex parte verifications

For *ex parte* verifications, ABHW recommends that CMS define "disabling mental disorder" to include, at a minimum, any individual who has either:

1. **a qualifying diagnosis; OR**
2. **at least one claim for Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), residential, or inpatient level of care within the past 60 months with a primary diagnosis of MH;**
3. **Worked for and/ or participated in a supported employment program or peer support specialist program for individuals with MH conditions within the past 6 months.**

The ISMICC definition appropriately acknowledges that a wide range of MH conditions can be sufficiently acute to become "disabling," i.e., to cause a "functional impairment that substantially interferes with or limits one or more major life activities," including employment. Any individual who is receiving treatment in an intermediate, residential, or inpatient level of care is, by definition, experiencing significant disruption to their ability to work and participate in other major life activities.

We also note that participation in a supported employment program or a peer support specialist program for individuals with MH conditions would fulfill not only the statutory intent to ensure that vulnerable individuals with MH conditions do not experience disruptions to their treatment, but also the intent to promote engagement in employment activities by Medicaid-eligible individuals. We therefore recommend that CMS include participation in supported employment and peer support specialist programs in any definition for "disabling mental disorder" that is used for ex parte verifications. Additionally, CMS should clarify that volunteer service or employment as a peer support specialist qualifies as a community engagement activity for the purpose of meeting this requirement.

Definition for "Substance Use Disorder"

Finally, we believe that the definition of a "substance use disorder" is clear. **We recommend that regulations define "SUD" to mean meeting criteria for any SUD diagnosis, including early or sustained remission in the latest edition of the Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD). For ex parte verifications, we recommend,**

at a minimum, that the regulations require states to include any health care claim with a primary diagnosis of SUD made within the past 60 months.[4]

> Additionally, OBBBA cross-references the Supplemental Nutrition Assistance Program (SNAP) statute, which defines“ drug addiction or alcoholic treatment and rehabilitation program” as “a private nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act.[5] to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics.”[6] Any patient who is participating in SUD treatment should have an SUD diagnosis and therefore qualify as medically frail, so we suggest defining “participating” in treatment to mean any individual who has received any service with a **diagnosis code of SUD within the past 60 months** from any private non-profit SUD provider, or any publicly operated entity that provides SUD and/or mental health treatment that would be eligible to receive funding under part B of title XIX of the Public Health Service Act, including but not limited to Community Mental Health Centers (CMHC), Certified Community Behavioral Health Centers (CCBHCs) and Opioid Treatment Program (OTP) and designating such individuals as “medically frail” under the SUD exemption to maintain continuity of care and reduced administrative burdens following program completion.

II. Practical considerations for implementation

Methodologies for determining eligibility for an exemption

A range of strategies can be used to make determinations of whether an individual meets the eligibility criteria for an exemption from the new Medicaid community engagement. CMS guidance can help to ensure that states follow best practices for identifying vulnerable individuals whose MH/SUD conditions prevent or materially impede their ability to participate in employment and other qualifying activities, and whose access to essential treatment services may be disrupted by an inappropriate eligibility or enrollment determination.

Attestation and community-based verification mechanisms should be key components of the medically frail determination process. Many individuals with serious behavioral health conditions lack recent claims data or formal diagnoses due to barriers such as limited access to care, stigma, or prior coverage disruptions.

We recommend clarifying that CMS should allow states to establish multi-channel pathways for identifying medically frail individuals, including:

- Self-attestation and third-party referrals (for example, performed by community health workers, probation officers, recovery peers, or case managers);

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[4] https://pubmed.ncbi.nlm.nih.gov/15797639/

[5] 42 U.S.C. 300x et seq.

[6] 7 CFR § 271.2

- Temporary protection or presumptive eligibility pending clinical confirmation; and
- Use of claims data only as one validation layer, not the sole determinant.

These steps would help ensure that ex parte systems remain inclusive of individuals most at risk of losing coverage, particularly those whose behavioral health conditions or recovery engagement are not fully reflected in claims data. The overarching goal should be to provide states with maximum flexibility to integrate data-driven verification with human attestation while maintaining program integrity.

States rely on a range of community and government stakeholders to support Medicaid eligibility and enrollment. CMS should encourage states to align their documentation and reporting requirements and support bidirectional data sharing between states and health plans. To ensure accurate documentation of compliance with or exemptions from the community engagement requirements, we encourage CMS to provide technical assistance and clear guidance to states, ensuring that application questions, IT infrastructure, and data-sharing processes are aligned and interoperable across states.

Lastly, this underscores the importance of integrated systems and provider training. It is also crucial to acknowledge that ongoing workforce shortages may lead to significant delays in accessing care, which could inadvertently prevent individuals from obtaining the necessary documentation to qualify for an exemption.

- Appropriate data look-back period for determinations of "medically frail"

ABHW appreciates the statutory requirements for states to implement ex parte verifications to ensure that eligible individuals are automatically identified and protected from loss of coverage. The chronic, episodic, and recurring nature of MH/SUD conditions makes it necessary to provide for a significant look-back period for determinations of medically frail status based on health care claims and related data sources.

ABHW recommends that regulations require states to undertake data-matching reviews to determine the medically frail status of an individual when making any eligibility determination or re-determination, including upon enrollment and before disenrolling the individual for failure to comply with the community engagement requirements.

ABHW further recommends that the regulations provide that whenever an eligibility determination is made, a minimum look-back period of at least 60 months must be applied for the criteria for determining whether the individual is "medically frail."

- Use of enrollment questionnaires or screening tools

A key concern for eligibility for an exemption based on medically frail status is that many individuals with qualifying MH/SUD conditions are not currently diagnosed or participating in treatment. This concern may be compounded by an unenrolled individual's inability to pay out of pocket for the provider visit. Barriers to access to MH/SUD providers and services in many areas, and in particular to the higher levels of care necessary to qualify as having a "disabling mental disorder," may further limit the ability of an otherwise-eligible individual to obtain a qualifying diagnosis or service. Systemic and practical obstacles prevent individuals from obtaining timely or appropriate behavioral health services and hinder individuals from receiving an assessment or a qualifying diagnosis necessary to access treatment or benefits. As an example, provider shortages, particularly in rural or underserved areas, lead to long wait times for evaluations or ongoing care. Bed shortages in inpatient or residential facilities can delay or entirely prevent admission for individuals in crisis. Transportation challenges and a lack of broadband access for telehealth can further hinder individuals from receiving an assessment or a qualifying diagnosis necessary to access treatment or benefits.

ABHW recommends that regulations provide states the option to allow individuals to identify or attest to being medically frail using a questionnaire or screening tool that is either self-administered or completed with the assistance of a community outreach worker, and to provide for temporary enrollment for individuals who self-refer, with a requirement for a health care provider visit to confirm medically frail status within 90 days. However, a 90-day limit to see a provider following a screening may be unrealistic in certain geographic areas with limited provider availability.

Any proposed time limit for completing screenings should be sufficiently flexible to account for longer wait times, particularly in rural or underserved areas. Telehealth appointments should also be permitted to satisfy these requirements where appropriate.

- Health care provider referrals

Another key concern for eligibility determinations is that patients who are not currently enrolled or are at risk of disenrollment may be deterred from seeking treatment if they are unsure that it will be covered, even where such treatment would qualify them for an exemption. Providers may also be reluctant to accept patients who are not enrolled and may not qualify, or who are enrolled but may be at risk for disenrollment.

ABHW recommends that regulations stipulate that eligibility for the exemption applies as of the date of service when any qualifying provider visit or service is delivered, and that enrollment may be applied retroactively up to 1 month. Thus, for example, if a non-enrolled individual presents for an office visit and is diagnosed with an SUD or SMI, the individual could be retrospectively enrolled and covered for that visit for up to one month after the date of service. Retroactive eligibility would help to ensure that the community engagement requirements do not inappropriately deter patients and providers from seeking/providing medically appropriate services. There is an existing retroactive enrollment authority under 42 CFR §435.915 that reduces care delays and uncompensated provider risk, particularly in behavioral health settings. Retroactive enrollment enhances patient access while promoting administrative feasibility for CMS. It is also important to note that delayed or foregone care disproportionately affects individuals with mental health and substance use disorders due to stigma and the episodic nature of these conditions.

Oversight and community input for state processes for implementing community engagement requirements

State Medicaid agencies with limited budgets and staff may face challenges in implementing and enforcing the new community engagement requirements. Despite the best efforts of these teams, the roll-out of these new requirements is likely to pose significant challenges, and there is a significant risk that individuals who qualify for an exemption will be inappropriately disenrolled or denied enrollment. It is therefore imperative for CMS's regulations to establish processes for state oversight and community input to ensure that best practices are identified and adhered to and that missteps are corrected.

- <u>Oversight Review of Eligibility and Enrollment Determination Processes</u>

CMS regulations should require states to develop and implement strategies to monitor and audit compliance with federal and state requirements for identifying individuals who may qualify for exemptions to the community engagement requirements. Key elements for oversight and monitoring include, but are not limited to, the reliability and validity of the state's data-matching strategy and data privacy and security requirements for sensitive MH/SUD treatment records. Audit designs and results should also be publicly reported.

ABHW also recommends that the regulations provide for CMS to survey and report on national trends, best practices, and empirical data, such as outcomes or findings from states' monitoring and audit strategies.

- <u>Consumer and Community Stakeholder Input for Process Development and Implementation</u>

Medicaid agencies should invite participation and input from consumer advisory bodies and behavioral health and disability community entities in process development and implementation planning for the community engagement requirements and exemption eligibility determinations.

ABHW recommends that the regulations require states to design and be approved to implement a consumer and community stakeholder input process for process development and implementation planning for the community engagement requirements exemption of eligibility determinations.

ABHW also recommends that the regulations provide for CMS to survey and report on national trends and best practices for community and stakeholder input processes and outcomes.

Other considerations

- Qualifying MH treatment time should count toward work hours requirements

Participation in MH treatment can require a significant time commitment that may interfere with the individual's ability to meet the monthly requirements for work hours. To the extent that an individual who is participating in an IOP or higher level of care does not meet the standard for "medically frail," the time in treatment may exceed 80 hours per month.[7,8]

ABHW recommends that, IF the exemption for "disabling mental disorder" is defined narrowly (i.e., such that participation in an IOP and higher levels of care do not by definition qualify the individual as "medically frail"), the regulations should provide that the time participating in medically necessary MH treatment is defined to count toward the individual's required number of work hours. Treatment participation should be recognized as a legitimate work activity that supports both health and employability. Counting such participation toward required work hours promotes fairness, reduces administrative burden, and prevents penalizing individuals who are actively engaged in care.

A qualifying mental health treatment may include any service, program, or activity that is medically necessary for the diagnosis, treatment, or management of an MH/SUD and is provided by a licensed behavioral health professional**.**

- Guidance and Templates for Data Sharing

ABHW urges CMS to develop guidance or templates that advise states on data sharing and promote consistency. Standardization will reduce administrative burden and minimize variation across states as they develop their own data systems.

III. Data privacy and security considerations for SUD treatment information

Determinations of eligibility for an exemption to the Medicaid community engagement requirements for individuals with an SUD will often depend on SUD diagnosis and treatment records that are protected by 42 U.S. Code § 290dd-2 and implementing regulations at 42 CFR Part 2 (Part 2). These protections apply to records created by SUD treatment providers that identify an individual as having an SUD, and impose special

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[7] https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen

[8] https://www.cbpp.org/research/health/harm-to-people-with-substance-use-disorders-from-taking-away-medicaid-for-not

protections for data privacy and security for Part 2 records. In particular, Part 2 information generally cannot be disclosed without patient consent.

The latest updates to the Part 2 regulations permit patients to provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.[9] These regulations specifically define "payment" to include eligibility determinations (via cross-reference to the rules for the Health Insurance Portability and Accountability Act (HIPAA)).[10] Thus, it is reasonable to conclude that patient consent to share for "treatment, payment, and health care operations" ("TPO") includes the use of such records to determine eligibility for a Medicaid community engagement requirement exemption.

However, as noted above, enforcement of this new provision allowing a single consent to share Part 2 records for all TPO purposes will not begin until February 16, 2026. At present, a wide range of stakeholders continue to have questions about the implementation of the new regulations. The new regulations also impose financial penalties for violations and create a new enforcement infrastructure, both of which align with HIPAA enforcement. Given the significant uncertainty of interpretation and anxieties about the new enforcement of the Part 2 rules, it will be helpful for CMS to clarify the application of the Part 2 rules to SUD records that are used in eligibility determinations for exemptions to the Medicaid community engagement requirements.

To avoid ambiguity in implementation, ABHW recommends that CMS clarify in regulation that determinations of eligibility for a community engagement requirement exemption based on a SUD diagnosis or treatment are considered Part 2 records and therefore protected under the Part 2 prohibition on use and disclosure without patient consent.[11]

Similarly, ABHW also recommends that CMS clarify in the new community engagement requirements that determinations of eligibility for an exemption should be met if a patient granted consent for "payment" purposes under Part 2. In other words, a patient who consents to share Part 2 records for TPO purposes should be allowed to use that original consent for determinations of eligibility for a community engagement requirements exemption. We hope that the process is clear, does not create any added burden, or hinder the exemption determination process.

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[9] 42 CFR 2.31(a)(4)(i).

[10] 42 CFR 2.11 "Payment."

[11] 42 U.S.C. § 290dd-2(a)–(b), Confidentiality of Substance Use Disorder Patient Records, "Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research… shall be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b).";42 C.F.R. §§ 2.13(a), 2.31(a).

2) ADDITIONAL RECOMMENDATIONS

I. Managed Care Organizations Play Key Role Connecting Patients to Services

Managed Care Organizations (MCOs) will play a crucial role in the successful implementation of the OBBBA by serving as a vital link connecting individuals to the care and community resources they need. They are uniquely positioned to help their members access SUD and MH providers, coordinate services, and support engagement in treatment and recovery.

For example, MCOs were instrumental in collaborating with CMS and state agencies during the reinstatement of nationwide redeterminations following the conclusion of the public health emergency. Across many states, MCOs supported the development and execution of outreach and education strategies, shared data related to disenrollments and other key metrics, collaborated on process improvement initiatives, and worked to ensure that beneficiaries could successfully navigate the redetermination process. We recommend that CMS schedule regular meetings in 2026 with key stakeholders to discuss guidance, education strategies, operational barriers, best practices, and other issues related to the community engagement requirements.

However, while MCOs can effectively facilitate access to care, they are prohibited by law from supporting the state in determining beneficiary compliance. That function must be handled by state agencies to ensure consistency, fairness, and the appropriate separation between care coordination and eligibility determination.

II. Self-Attestations

Individuals should be allowed to complete their own self-attestations for the community engagement requirements in the OBBBA to ensure the process is accessible and efficient. Allowing self-attestation minimizes administrative burdens for patients, providers, and states and delays that can prevent eligible individuals from receiving timely support, especially those facing barriers such as limited internet access, transportation challenges, or unpredictable work schedules. These self-attestations should be available for completion in either electronic or paper form to accommodate individuals who may have limited technological access or proficiency. Moreover, some states have the modern IT infrastructure and data-sharing capabilities to easily validate these self-attestations through existing systems that interface with employment, education, and training databases, as well as databases that can attest to individuals meeting the exemption based on their diagnoses. This technology-enabled verification approach ensures integrity and accuracy while maintaining a user-friendly, low-burden process for individuals.

III. Grant States Flexibility to Delay Implementation Until Infrastructure is in Place

States need adequate time to develop and test robust data-sharing and IT capabilities that will enable accurate verification of self-attestations, coordination across programs, and real-time tracking of participation. If states are demonstrating a good faith effort and submitting progress of implementation and any barriers, as included in the statute, they should be granted an exemption from compliance until no later than December 31, 2028.

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Thank you for your attention to these recommendations for regulations to implement the new Medicaid community engagement requirements imposed by the OBBBA legislation. ABHW is committed to working with CMS and other partners to ensure that these new requirements are implemented in alignment with Congressional intent, including with regard to the statutory exemptions for individuals with disabling MH disorders and/or who have an SUD.

Sincerely,

Deborah H. Witz

Debbie Witchey, MHA
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