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

July 31, 2026

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

Re: Interim Final Rule: Medicaid Community Engagement Requirement for Certain Individuals, CMS-2454-IFC

Dear Administrator Oz:

The Association for Behavioral Health and Wellness (ABHW) respectfully request that the Centers for Medicare & Medicaid Services (CMS) consider the following comments and recommendations in response to the Interim Final Rule with Comment Period (IFC or Rule) implementing the Medicaid community engagement requirements.

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 mental health (MH), substance use disorders (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 improving outcomes in 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 operationalizing the behavioral health provisions of the OBBBA. We also sought input from other experts and organizations and continue to do so. ABHW appreciates that CMS incorporated some of our suggestions related to mental health (MH) and substance use disorders (SUDs) from the comment letter we submitted in November 2025.

Successful implementation of the community engagement requirements will depend on recognizing the unique operational realities of the behavioral health system. Unlike much of the broader healthcare system, behavioral health providers have historically been excluded from significant federal health information technology investments, resulting in lower adoption of interoperable electronic health records (EHRs) and less complete clinical and claims data. As a result, states may face greater challenges identifying individuals with MH/SUD who qualify for exclusions or exceptions through automated, ex parte processes. Without appropriate safeguards, these limitations could lead to inappropriate coverage losses for eligible beneficiaries. We therefore urge CMS to engage behavioral health stakeholders through listening sessions and incorporate

implementation flexibilities that account for these data limitations while minimizing administrative burden and disruptions in care.

We share our additional recommendations regarding the IFC below and look forward to continuing to work with you and your staff to ensure the regulations are workable and efficient.

1) **Eliminate the Functional Impairment Overlay from the Medical Frailty Definition**

ABHW respectfully urges CMS to eliminate the requirement that an individual demonstrate a functional limitation that impairs their ability to meet the 80-hour monthly community engagement requirement, in addition to having a qualifying medical condition. Consistent with Congress's intent and the statutory framework, a diagnosis falling within one of the five statutory categories of medical frailty should be sufficient to establish eligibility for the exemption.

The additional functional impairment requirement is not required by statute and unnecessarily complicates implementation. A diagnosis-based standard tied to qualifying medical conditions provides a more objective, consistent, and administratively feasible approach to identifying medically frail individuals. It aligns with existing clinical practice, relies on information routinely documented by treating clinicians, facilitates automated identification through claims and encounter data, improves auditability, and reduces administrative burden for states, providers, and beneficiaries.

The proposed functional impairment standard would require providers to produce individualized documentation explaining how a patient's condition affects their ability to meet community engagement requirements rather than relying on existing diagnostic information. This would necessitate new clinical workflows, EHR modifications, documentation protocols, staffing resources, and administrative processes. As discussed above, these burdens are particularly significant for behavioral health providers, who have historically lagged other sectors in health IT adoption, as many were excluded from the HITECH Act's EHR incentive programs. Combined with persistent interoperability barriers, these limitations may delay the exchange of clinical information needed to verify eligibility, creating additional administrative burden for providers and increasing the risk that eligible individuals experience gaps in Medicaid coverage. Additionally, this will also be compounded by the reduction in retroactive Medicaid eligibility under H.R. 1 from three months to one month, increasing the consequences of delays in eligibility determinations.

Beyond administrative burden, the additional functional impairment requirement diverts provider time away from direct patient care, contributes to clinician burnout, and may generate office visits whose primary purpose is completing eligibility documentation rather than delivering medically necessary treatment. Delays in establishing medical frailty status may also interrupt Medicaid coverage, delaying access

to behavioral health and medical services and reducing provider capacity for patients requiring clinical care.

The functional impairment standard is also inherently subjective. Without a standardized methodology, determinations are likely to vary across providers and states, creating inconsistent access to exemptions and increasing the likelihood of appeals and administrative disputes. Because these determinations are administrative, not measures of clinical quality, disagreements regarding exemption decisions could also negatively affect patient experience measures, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS), despite having little relationship to the quality of care delivered.

Behavioral Health Considerations

The functional impairment requirement is particularly challenging for individuals with MH and SUD conditions. These conditions are frequently chronic, episodic, and recurrent, with symptoms that fluctuate over time. Functional limitations may not be evident during a single clinical encounter, and claims data often fail to capture current severity because of treatment gaps, lack of insurance coverage, stigma, or the confidentiality protections of 42 CFR Part 2 (Part 2).

Past experiences with Medicaid community engagement requirements in Arkansas and Georgia demonstrates that administrative complexity, rather than eligibility itself, often results in coverage loss. For individuals with MH/SUD conditions, even brief interruptions in coverage can disrupt access to medications, counseling, recovery supports, and care coordination, increasing the risk of relapse, psychiatric decompensation, emergency department utilization, and hospitalization. A diagnosis-based exemption would reduce unnecessary coverage churn while providing a clearer and more consistent administrative standard.

Operational challenges are particularly acute in states with behavioral health carve-out arrangements. Primary care providers may not have ready access to behavioral health records maintained by separate managed care organizations (MCOs), county behavioral health agencies, or specialty SUD treatment providers. For example, in California, much specialty SUD treatment is delivered through county behavioral health systems, meaning documentation supporting a medical frailty exemption may depend on records that other treating providers cannot readily obtain or verify without specific patient consent.

42 CFR Part 2 Considerations

These operational barriers are compounded by the confidentiality requirements of Part 2. The medical frailty determination for SUD patients may require documentation extending beyond diagnosis codes to include functional impairment, and providers may need additional patient consent before disclosing information necessary to support an exemption. **CMS should clarify that patient consent accompanying a provider's medical frailty attestation, whether incorporated into the attestation itself or executed separately, may authorize disclosures**

necessary to comply with Part 2. Without this clarification, the exemption process may be delayed by avoidable consent barriers.

Patients are unlikely to understand why their treating providers cannot readily furnish documentation supporting an exemption when relevant records reside with separate behavioral health entities or county agencies. This unnecessary fragmentation risks creating frustration and delays that are unrelated to the quality of care provided.

Recommendations:
Accordingly, ABHW recommends that CMS:

- **Eliminate the functional impairment requirement and adopt a diagnosis-based medical frailty standard consistent with the statute.**
- **Establish minimum federal standards for qualifying medical conditions while allowing states to expand their condition lists for the functional impairment requirement as well as all medically frail exemptions.**
- **Require states to use all available data sources, including managed care encounter data, pharmacy claims, care management for information, and other available clinical data, to identify potentially medically frail individuals.**
- **Treat recent use of intensive behavioral health services, including inpatient psychiatric care, residential treatment, partial hospitalization (PHP), intensive outpatient programs (IOP), crisis stabilization services, Assertive Community Treatment (ACT), Certified Community Behavioral Health Clinics (CCBHCs), Opioid Treatment Programs (OTPs), and medications for opioid use disorder (MOUD), as presumptive evidence of medical frailty or, at a minimum, as mandatory triggers for further exemption review without terminating Medicaid coverage.**
- **Ensure state Medicaid eligibility determination processes account for episodic illness, relapse, claims lag, and periods during which individuals lacked insurance coverage.**

2) Definition of SUD: Stable Recovery: Eliminate the Arbitrary Five-Year Recovery Limitation

ABHW recommends that CMS eliminate the proposed five-year limitation on individuals with SUDs who are considered to be in "stable recovery." The IFC excludes these individuals from the medical frailty definition once they have been in recovery for five or more years. ABHW believes this threshold is arbitrary and lacks a clinical or scientific basis. Whether measured from diagnosis, initiation of treatment, or last substance use, the passage of time alone is not a reliable indicator of an individual's treatment needs, functional limitations, ability to satisfy community engagement requirements, or risk of relapse. Recovery is an ongoing process, not a fixed endpoint, and continued access to treatment, recovery supports, and other services remains

critical for many individuals long after they achieve remission. Research has shown that disruptions in recovery support services are a significant contributor to relapse.

Moreover, "stable recovery" is not a standardized clinical designation. It is neither a diagnostic classification under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM) nor an American Society of Addiction Medicine (ASAM) level of care. If CMS retains a time-based framework, it should rely on established clinical terminology. The DSM does not impose an upper limit on sustained remission, making these definitions far more clinically appropriate than an arbitrary five-year cutoff.

The proposed policy is also difficult to administer. Claims and encounter data may identify an SUD diagnosis or treatment history, but they generally do not capture an individual's recovery stage, duration of remission, relapse risk, recovery supports, or current functional status. Likewise, electronic health records do not routinely document a definitive "recovery start date" or consistently track periods of sustained recovery or recurrence of substance use. As a result, states would be required to make eligibility determinations using information that is not routinely collected or readily verifiable.

These challenges become even more significant once the temporary self-attestation policy expires. Beginning in 2028, individuals may be required to obtain provider documentation demonstrating that they have not been in stable recovery for five years. Because recovery has no standardized clinical beginning or end point, providers would be asked to make retrospective determinations that are inherently subjective and difficult to verify. The IFC also does not explain how states should calculate the five-year period, whether a relapse restarts the clock, or how gaps in treatment or insurance coverage should be treated. These operational uncertainties, coupled with the IFC's one-year maximum lookback period for ex-parte reviews, are likely to produce inconsistent eligibility determinations and unnecessary administrative barriers for individuals with qualifying SUDs.

Accordingly, ABHW recommends that CMS eliminate the proposed five-year recovery limitation. If CMS elects to retain a recovery-based framework, it should continue to permit beneficiary self-attestation on an ongoing basis, accept provider attestation without requiring documentation of a specific recovery timeline, and avoid requiring formal ASAM assessments or comparable evaluations solely for purposes of establishing medical frailty. These approaches would reduce administrative burden while improving the consistency and clinical validity of eligibility determinations.

Additionally, if CMS retains the five-year recovery limitation, it should clarify how that standard aligns with the proposed 12-month limit on claims and encounter data, applying the definition of "stable recovery" may require evidence from up to five years, CMS should permit the use of up to five years of look-back data for this purpose. In our comments on the proposed rule submitted in November of 2025, ABHW recommended that CMS allow a 60-month claims look back period to identify individuals with SUDs for purposes of determining

eligibility for the SUD exemption. We wish to clarify that this recommendation was intended solely to expand the timeframe for identifying eligible individuals through claims data. It was not intended to be a recommendation for a 60-month limit on the duration of eligibility for the SUD exemption or to suggest that individuals should lose eligibility after five years.

3) Definition of Disabling Mental Disorders

ABHW is grateful that CMS specifically identified the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), DSM-5, and ICD-10 as appropriate clinical frameworks that states may use when identifying individuals who qualify for the disabling mental disorder definition. In particular, the ISMICC definition of Serious Mental Illness (SMI)is already used by CMS in the SMI Section 1115 Demonstration and is grounded in clinical evaluation by a qualified professional, making it both meaningful and operationally feasible. **We request that CMS develop sub-regulatory guidance or model state plan language to highlight best practices for identifying individuals with disabling mental disorders who qualify as medically frail for the purposes of the community engagement requirement. CMS should encourage states to create a comprehensive list of diagnosis for disabling mental disorders. To protect people with these conditions from losing Medicaid coverage, we urge CMS to encourage states to create a comprehensive list of diagnoses, with input from people with MH, providers, and other relevant stakeholders**

Such guidance should also build on lessons learned from medical frailty determinations for the Alternative Benefit Plans (ABP) and 1115 demonstration contexts but would need to add discussion of best practices for determining that the MH condition significantly impairs the individual's ability to fulfill the community engagement requirement.

4) Extend the Self-Attestation Pathway

CMS is providing temporary flexibility through December 31, 2027, allowing states to accept self-attestation, screening tools, or statements made under penalty of perjury to verify eligibility for an exemption or exclusion, including medically frail status. Beginning January 1, 2028, states generally must require documentation when reasonably available, and individuals who previously relied on a penalty-of-perjury statement must provide reliable documentation at their next renewal.

ABHW appreciates CMS's decision to permit self-attestation and the use of screening tools till January 1, 2028. These pathways are critical for individuals whose conditions may not be reflected in available data, including those newly applying for coverage, those without recent insurance claims, individuals with protected SUD records, and those with new or worsening behavioral health conditions. Limiting the continued use of self-attestation beginning in 2028 could increase coverage disruptions for individuals who cannot readily obtain documentation or whose conditions are not easily verified through claims data.

The Rule also does not adequately account for barriers that may prevent eligible individuals from completing the attestation process. Individuals with MH or SUD conditions may face cognitive impairments, limited health literacy, trauma-related barriers, or criminal justice involvement that make navigating documentation requirements more difficult. In addition, the Rule's penalty-of-perjury language may discourage eligible individuals from making good-faith attestations. **CMS should clarify that states and other stakeholders that follow CMS-approved self-attestation procedures in good faith will not later be subject to adverse audit findings or penalties solely based on those procedures. We also encourage CMS to provide clear guidance and establish simplified, standardized processes that states can implement with confidence to demonstrate compliance with federal requirements**

Also, ABHW advocates that individuals who newly enroll in Medicaid after January 1, 2028, and who can demonstrate medical frailty should be permitted to self-attest and retain eligibility for the full twelve-month eligibility period without a mandatory six-month redetermination. Requiring an additional six-month verification creates unnecessary administrative complexity, increases beneficiary confusion, and risks inappropriate coverage losses among individuals who clearly qualify for the exemption.

Additionally, the self-attestation penalty-of-perjury framework raises significant implementation concerns. The IFC does not define the applicable penalty, specify whether the penalty arises under federal or state law, or explain how states should describe the attestation requirement to beneficiaries. Nor does it clarify whether penalties would apply when an individual makes a good-faith attestation that is later determined to be inaccurate. This ambiguity creates uncertainty for both states and beneficiaries and may discourage use of a self-attestation pathway that Congress expressly authorized states to rely upon.

These concerns are particularly significant for individuals with MH and SUD conditions, who may experience cognitive impairments, limited health literacy, trauma histories, or other barriers that make legalistic attestation language difficult to understand. Broad or undefined references to penalties for perjury may discourage eligible individuals from submitting valid, good-faith attestations, thereby creating unnecessary barriers to obtaining medically frail exemptions.

ABHW therefore requests that CMS clarify that penalties apply only to knowing and intentional false statements, not to good-faith errors or reasonable misunderstandings. CMS should also provide uniform guidance to states regarding the applicable legal standard, beneficiary notice language, and implementation of the self-attestation process to ensure that eligible individuals are not deterred from using a statutorily authorized pathway.

5) Review Periods, Verification, and Look-Back

Review Periods

The Rule establishes review periods for assessing whether applicable individuals have demonstrated community engagement, are deemed compliant, or are excluded. At application, states must require applicable individuals to demonstrate community engagement for at least one month immediately preceding the month of application and may require up to three months. Review periods are a significant churn driver. Each additional month of required demonstration and each additional verification point creates another opportunity for data mismatch, missing documentation, non-receipt of notices, or failure to respond. For individuals with MH/SUD conditions, frequent verification may be particularly disruptive because functional impairment, housing instability, treatment transitions, or relapse may affect ability to navigate administrative processes.

ABHW encourages CMS to provide implementation flexibilities where state systems are not yet equipped to reliably identify and verify exceptions and exclusions. CMS should also issue guidance on how states should treat individuals who become medically frail or enter treatment during a review period and ensure these individuals are not unnecessarily required to comply with community engagement documentation requirements.

12 Month Look Back

ABHW supports CMS' emphasis on using ex-parte data to identify individuals who qualify for medical frailty exemptions. However, limiting the claims and encounter data lookback period to 12 months may result in eligible individuals with serious mental illness or SUDs being missed because of gaps in treatment, changes in coverage, or incomplete records. These individuals may also face challenges obtaining historical clinical documentation on their own, particularly when records are fragmented across multiple providers or behavioral health carve-out systems.

We are concerned that relying solely on a 12-month claims lookback to assess functional impairment may fail to identify eligible individuals. Claims data may be incomplete due to delayed claim submission, gaps in care resulting from access barriers, or individuals currently receiving services for which claims have not yet been submitted. We recommend that CMS encourage states to use a more comprehensive approach by extending the claims lookback period to 24–36 months and incorporating active service authorization data from Medicaid MCOs to improve the accuracy of eligibility determinations and reduce inappropriate coverage losses.

CMS should also encourage states to leverage MCO encounter data, prior authorization records, pharmacy claims, care management information, and other available administrative data to identify individuals who may qualify for exemptions while minimizing unnecessary documentation burdens on beneficiaries and providers.

6) 42 CFR Part 2 and Privacy

ABHW appreciates CMS's commitment to work with HHS's Office for Civil Rights (OCR) to provide technical assistance on the interaction between the community engagement requirements, the medically frail exclusion for individuals with SUDs, and the confidentiality requirements of Part 2.

As we discussed above, Part 2 issues may arise when SUD diagnosis, treatment, medication, claims, encounter, authorization, care management, or referral information is used to identify whether an individual meets the SUD medically frail exemption. While some SUD information maintained by states or health plans may not be subject to Part 2, records originating from Part 2 programs may be subject to additional use and disclosure restrictions.

ABHW is concerned that, without additional guidance, states and MCOs may either be overly cautious and fail to use available SUD information to identify eligible individuals, resulting in avoidable coverage loss, or inconsistent application of Part 2's use and disclosure consent requirements, creating privacy risks and undermining patient trust.

ABHW encourages CMS and OCR to provide clear implementation guidance before January 1, 2027, addressing how SUD information may be used to verify eligibility while complying with Part 2. Guidance should address, at a minimum, the use of SUD claims and encounter data for eligibility determinations; when Part 2 consent is required; whether MCOs may share coded exclusion indicators rather than detailed clinical information; how Part 2-derived indicators should be stored in state eligibility systems; application of the minimum necessary standard and redisclosure requirements; the use of provider attestations; and beneficiary notice requirements regarding the use of SUD-related information.

Additionally, as we shared above, CMS should clarify that patient consent accompanying a provider's medical frailty attestation, whether incorporated into the attestation itself or executed separately, constitutes sufficient documentation to comply with Part 2.

7) Clarify that Activities of Daily Living Include Instrumental Activities of Daily Living

CMS should clarify that the definition of activities of daily living encompasses both traditional activities of daily living (ADLs) and instrumental activities of daily living (IADLs). While ADLs refer to basic self-care activities such as bathing, dressing, eating, toileting, and transferring, IADLs include the more complex tasks necessary for independent living, such as managing medications, handling finances, preparing meals, shopping, using transportation, and maintaining a household.

Recognizing IADLs would more accurately capture the range of functional limitations experienced by many individuals with behavioral health conditions and chronic illnesses. These individuals may be fully capable of performing basic self-care activities while still experiencing significant impairments in higher-order cognitive, executive functioning, or social skills that limit their ability to live independently, maintain employment, or manage their health. Explicitly including IADLs would help ensure that individuals with serious behavioral health conditions are appropriately identified and not excluded based on an overly narrow interpretation of functional impairment.

8) Address Hospitalization and Presumptive Eligibility

Individuals receiving inpatient hospital care, including inpatient psychiatric and clinically appropriate residential behavioral health treatment, should not be required to demonstrate compliance with community engagement requirements during hospitalization. Likewise, individuals seeking hospital presumptive eligibility should not be required to demonstrate prior compliance before receiving medically necessary inpatient services. During periods of hospitalization and residential treatment, beneficiaries and providers should be focused on delivering clinically appropriate care rather than documenting work or community engagement activities. Clarifying that these protections extend to residential treatment is particularly important given the critical role these services play in treating serious mental illness and substance use disorders.

Additionally, CMS should provide states with support and guidance to alleviate any potential burdens implementation may have on presumptive eligibility processes.

9) Clarify the Role of Managed Care Organizations

ABHW appreciates CMS' recognition that MCOs have an important role in supporting implementation of community engagement requirements. Through their contractual relationships with states, MCOs maintain longstanding relationships with members, providers, and community-based organizations that position them to support beneficiary outreach, education, care coordination, and identification of individuals who may qualify for exemptions or exceptions.

The Medicaid unwinding process demonstrated the value of leveraging MCOs as enrollment and retention partners. Throughout the unwinding, CMS encouraged states to work with plans to conduct beneficiary outreach, update contact information, and assist members with renewal processes. Many states successfully relied upon MCOs' care management infrastructure, provider networks, and communication capabilities to help eligible individuals maintain coverage and navigate complex renewal requirements.

While the IFC appropriately distinguishes between activities that health plans may perform, such as outreach, education, referrals, and information sharing, and functions that remain the responsibility of states, including eligibility determinations and notices of noncompliance, additional implementation guidance is needed. **ABHW**

encourages CMS to issue practical implementation guidance, develop model managed care contract language, provide examples of permissible plan activities, and establish ongoing opportunities for dialogue among CMS, states, and MCOs to promote consistent implementation nationwide.

In particular, ABHW recommends that CMS establish clear, standardized communication requirements to ensure timely coordination between states and Medicaid MCOs. States should notify both affected individuals and their MCOs concurrently when an individual is identified as subject to the community engagement requirements or is under eligibility review. CMS should also issue updated guidance on the scope of permissible MCO activities to support implementation, including the community engagement requirements, six-month renewals, and whether states may permit MCOs to assist members with applications, consistent with CMS's post-Public Health Emergency (PHE) guidance. This guidance should also clarify how MCO activities may be financed, including which activities may be incorporated into capitation payments, treated as in-lieu-of services where appropriate, or included in the medical loss ratio (MLR). Any responsibilities delegated to MCOs should be appropriately reflected in Medicaid payment. To facilitate effective operations, states should provide MCOs with timely information, including identification indicators, file specifications and transmission schedules, the applicable community engagement standard, and updates on hardship requests, appeals, eligibility determinations, and exemption status. Timely information sharing will enable MCOs to conduct outreach, help beneficiaries maintain coverage, and proactively coordinate care, reducing coverage disruptions and supporting better health outcomes.

Some key questions that MCOs still have:

- **What activities may MCOs undertake to educate, assist, or support enrollees in meeting and maintaining community engagement requirements?**
- **Will CMS provide standardized documentation requirements for each community engagement pathway (for example employment, education, caregiving, income-based exceptions) to ensure consistent state implementation?**
- **Will beneficiaries receive advance notice and an opportunity to respond before being reclassified as an applicable individual, qualifying for a mandatory exception, or becoming a specified excluded individual?**
- **Will CMS review state community engagement policies for consistency with federal requirements, or may states adopt differing statutory approaches that create variation in Medicaid eligibility across states?**

10) State Implementation Flexibility

ABHW is grateful that the IFC specifies the steps for a state to request a temporary good faith effort exemption from compliance with timely implementation of the community engagement requirements. **We urge CMS to provide good faith waivers for up to 12 months, as needed. We also encourage CMS to create templates for good faith waivers and approve these waivers without requiring what the IFC considers "extraordinary, severe, or unexpected issues that hinder their progress" since states are already facing many implementation challenges**. This will help states build and test the data-sharing and IT systems required for accurate verification and real-time tracking, and those demonstrating good-faith progress, as outlined in the statute, should receive a temporary compliance exemption through December 31, 2028.

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Thank you for your attention to these recommendations to implement the new Medicaid community engagement requirements. We appreciate your consideration and your continued partnership to ensure that individuals and families affected by MH/SUD do not lose coverage. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO