AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

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 (CMS-2454-IFC)**

Submitted electronically via Regulations.gov

Dear Administrator Oz and Deputy Administrator Brillman:

On behalf of American Psychological Association Services Inc. (APA Services), please accept the following comments in response to your Proposed Rule concerning the **Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)**, published in the Federal Register on June 3, 2026. APA Services is the companion organization of the American Psychological Association (APA), which is the largest scientific and professional organization representing the discipline and profession of psychology, as well as over 190,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

APA Services is deeply concerned that the interim final rule with comment period (IFC) on Medicaid Work Reporting and Community Engagement (WR/CE) Requirements will create onerous hurdles that put coverage at risk for many people with mental health conditions and substance use disorders (MH/SUD). **We urge the Centers for Medicare & Medicaid Services (CMS) to revise this interim final rule (IFR) to protect the millions of people who rely on Medicaid for life-saving MH/SUD care. Denying critical support of and access to mental and behavioral health services does not align with the goals of the Great American Recovery Initiative.**

APA Services would like to especially highlight four core areas of concern with the IFR:

1. The IFR, in exceeding its statutory authority, now requires states to also evaluate whether an individual's **condition "significantly impairs" their ability to work;**
2. **States can accept self-attestation in 2027**, but CMS limits reliance on self-attestation beginning in 2028;

3. Timely publication of implementation data and **approving good-faith state waivers when additional time is needed;** and
4. **Engagement** with other provider and patient groups.

Medicaid's Behavioral Health Landscape

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 crises. Executive Order 14379, Addressing Addiction Through the Great American Recovery Initiative, clearly sets forth urgent actions to address addiction and recovery. Through Medicaid coverage, children and adults can now 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 roughly 24 percent.[1]

APA Services fears that the IFR 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 the One Big Beautiful Bill Act (H.R. 1), Public Law (P.L.) 119-21, including eligible individuals who will not be able to navigate the new WR/CE requirements.[2] The authors of a June 2026 RAND report estimated 7.6 million fewer Medicaid enrollees in 2034.[3]

However, CBO's estimates did not account for the policies outlined in the IFR, 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.

Individuals with behavioral disorders that impair their functional capacity are particularly likely to have difficulty documenting that they meet the proposed criteria for exclusion from CE requirements. Only about half of U.S. adults with a mental illness receive treatment, and among those aged 12 or older needing substance abuse treatment, only about 1 in 5 received treatment.[4] Consequently, many

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[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.* 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] Rand Report**, State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act, (2026, June 18).**

[4] 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* (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases

individuals with a disabling mental disorder or a substance use disorder will be unable to document this with claims data.

APA Services offers specific recommendations below to improve implementation of WR/CE requirements and minimize coverage losses for eligible individuals who have MH/SUD. This is a follow-up to the recommendations we endorsed in advance of CMS' publication of the IFR.[5]

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

APA Services is 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 WR/CE requirements, and increases the administrative burden required to qualify for the exclusion. H.R. 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." While those who are not yet in "stable recovery (which means, an individual who is in recovery for 5 or more years)" may meet medical frailty criteria, those who have been in recovery for 5 or more years will likely not meet the criteria according to the IFR. CMS does not specify how to determine when recovery begins.[6]

According to a July 2026 report, **New Federal Medicaid Work Reporting Requirements Rule Threatens Coverage for Vulnerable Americans: An Explainer of the Interim Final Rule**, from the Georgetown University Center on Children and Families (CCF), "[f]ewer people will qualify as medically frail with the eleventh-hour addition of the IFR's requirement that the individual's condition 'significantly impair' their ability to work or participate in qualifying activities.[7]"

H.R. 1 outlines five categories of qualifying health conditions to be considered medically frail – **Blindness or Disability, Substance Use Disorder (SUD), Disabling Mental Disorder, Physical, Intellectual, or Developmental Disability, and Serious or Complex Medical Condition**.[8] Under a plain language reading of the law, all individuals who have one of these qualifying conditions should be excluded from WR/CE requirements. However, in the IFR, 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 WR/CE requirements. Not only does this addition go beyond the text of the statute, but it also goes against the intent of the exemption, which was to protect those at highest risk of experiencing adverse health effects from losing their health coverage due to WR/CE requirements.

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[5] 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

[6] Georgetown University Center on Children and Families report, **New Federal Medicaid Work Reporting Requirements Rule Threatens Coverage for Vulnerable Americans: An Explainer of the Interim Final Rule, (2026, July 16, 2026).**

[7] Georgetown University Center on Children and Families report, **New Federal Medicaid Work Reporting Requirements Rule Threatens Coverage for Vulnerable Americans: An Explainer of the Interim Final Rule, (2026, July 16, 2026).**

[8] State Health and Value Strategies (SHVS), June 9, 2026, New CMS Interim Final Rule on Medicaid Work Reporting Requirements

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

In addition to concerns about the appropriateness of the IFR's definition of "medically frail," APA Services believes 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 WR/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.

The barriers people face in accessing MH/SUD care are well-documented and persistent, and are likely to negatively impact an individual's ability to secure documentation to meet WR/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.[9]

An estimated 45 percent of the U.S. population lives in a mental health professional shortage area.[10] 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.[11] 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.[12] These significant access issues make it difficult for people with MH/SUD to secure documentation or generate claims data needed to meet the new WR/CE requirements or qualify for an exclusion.

Moreover, while the IFR notes that "States may accept provider documentation," to demonstrate that an individual meets the medically frail exclusion, many providers do not have guidance, experience, or resources to certify that an individual cannot work. **APA Services urges CMS to recognize the critical role that MH/SUD care professionals will inevitably play in facilitating Medicaid WR/CE compliance**.

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[9] 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

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

[11] 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

[12] 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/

As frontline service providers, behavioral health specialists, including psychologists, will be at the nexus of eligibility and WR/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 limits 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 WR/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.

States Should Extend Self-Attestation Beyond CY 2027

APA Services is 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 WR/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 worse for people with substance use disorders, with only about 1 in 5 receiving treatment.[13]

According to the Georgetown CCF Report, "the IFR narrows the definition of medical frailty to individuals who can show their health condition 'significantly impairs the individual's ability to comply' with [WR/CE requirements] and the IFR imposes rigorous new verification rules specific to medical frailty, including **heavy restrictions on self-attestation**.[14]"

Self-attestation is an individual's signed declaration submitted under penalty of perjury and is auditable by the state or CMS (widespread practice in other areas of Medicaid policy, such as attesting to pregnancy). In 2027, the state may accept information, such as self-attestation, but, beginning January 1, 2028, when data sources available to the state do not provide necessary information, the state must require documentation whenever it is reasonably available. **APA Services urges CMS to expand states' ability to allow for further self-attestation for all conditions past 2027, while individuals secure documentation of their condition.**

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

[13] 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

[14] Georgetown University Center on Children and Families report, **New Federal Medicaid Work Reporting Requirements Rule Threatens Coverage for Vulnerable Americans: An Explainer of the Interim Final Rule, (2026, July 16, 2026).**

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

Finally, APA Services is concerned about the short timeline for implementation, particularly when previous informal guidance from CMS to state Medicaid authorities suggested that data-matching and ex parte would facilitate exclusion and exception determinations. With the new medically frail definition outlined in the IFR, states will have to go back to the drawing board to reassess data systems, staff training, beneficiary communication, and other processes. This will not only increase the cost of implementation, but it will also make it harder for CMS to audit WR/CE implementation.

Additional Recommendations to Improve WR/CE Implementation and Oversight

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, **APA Services urges 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.**

Make data collection on WR/CE implementation publicly available: APA Services appreciates CMS' intent to collect data on WR/CE implementation, including data on enrollment, outcome of eligibility determinations, and WR/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, APA Services believes 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 IFR considers "extraordinary, severe, or unexpected issues that hinder their progress" since states are already facing many implementation challenges.**

Conclusion

Thank you for the opportunity to weigh in on this significant IFR and submit our comments. **APA Services welcomes an opportunity to work with the administration to** simplify the complexities of the IFR to prevent millions of eligible beneficiaries who rely on Medicaid from losing their access to health care, including mental and behavioral health care APA Services would be interested in partnering with you to

shape guidance to states, communities and behavioral health providers, including psychologists, that do not result in the improper termination or denial of access to behavioral services supported by Medicaid. We would also be interested in collaborating with the administration to ease the further erosion of providers who serve Medicaid populations given the likelihood of new burdens threatening provider participation rates.

To the extent that APA and psychologists can serve as a resource to the Administration in any way, please feel free to reach out to Stephen R. Gillaspy, PhD, Deputy Chief of Health Policy and Healthcare Financing, at sgillaspy@apa.org.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association Services, Inc.