July 31, 2026

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

The Honorable Dan Brillman
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
Centers for Medicaid and CHIP 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

Dear Administrator Oz and Deputy Administrator Brillman:

The Mental Health Liaison Group (MHLG) is a coalition of national organizations representing people with mental health conditions and substance use disorders (MH/SUD), family members, mental health and addiction providers, advocates, and other stakeholders committed to strengthening Americans' access to MH/SUD care. As the experts on the policy issues that impact people with MH/SUD, we are deeply concerned that the interim final rule with comment period (IFC) on Medicaid community engagement (CE) requirements will create onerous hurdles that put coverage at risk for many people with MH/SUD. We urge the Centers for Medicare & Medicaid Services (CMS) to revise this interim final rule to protect the millions of people who rely on Medicaid for life-saving MH/SUD care.

Background

Medicaid is the largest payer of MH/SUD services in the country and plays a crucial role in addressing our nation's ongoing mental health and addiction crisis. Through Medicaid coverage, people can access critical services and recovery supports like medications for opioid use disorder (MOUD), therapy, inpatient treatment, prescription medications, and crisis care. Medicaid expansion has allowed more people with MH/SUD to access the care they need, with nearly 24 percent of people in the expansion population having a MH/SUD diagnosis[1].

[1] Saunders, H., Diana, A., Hinton, E., & Rudowitz, R. (2025, June 23). Implications of Medicaid work and reporting requirements for adults with mental health or substance use disorders. *KFF*.

We fear that the IFC will cause Medicaid coverage losses, leaving many people with MH/SUD without access to critical services. The Congressional Budget Office (CBO) estimated that 5.3 million people were projected to lose Medicaid coverage under Public Law (P.L.) 119-21, including eligible individuals who will not be able to navigate the new CE requirements[2]. However, CBO's estimates did not account for the policies outlined in the IFC, which create additional hurdles for the new requirements beyond those in the statute. Unfortunately, eliminating health coverage for millions of people does not eliminate their need for MH/SUD treatment. Instead, people will likely forego routine health care, waiting until their health issue becomes a critical and more costly emergency — a dynamic which strains the overall health care system and harms individuals.

We offer specific recommendations below to improve implementation of CE requirements and minimize coverage losses for eligible individuals who have MH/SUD. This is a follow-up to the recommendations we submitted in advance of CMS' publication of the IFC[3].

Remove "Significantly impairs" Requirement from "Medically Frail" Definition

We are deeply concerned with CMS' interpretation of the medically frail exclusion because it inappropriately limits the number of individuals with MH/SUD who can be excluded from CE requirements, and increases the administrative burden required to qualify for the exclusion. P.L. 119-21 includes a list of specified excluded individuals, such as an individual who is medically frail or otherwise has special needs. This exclusion category is most relevant to people with MH/SUD because it includes individuals "with a substance use disorder" and those "with a disabling mental disorder." Under a plain language reading of the law, all individuals who have one of these qualifying conditions should be excluded from CE requirements. However, in the IFC, CMS adds an additional requirement and specifies that an individual who is medically frail cannot be excluded based solely on their diagnosis, but must also prove that their condition significantly impairs their ability to meet CE requirements. Not only does this addition go beyond the text of the statute, it goes against the intent of the exclusion, which was to protect those at highest risk of experiencing adverse health effects from losing their health coverage due to CE

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https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/

[2] Congressional Budget Office. (2025, October 28). CBO supplemental cost estimate: P.L. 119-21, Title VII, Subtitle B, Chapter 1. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[3] Mental Health Liaison Group (2025, December 17). Comments on guidance on community engagement requirements for individuals with mental health conditions and substance use disorders. https://www.mhlg.org/wordpress/wp-content/uploads/2025/12/MHLG-Letterhead_NAMI-LAC-Work-Req-Letter_12.17.25.pdf

requirements. These individuals should not be subject to a greater burden or higher standard than other specified excluded individuals. We urge CMS to revise the medically frail exclusion to remove the additional requirement to demonstrate that a condition "significantly impairs" ability to meet CE requirements.

In addition to concerns about the appropriateness of the IFC's definition of "medically frail," we believe the definition will also cause extensive implementation issues for both patients and providers. MH/SUDs can cause substantial functional impairments, with fluctuating impacts on psychological, social, occupational, and educational functioning. As a result, people's ability to meet and document CE requirements will also fluctuate, requiring people to prove they are unable to work to keep their Medicaid coverage at times when they need care the most. For millions of Americans, MH/SUD treatment — made possible by public or private insurance — is a prerequisite for being able to work.

Our organizations consistently hear about the barriers people face in accessing MH/SUD care that would impact their ability to secure documentation to meet CE requirements. The Health Resources and Services Administration has described the state of unmet need as "a mental health crisis," with substantial supply, distribution, and other challenges limiting the capacity of the MH/SUD workforce to meet demand[4]. An estimated 45% of the U.S. population lives in a mental health professional shortage area[5]. Low reimbursement rates have led to historically low Medicaid participation rates, which further exacerbates the lack of access to care for people with Medicaid coverage[6]. A recent analysis by the HHS Office of the Inspector General on selected counties across the country found that, on average, there were about 3 active MH/SUD providers per 1,000 enrollees in Medicaid managed care plans, with some counties having no active MH/SUD providers per 1,000 enrollees[7]. These significant access issues make it difficult for people with MH/SUD to secure documentation or generate claims data needed to meet the new CE requirements or qualify for an exclusion.

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[4] Health Resources and Services Administration. (2025). State of the behavioral health workforce, 2025. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

[5] Health Resources and Services Administration (2026). Health workforce shortage areas. https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

[6] National Academies of Sciences, Engineering, and Medicine. (2024). Expanding behavioral health care workforce participation in Medicare, Medicaid, and marketplace plans. https://www.nationalacademies.org/projects/HMD-HCS-23-02/publication/27759

[7] U.S. Department of Health and Human Services, Office of Inspector General. (2024, April 3). A lack of behavioral health providers in Medicare and Medicaid impedes enrollees' access to care (OEI-02-22-00050). https://oig.hhs.gov/reports/all/2024/a-lack-of-behavioral-health-providers-in-medicare-and-medicaid-impedes-enrollees-access-to-care/

Moreover, while IFC notes that "States may accept provider documentation," to demonstrate that an individual meets the medically frail exclusion, providers do not have guidance, experience, or resources to certify that an individual cannot work. We urge CMS to recognize the critical role that MH/SUD care professionals will inevitably play in facilitating Medicaid CE compliance. As frontline service providers, they will be at the nexus of eligibility and CE exclusion processes, and will often serve as the primary source of information for patients seeking to navigate Medicaid eligibility requirements. It is critical that CMS limit the burden placed on MH/SUD care professionals in determining and documenting that a Medicaid applicant has a qualifying disorder so that they can focus on delivering care to their patients. We urge CMS to encourage Medicaid programs to provide specific guidance and reimbursement for assessing and documenting the existence of functional limitations for patients for purposes of determining compliance with or exclusion from CE requirements. Lack of clear guidance on how to navigate these new requirements and additional uncompensated workload will further disincentivize MH/SUD providers from participating in the Medicaid program.

We are also concerned that the new medically frail definition will inhibit states' ability to use ex parte data-matching as a strategy for streamlining verification and compliance, particularly for automatically identifying those who qualify for an exclusion. With the new requirement to assess severity and impact on ability to comply with the CE requirement, states will need additional data that will be particularly challenging to access for many people with MH/SUD who should qualify for an exclusion. Only about half of Americans with a mental health condition receive treatment, and rates are even lower for people with substance use disorders, with only about 1 in 5 receiving treatment[8]. Furthermore, due to gaps in federal investment, MH/SUD providers have not adopted health information technology at the same rate as the healthcare system more broadly. The MH/SUD field was largely excluded from the major health information technology (IT) infrastructure incentives provided under the Health Information Technology for Economic and Clinical Health Act. As a result, MH/SUD clinicians and providers are far less likely than most other health care providers to work with electronic health records (EHR) systems capable of communicating with external medical/surgical systems. Ex parte processes based on claims data shared through interoperable health IT systems cannot be relied upon for Medicaid eligibility determinations for individuals with MH/SUD in the same way they can be for individuals with other conditions. This will make it challenging for states to obtain

[8] Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 national survey on drug use and health. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

the necessary MH/SUD patient information that might automate exclusions for other populations. We urge CMS to hold listening sessions with organizations who work with people with MH/SUD to discuss implementation challenges and inform changes to the IFC that would minimize coverage losses for eligible beneficiaries.

Finally, many of our organizations work closely with state governments, and we are concerned about the short timeline for implementation. Previous informal guidance suggested that data-matching and ex parte would facilitate exclusion and exception determinations. With the new medically frail definition outlined in the IFC, states will have to go back to the drawing board to reassess data systems, staff training, and beneficiary communication, among other processes. This will not only increase the cost of implementation, but it will also make it harder for CMS to audit CE implementation.

Additional Recommendations to Improve CE Implementation and Oversight

In addition to revising the medically frail definition, we offer the following recommendations:

- **Encourage states to create a comprehensive list of diagnoses for disabling mental disorder:** All mental health conditions can be disabling at various points. 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 impacted by mental health conditions, providers, and other relevant stakeholders.
- **Allow states more flexibility to implement self-attestation:** Self-attestation can be a valuable tool when documentation is not easily available due to the barriers outlined above. A plain reading of P.L. 119-21 allows for self-attestation, and we urge CMS to expand states' ability to allow for further self-attestation for all conditions past 2027, while individuals secure documentation of their condition.
- **Make data collection on CE implementation publicly available:** We appreciate CMS' intent to collect data on CE implementation, including data on enrollment, outcome of eligibility determinations, and CE compliance. We urge CMS to make this data publicly available in a timely manner so that advocates and interested parties at the state and federal level can identify concerning trends or issues, and work with stakeholders to address them.
- **Grant good faith waivers:** Given the unexpected additional requirement that states determine whether a condition significantly impairs an individual's ability to work, we believe states will need more time to correctly implement these new

requirements. We urge CMS to provide 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.

Conclusion

We thank CMS for the opportunity to comment on this significant IFC. We appreciate CMS' consideration and continued partnership in supporting individuals and families affected by MH/SUD. For any questions or further discussion, please do not hesitate to contact Hannah Wesolowski, Chief Advocacy Officer at the National Alliance on Mental Illness (hwesolowski@nami.org), or Stephen Gillaspy, PhD, Deputy Chief, Health Policy and Healthcare Financing at the American Psychological Association Services (sgillaspy@apa.org).

Sincerely,

National Alliance on Mental Illness
American Psychological Association Services
Legal Action Center
American Psychiatric Association
Inseparable
American Academy of Child and Adolescent Psychiatry
American Art Therapy Association
American Counseling Association
American Foundation for Suicide Prevention
American Association for Marriage and Family Therapy
American Association of Psychiatric Pharmacists
American Association for Psychoanalysis in Clinical Social Work
American Association on Health and Disability
Anxiety and Depression Association of America
Association for Behavioral Health and Wellness
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
Crisis Text Line
Depression and Bipolar Support Alliance
Easterseals, Inc.
Global Alliance for Behavioral Health and Social Justice

Huntington's Disease Society of America
International Society of Psychiatric-Mental Health Nurses
Maternal Mental Health Leadership Alliance
National Alliance to End Homelessness
National Association for Behavioral Healthcare
National Association for Rural Mental Health (NARMH)
National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National Council for Mental Wellbeing
National Eating Disorders Association
National Register of Health Service Psychologists
Network of Jewish Human Service Agencies
NHMH - No Health without Mental Health
Policy Center for Maternal Mental Health
Psychotherapy Action Network (PsiAN)
Recovery Innovations
Residential Eating Disorders Consortium
SMART Recovery
The Jed Foundation
The Kennedy Forum
The National Alliance to Advance Adolescent Health
The Trevor Project
Treatment Advocacy Center (TAC)