July 31, 2026

The Honorable Robert Kennedy, Jr.
Secretary Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) interim final rule with comment period (IFC) on the Medicaid community engagement requirements (CMS-2454-IFC).

As the largest payer of substance use disorder and mental health care,[1] Medicaid plays a vital role in addressing our country's ongoing opioid public health emergency and mental health crisis.[2] Nearly 1 in 4 adults enrolled in Medicaid through the expansion pathway have a substance use disorder or mental health condition.[3] Medicaid is also the primary source of coverage for people leaving incarceration, with many individuals eligible because of the expansion.[4] As national, state, and local organizations with deep expertise on the policy issues affecting these populations, the undersigned 70 organizations want to ensure the community engagement requirements are consistent with the plain language and intent in Public Law 119-21, to prevent millions of eligible individuals from losing their Medicaid coverage and, with it, their access to affordable health care.

A. Specified Excluded Individuals: Medically Frail Definition – 42 C.F.R. § 435.554(c)(5)(i)

We urge CMS to amend its definition of "medically frail" to remove the requirement that the individual's health condition significantly impairs their ability to comply with the community

[1] "Behavioral Health," Medicaid and CHIP Payment and Access Commission (accessed June 23, 2026), https://www.macpac.gov/topic/behavioral-health/.
[2] Heather Saunders & Elizabeth Hinton, "Medicaid Mental Health and Substance Use: Expansion Trends and the Fiscal Pressure Ahead," KFF (May 13, 2026), https://www.kff.org/medicaid/medicaid-mental-health-and-substance-use-expansion-trends-and-the-fiscal-pressure-ahead/
[3] Heather Saunders et al., "Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders," KFF (June 23, 2025), https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/.
[4] MACPAC, "Chapter 3: Access to Medicaid Coverage and Care for Adults Leaving Incarceration," Medicaid and CHIP Payment and Access Commission (June 2023), https://www.macpac.gov/wp-content/uploads/2023/06/Chapter-3-Access-to-Medicaid-Coverage-and-Care-for-Adults-Leaving-Incarceration.pdf.

engagement requirement, as we believe CMS has (1) exceeded its statutory authority in promulgating this definition and (2) created a standard that is unworkable for states, providers, and beneficiaries.

1. CMS's Definition of "Medically Frail" Exceeds Statutory Authority

CMS did not adopt a reasonable interpretation of "medically frail" given the plain language in Public Law 119-21. Although CMS was granted authority by Congress to define "who is medically frail or otherwise has special medical needs," the interpretation must still align with the best reading of the statute.[5] The plain language in Public Law 119-21 provided a list of populations ("specified excluded individuals") who were explicitly exempt from the community engagement requirements.[6] The statutory text has no language to suggest that the individuals who fit into the "medically frail or otherwise has special medical needs" category be unable to work or otherwise unable to meet the community engagement activities. More broadly, the best reading of the statute does not limit specified excluded individuals to those who are unable to meet community engagement requirements except where explicitly specified (for example, veterans with a total disability rating[7]), particularly when other populations are excluded for reasons unrelated to work (for example, American Indians or Urban Indians[8]). Instead, Congress clearly intended to protect vulnerable populations for whom access to affordable health care should *not* be contingent upon one's ability to work or meet the community engagement activities, including those who are medically frail or otherwise have special medical needs. That is why these individuals are in the "specified excluded" category: their status must be determined *prior* to a consideration of whether they are meeting or able to meet the community engagement requirements, and not "applicable individuals."

In fact, the context within Public Law 119-21 suggests this is an impermissible interpretation of the statute. CMS claims that basing medical frailty "solely on diagnosis or condition would risk sweeping in individuals whose conditions do not significantly impair their functional capacity," when that is exactly what Congress wrote into the law by specifically including conditions like substance use disorders and serious or complex medical conditions.[9] If all sub-populations within the "medically frail" category were intended to meet a standard of significant impairment, then Congress could have included such qualifying language as it did with specific populations such as a "blind or disabled (as defined in section 1614 of the Act)", or individuals with a physical, intellectual, or developmental disability that "significantly impairs their ability to perform 1 or more activities of daily living."[10] Congress clearly contemplated these types of standards – inability to work or significant impairments, respectively – for certain conditions, and elected not to apply them to others. As such, CMS's interpretation in the IFC cannot be what Congress intended in the statute, and goes beyond the plain language of the text.

The best reading of the statute would be that CMS can supplement categories of "medically frail" in the rulemaking process, but the agency does not have the authority to redefine or narrow the five categories that Congress expressly included. Note that prior to listing the five sub-categories, Congress used the word "including." This suggests that, at a minimum, CMS must include those five conditions, and in defining the "medically frail or otherwise has special medical needs" category, CMS had permission

[5] Loper Bright Enters. v. Raimondo, 603 U.S. __ (2024).
[6] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).
[7] § 1396a(xx)(9)(A)(ii)(IV).
[8] § 1396a(xx)(9)(A)(ii)(II).
[9] 91 Fed. Reg. 33348, 33373 (June 3, 2026).
[10] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa), (dd).

from Congress to include others. This was how rational readers interpreted the statute, as CMS even acknowledged it had this authority in the preamble when it indicated it was "not using our authority at section 1902(xx)(9)(A)(ii)(V) of the Act to add additional categories to the definition of medically frail."[11]

While this is at least a permissible reading of CMS's statutory authority, we encourage CMS to reconsider this position to include individuals who are experiencing homelessness as "medically frail." CMS asserts that this would not be reasonable because "that circumstance is not a medical condition."[12] While true, the plain language of the statute does not exclude this interpretation. Rather, individuals who are experiencing homelessness can clearly fit into the language of "otherwise has special medical needs" for which states have a legitimate interest in ensuring those needs can be addressed through Medicaid.

Moreover, we offer the following comments on how this applies to people with substance use disorders and people with disabling mental disorders, whom, again, Congress wrote in the plain language of Public Law 119-21 to be excluded from this requirement without consideration of their ability to meet the community engagement requirements.

i. Individuals with a Substance Use Disorder – 42 C.F.R. § 435.554(c)(5)(i)(B)

We commend CMS for recognizing that substance use disorders have different clinical levels (mild, moderate, and severe), for applying this category to individuals with a substance use disorder regardless of whether they are in an active treatment program, and for identifying the DSM-5 and ICD-10 as resources for states to set criteria to identify individuals with substance use disorders.[13] We agree with CMS's analysis that this interpretation is the only logical reading of the plain language of the statute, since Congress included no qualifiers to suggest limiting this sub-category of medical frailty.[14] As one small note, the ICD-11 has replaced the ICD-10, and we encourage CMS to use the most updated version in its guidance to states.[15]

We appreciate that CMS has acknowledged that substance use disorders are chronic conditions and those in recovery are considered to have a substance use disorder. The text of the statute requires all individuals with substance use disorders be excluded from the community engagement requirements, and CMS may not limit it through requirements to show significant impairment or by length of recovery.

If CMS proceeds with this definition of "medically frail," we urge CMS to recognize that recovery is unique for every individual, and it is not linear. CMS asserts that "the risk of SUD recurrence for an individual in stable recovery [5 or more years] is approximately the same as the general population." Should one follow the citation, and the chain of citations to get to where this was first posited, it appears that this claim is drawn from a series of studies ranging from 1989-2007 that only focused on alcohol use disorder and defined recovery as abstinence.[16] This suggests that these findings may not in fact be

[11] 91 Fed. Reg. at 33373.
[12] *Id.*
[13] *Id.* at 33374.
[14] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb).
[15] "International Statistical Classification of Diseases and Related Health Conditions," World Health Organization (accessed June 25, 2026), https://www.who.int/standards/classifications/classification-of-diseases.
[16] CMS cited Frone MR, Chosewood LC, Osborne JC, and Howard JJ. (2022). "Workplace Supported Recovery from Substance Use Disorders: Defining the Construct, Developing a Model, and Proposing an Agenda for Future Research."

generalizable. Some people who are in recovery for more than five years may still be unable to meet the community engagement requirements, especially since outcomes vary based on substance, sub-population, and access to treatment. Consistent with this intent, CMS may want to adopt alternative language at 42 C.F.R. § 435.554(c)(5)(i)(B) that would be more appropriate for the ongoing opioid public health emergency,[17] and potential future drug crises, such as, "With a substance use disorder, including an individual who is in recovery for at least 5 years;".

We are also concerned that CMS has created somewhat of a contradiction here that will be difficult for states and enrollees to implement. On the one hand, CMS clearly states in the preamble that this category applies to individuals regardless of whether they are in an active treatment program.[18] We strongly support this interpretation, particularly because there is no qualifying language to suggest otherwise, and secondarily because there is a separate exemption for people who are participating in certain substance use disorder treatment, although this other exemption is limited and does not apply to all treatment settings.[19] However, CMS is also requiring claims and encounter data, or at least some documentation, to demonstrate that an individual is considered medically frail. By requiring claims data or ongoing access to qualified providers, the IFC contradicts the terms of the statute, including its own interpretation of the statute in the preamble. This is not only internally self-contradictory, but also not the best reading of the statute and clearly beyond what Congress intended.

Occupational Health Science 6 (4): 475-511. https://doi.org/10.1007/s41542-022-00123-x. For the same assertion, this article cited Kelly, J. F., Greene, M. C., & Bergman, B. G. (2018). Beyond abstinence: Changes in indices of quality of life with time in recovery in a nationally representative sample of U.S. adults. *Alcoholism: Clinical and Experimental Research*, *42*(4), 770–780. https://doi.org/10.1111/acer.13604. This article cited four papers, two of which were limited to alcohol (Dawson DA, Goldstein RB, Saha TD, Grant BF (2015) Changes in **alcohol** consumption: United States, 2001–2002 to 2012–2013. Drug Alcohol Depend 148:56–61. ADDICTION RECOVERY AND QUALITY OF LIFE 779; Grant BF, Goldstein RB, Saha TD, Chou SP, Jung J, Zhang H, Pickering RP, Ruan WJ, Smith SM, Huang B, Hasin DS (2015) Epidemiology of DSM-5 **alcohol use disorder**: results from the national epidemiologic survey on alcohol and related conditions III. JAMA Psychiatry 72:757–766) and one which was limited to abstinence (Dennis ML, Foss MA, Scott CK (2007) An eight-year perspective on the relationship between the duration of **abstinence** and other aspects of recovery. Eval Rev 31:585–612). The fourth paper was the one which actually articulated that stability is the point at which the risk of future lifetime relapse drops below 15% after 5 years of "continuous recovery" on page 33, but the citations on which that assertion was based were again limited to alcohol, as well as the aforementioned study limited to abstinence. White WL (2012) Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868–2011. Philadelphia Department of Behavioral Health and Intellectual Disability Services, Philadelphia, PA. (accessed at https://www.naadac.org/assets/2416/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf) (citing De Soto, C.B., O'Donnell, W.E., & De Soto, J.L. (1989). Long-term recovery in **alcoholics**. Alcoholism: Clinical and Experimental Research, 13, 693-697. Vaillant, G. E. (1996). A long-term follow-up of male **alcohol** abuse. Archives of General Psychiatry, 53(3), 243-249. Nathan, P., & Skinstad, A. (1987). Outcomes of treatment for **alcohol** problems: Current methods, problems and results. Journal of Consulting and Clinical Psychology, 55, 332-340. Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former **alcohol** dependence: United States, 1992. Alcoholism: Clinical and Experimental Research, 20(4), 771-779. Jin, H., Rourke, S. B., Patterson, T. L., Taylor, M. J., & Grant, I. (1998). Predictors of relapse in long-term abstinent **alcoholics**. Journal of Studies on Alcohol, 59, 640-646. Dennis, M. L., Foss, M. A., & Scott, C. K. (2007). An eight-year perspective on the relationship between the duration of **abstinence** and other aspects of recovery. Evaluation Review, 31(6), 585-612. Schutte, K., Byrne, F., Brennan, P., & Moos, R. (2001). Successful remission of late-life **drinking** problems: A 10-year follow-up. Journal of Studies on Alcohol 62, 322-334.). PDFs enclosed.

[17] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," U.S. Department of Health & Human Services (June 4, 2026), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-4Jun2026.aspx.

[18] 91 Fed. Reg. at 33373.

[19] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(VII)

Moreover, only 1 in 6 individuals who need substance use disorder treatment receive it.[20] The top four most common reasons for not receiving treatment among those who perceived an unmet need for treatment are: thinking they should have been able to handle their alcohol or drug use on their own (82.5%), not being ready to stop or cut back on using alcohol or drugs (68.4%), not being ready to start treatment (67.7%), and not having enough time for treatment (54.3%).[21] Other common reasons include concerns about stigma and what would happen if others found out they were in treatment,[22] as well as issues related to access and finding treatment.[23] Many of the individuals who report these barriers are not going to be willing or able to find a provider who can document their medically frail status, in contrast to CMS's unsubstantiated claim that a documentation requirement "will motivate individuals to access care."[24] CMS must account for this significant percentage of people with substance use disorders whom Congress intended to exclude from the community engagement requirements. Thus, consistent with CMS's intent – and clear statutory obligation – to ensure this exclusion applies to individuals who are not in active treatment, we encourage CMS to adopt greater flexibilities for self-attestation and demonstrating medically frail status, as discussed in greater detail later in these comments.

ii. Individuals with a Disabling Mental Disorder – 42 C.F.R. § 435.554(c)(5)(i)(C)

Mental illnesses are chronic health conditions that fluctuate from day to day and week to week, and it is vital that individuals with these conditions have access to affordable coverage and health care. As noted for substance use disorders, we encourage CMS to refer states to the ICD-11, rather than the ICD-10, as this is the most updated version for diagnosing mental health conditions.[25] Although CMS did not offer additional regulatory language to clarify what constitutes a "disabling mental disorder" for purposes of the medically frail exemption, we again highlight that these individuals should not be required to further demonstrate that their condition significantly impairs their ability to meet the community engagement requirements.

CMS contends that "there are numerous definitions of disabling mental disorders," and then proceeds to define "mental disorder" without the "disabling" qualifier.[26] The only description offered of a *disabling* mental disorder is one that "may significantly impair an individual's ability to complete major life activities, such as their ability to work or volunteer and can be either permanent or temporary."[27] In so doing, CMS acknowledged that what distinguishes an individual with a "disabling mental disorder"

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[20] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2025 National Survey on Drug Use and Health," SAMHSA 54 (July 2026), https://www.samhsa.gov/data/sites/default/files/reports/rpt57150/2025-nsduh-annual-national-report.pdf.
[21] *Id.* at 58.
[22] Additional reasons individuals reported not receiving substance use disorder treatment despite a perceived unmet need: being worried about what people would think or say if they got treatment (41.4%); thinking bad things would happen if people knew they were in treatment, such as losing their job, home, or children (34.9%); and being worried that information would not be kept private (37.4%). *Id.* at 58-59, 134.
[23] Additional reasons individuals reported not receiving substance use disorder treatment despite a perceived unmet need: not knowing how or where to get treatment (40.5%) and not being able to find a treatment program or healthcare professional they wanted to go to (32.7%). *Id.* at 59.
[24] 91 Fed. Reg. at 33406.
[25] "International Statistical Classification of Diseases and Related Health Conditions," World Health Organization (accessed June 25, 2026), https://www.who.int/standards/classifications/classification-of-diseases.
[26] 91 Fed. Reg. at 33374.
[27] *Id.* at 33374-75.

from an individual who is "disabled" – a separate sub-category under medically frail[28] – is that it "may" significantly impair their ability to complete major life activities. This is an important distinction because Congress did not require a full disability standard for this sub-population, but rather to include those individuals whose conditions *may* lead to functional limitations. By not limiting it to those who are currently or consistently unable to work or complete other major life activities, Congress recognized the importance of ensuring that people with mental illnesses could receive ongoing treatment and care coordination under Medicaid to maintain functioning and prevent their conditions from deteriorating.

The Americans with Disabilities Act (ADA) also covers individuals with mental health conditions, though the functional limitations are broader than ability to work. Individuals are protected under the ADA if their health condition "substantially limits one or more major life activities," which includes, but is not limited to, "caring for oneself, … eating, sleeping, learning, reading, concentrating, thinking, communicating, working …" as well as "major bodily functions" including neurological and brain functioning.[29] However, since Congress did not use the same language as that used for SSA or even in the ADA (for example, "an individual with a mental disability," or "an individual whose mental impairment substantially limits one or more major life activities"), the category of "disabling mental disorders" must have been intended to encompass a broader scope of individuals not already captured under the other definitions, and certainly not solely be limited to those who are currently or consistently unable to work, volunteer, or otherwise participate in community engagement activities. We are concerned that CMS's discussion in the preamble may lead states to develop overly narrow lists of mental health conditions that qualify for exclusion, when the statutory language clearly enables this definition to be broader.

Nearly half of adults with any mental illness do not receive treatment for their conditions.[30] Even among those who do, many receive services that may not be covered by Medicaid and thus not represented in claims and encounter data, including the 11.5% who received services from a support group and 4.6% who received services from a peer support specialist or recovery coach.[31] These percentages are even higher among those with serious mental illness, 16% and 6.2%, respectively. Moreover, similar to those with substance use disorders described above, the most common reason for not receiving treatment despite a perceived unmet need include thinking they should have been able to handle their mental health, emotions, or behavior on their own (72.9%).[32] Other common reasons include not having enough time for treatment (48.3%), not being ready to start treatment (47.7%), not knowing how or where to get treatment (44.9%), and not finding a treatment program or a healthcare professional they wanted to go to (43.2%).[33] The individuals who report these barriers are not going to be willing or able to access a provider who can document their medically frail status, in contrast to CMS's unsubstantiated claim that a documentation requirement "will motivate individuals to access care."[34] CMS must account for this significant percentage of people with disabling mental disorders whom Congress intended to exclude

[28] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(aa).
[29] §§ 12102(1), (2).
[30] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2025 National Survey on Drug Use and Health," SAMHSA 63 (July 2026), https://www.samhsa.gov/data/sites/default/files/reports/rpt57150/2025-nsduh-annual-national-report.pdf.
[31] *Id.* at 65.
[32] *Id.* at 67.
[33] *Id.*
[34] 91 Fed. Reg. at 33406.

from the community engagement requirements. Thus, we encourage CMS to adopt greater flexibilities for self-attestation and demonstrating medically frail status, as discussed in greater detail below.

2. CMS's Definition of "Medically Frail" is Unworkable for States, Enrollees, and Providers

Demonstrating an individual has a condition that counts as medically frail – particularly for those conditions for which rates of treatment access are low, like substance use disorders and mental health conditions – was already going to be a significant paperwork burden. The new additional standard to demonstrate the condition significantly impairs one's ability to meet the community engagement requirements – which is beyond the best reading of the statute – is going to be a paperwork nightmare.

For people with substance use disorders and disabling mental disorders in particular, this is especially unworkable and problematic. As noted above, approximately 5 in 6 with a substance use disorder and 1 in 2 with a mental health condition do not receive treatment for their conditions.[35] Although rates of treatment are higher in Medicaid than other payers,[36] there are still far too many enrollees who lack access to evidence-based care but nonetheless have a substance use disorder or disabling mental disorder that should qualify them as a specified excluded individual. A part of this problem is the lack of active behavioral health providers who accept Medicaid, which, as the U.S. Department of Health & Human Services Office of Inspector General notes, "impedes enrollees' access to care."[37] Thus, the very reason many Medicaid enrollees cannot access the treatment they need – or experience delays in getting such care – is the same one that may prevent them from having claims and encounter data, let alone other documentation, that would demonstrate their medically frail conditions. Nonetheless, these individuals still need Medicaid coverage, as they may be receiving care for other conditions, including preventative and primary care services that would help them better access mental health and substance use disorder treatment in the future.

Not only are there significant provider shortages of those who can diagnose and treat Medicaid enrollees with a substance use disorder or mental health condition, but it is not within their scope of practice or licensure/certification to determine whether someone's condition significantly impairs their ability to meet the community engagement activities. This is not what practitioners are trained to do, they do not know how to do it, and many would be uncomfortable making these types of determinations. Even if this were within a practitioner's scope of practice, it would not be something that would be self-evident or readily apparent in claims or encounter data, as this is rarely relevant to treating these conditions. Instead, this will require practitioners to take time away from treating their patients, further exacerbating the mental health and addiction provider shortages and access challenges. Furthermore, as MACPAC has reported, adoption of electronic health records is low among mental health and substance use disorder providers.[38] And, if providers are unable to make this determination when they are the ones

[35] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2025 National Survey on Drug Use and Health," SAMHSA 54, 63 (July 2026), https://www.samhsa.gov/data/sites/default/files/reports/rpt57150/2025-nsduh-annual-national-report.pdf.
[36] Tami L. Mark et al., "The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.
[37] U.S. Department of Health & Human Services, Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care," U.S. Department of Health & Human Services, OEI-02-22-00050 (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.
[38] MACPAC, "Chapter 4: Integrating Clinical Care through Greater Use of Electronic Health Records for Behavioral

actively interacting with these individuals, it stands to reason that Medicaid agency staff or algorithms would also be unable or unqualified to do so. That is, despite CMS's assertion that identifying specified excluded individuals will be automated, and that there will be sufficient ex parte data to make these determinations, the reality is that it will not and often cannot be.

If CMS does proceed with requiring documentation or other verification, then it is imperative that the agency allow states to include a broad range of individuals and organizations that can identify individuals who are excluded from these community engagement requirements. At a minimum, this must include peer support specialists and community health workers, but it should also include other organizations and individuals that provide services and supports for people who would fall into the medically frail sub-categories – including people with mental health conditions and substance use disorders – such as case managers, recovery residences, drug courts, and so on.

Neither states nor providers have the funding, staffing, or time to operationalize or implement this new standard of significant impairment, nor did CMS engage in the appropriate reasoning or budget impact analysis to support moving forward with this interpretation, given the actual burden it will require.

B. Specified Excluded Individuals: Participating in a Drug Addiction or Alcoholic Treatment and Rehabilitation Program – § 435.554(c)(8)

We commend CMS for not establishing a minimum time commitment requirement for individuals participating in a drug addiction or alcoholic treatment and rehabilitation program who are specified excluded individuals under these new community engagement requirements. Clearly Congress is capable of setting minimum time commitments, as it has done so for applicable individuals to comply with the community engagement requirements, so we agree with CMS's interpretation not to do so here. For similar reasons though, it would be inconsistent with the statute for states to set minimum standards for participation, and we urge CMS to remove this second sentence from 42 C.F.R. § 435.554(c)(8), as this is not the best reading of the statute.

C. Self-Attestation and Documentation Requirements – §§ 435.557 & 435.558

CMS has also exceeded its statutory authority by limiting the use of self-attestation to calendar year 2027, and then only once per beneficiary enrollment period, for individuals who are excluded as "medically frail" from the community engagement requirements.

Existing Medicaid regulations expressly provide that state Medicaid agencies may accept self-attestation, unless otherwise required by *law*:

> Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if

Health," Medicaid and CHIP Payment and Access Commission (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf.

the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.[39]

However, the statutory language establishing the new community engagement requirements contains no such requirement of other procedures. Contrast this with the citizenship and immigration status information referenced in that regulation, where there is an explicit requirement in the statute for "satisfactory documentary evidence of citizenship or nationality."[40]

Instead, the statute governing the community engagement requirements contains language in multiple places that mirrors the regulation authorizing states to accept self-attestation, and never contains a reference to documentation or documentary evidence. First, the law allows states to "elect to not require an individual to verify information resulting in" an applicable individual being deemed compliant with the requirements under the mandatory exceptions,[41] including when the individual was a specified excluded individual.[42] And second, the law requires states to use ex parte verifications to determine an individual is complying with the new requirements or is a specified excluded individual "without requiring, where possible, the applicable individual to submit additional information."[43] Note here that Congress used the language "additional information," rather than documentation. That is, Congress clearly contemplated that this process would be consistent with the existing regulations and framework for determining eligibility, and did not authorize CMS to set a higher documentation standard for this eligibility requirement than for others.

In this IFC, CMS failed to offer any statutory authority for requiring documentation for these individuals, let alone why they cannot self-attest to this aspect of their eligibility on an ongoing basis as they are entitled to do for other eligibility requirements. As the plain text of the law does not require documentation, CMS has exceeded its statutory authority and must rescind these documentation requirements in 42 C.F.R. § 435.557 and permit states to use self-attestation on an ongoing basis.

Finally, we appreciate that CMS has recognized that medically frail status is unlikely to change within a 12-month period by enabling states to re-verify their medical frailty status at least every 12 months,[44] though instead we urge CMS to adopt "no more than every 12 months" as we believe that is more appropriate for these conditions. Moreover, regardless of whether CMS continues to require a 12-month standard and documentation (beyond its statutory authority), we encourage CMS to remove the requirement that data or documentation demonstrating this status be from the preceding 12 months.[45] We appreciate that CMS has adopted a broad definition of adjudicated claims, but we still believe this approach is unworkable and inconsistent with the plain text of the law. With respect to individuals with substance use disorders, this effectively imposes a treatment mandate on this population, where even CMS has agreed that there should not be one. For disabling mental disorders, CMS has acknowledged that these can be temporary or permanent. While we appreciate CMS's desire to establish a standardized timeline, the additional paperwork burden this creates for individuals, providers, and state Medicaid agencies is not "consistent with simplicity of administration and the best interests of the applicant or

[39] 42 C.F.R. § 435.945(a).
[40] 42 U.S.C. § 1396b(x).
[41] § 1396a(xx)(3)(A).
[42] § 1396a(xx)(3)(A)(i)(I).
[43] § 1396a(xx)(5).
[44] 42 C.F.R. § 435.558(a)(2)(iii).
[45] § 435.557(f)(1).

beneficiary,"[46] and merely increases the likelihood that eligible individuals will be wrongfully terminated.

Instead, states should be able to look as far back as is appropriate. For conditions that are permanent or unlikely to change, this would certainly be longer than 12 months. For example, for people with substance use disorders, to the extent that CMS maintains its 5-year benchmark for recovery, then individuals should not have to demonstrate – nor have documentation that demonstrates – they qualify as a specified excluded individual more than once per this 5-year period.

* * *

Thank you for the opportunity to submit these comments. We are eager to partner with you to ensure these regulations are consistent with the federal law and do not result in the improper termination or denial of Medicaid to eligible individuals. To discuss these comments further, please do not hesitate to contact us at dsteinberg@lac.org.

Sincerely,

Legal Action Center
1199SEIU
Addiction Treatment Systems
AHEC West
American Association on Health and Disability
American Foundation for Suicide Prevention
American Psychological Association Services
AMERSA
Baltimore Harm Reduction Coalition
Behavioral Health System Baltimore
BrightView
Broken No More
Center for Employment Opportunities (CEO)
Circles of Solidarity
Coalition of Medication Assisted Treatment Providers and Advocates (COMPA)
Community Behavioral Health Association of Maryland
Community Health Project Los Angeles
Concerted Care Group
CORA
Destination Tomorrow
Drug Policy Alliance
Faces & Voices of Recovery
Friends of Recovery – New York
Health Justice for NY
Horizon Health Services, Inc.
Horizon Village, Inc.
IC&RC

[46] 42 U.S.C. § 1396a(a)(19).

Illinois Harm Reduction and Recovery Coalition
Impact MN
International Society for Psychiatric Mental Health Nurses
InUnity Alliance
JustLeadershipUSA
Kelly S. Ramsey Consulting, LLC
Key Point Health Services
Kolmac Integrated Behavioral Health
Lakeshore Foundation
Law Enforcement Action Partnership
Man Alive inc.
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Psychological Association
Massachusetts Law Reform Institute
Medicaid Matters New York
Medicare Rights Center
MedMark Treatment Centers
Mountain Top Cares Coalition
NAADAC, the Association for Addiction Professionals
NAATP
NAMI Maryland
National Alliance on Mental Illness
National Alliance to End Homelessness
National Association for Behavioral Healthcare
National Association of Social Workers
National Behavioral Health Association of Providers
National Disability Rights Network (NDRN)
Network for Public Health Law
New York State Council for Community Behavioral Healthcare
Overdose Prevention Initiative
Partnership to End Addiction
Pyramid Healthcare
Shatterproof
The Grayken Center for Addiction at Boston Medical Center
The Porchlight Collective SAP
Transitions Clinic Network
Treatment Alternatives for Stronger Communities
Treatment Communities of America
UMRFA
University of Maryland Resident & Fellow Alliance
Vital Strategies
We Are Down Home
Young People in Recovery