AMERICAN PSYCHIATRIC ASSOCIATION

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July 21, 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
Attention: CMS-2454-IFC
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:

The American Psychiatric Association (APA), the national medical specialty society representing more than 40,400 psychiatric physicians and their patients, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) interim final rule with comment period (IFC), *Medicaid Program; Community Engagement Requirement for Certain Individuals* (CMS-2454-IFC). APA is deeply concerned that several provisions of the IFC exceed the plain language of the statute, which is a departure from the implementation approach CMS previously outlined to states and will create significant barriers to coverage for people living with mental illness and substance use disorders. Unless revised, the IFC will increase hardship for beneficiaries, deepen coverage losses, and impose substantial administrative burdens on state Medicaid agencies and health care professionals.

Medicaid is the nation's single largest payer of mental health and substance use disorder services. Nearly one in three adult Medicaid beneficiaries have a mental health or substance use disorder (SUD).[1] Medicaid therefore plays an indispensable role in responding to the nation's ongoing overdose and mental health crises. Additionally, the Medicaid expansion population includes a substantial share of individuals with mental health or SUD diagnoses, and many people with mental illness also have co-occurring physical health conditions.[2] Interruptions in Medicaid coverage will delay treatment, worsen health outcomes, and increase patient reliance on emergency and crisis services leading to increased healthcare costs across systems.

[1] https://www.kff.org/mental-health/5-key-facts-about-medicaid-coverage-for-adults-with-mental-illness/
[2] https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/

APA urges CMS to recognize the enormous operational burden this IFC places on state Medicaid programs. The IFC requires states to implement major eligibility, verification, beneficiary outreach, systems, and reporting changes by January 1, 2027. In order to meet this deadline, these changes must be designed, funded, tested, communicated, and operationalized quickly, even though only a limited number of state legislatures are currently in session. CMS should provide meaningful flexibility, including recognition of good-faith implementation efforts, so that states are not forced to rush policies that could jeopardize coverage for people with serious health needs. **CMS should align the IFC with the statute and avoid adding barriers not intended or authorized by Congress.**

APA requests that CMS remove the requirement that an individual's condition must "significantly impair" their ability to meet community engagement requirements in order to qualify as medically frail. The IFC's "significantly impairs" standard for medically frail individuals exceeds statutory authority. The statute protects medically frail individuals, including those with disabling mental disorders, from being subject to these requirements. The IFC narrows that protection by requiring individuals not only to establish the existence of a qualifying condition, but also to prove functional impairment tied specifically to community engagement compliance. The additional obligation of significantly impairing their ability to meet community engagement requirements is not required by the statutory text and undermines the purpose of the exemption: preventing coverage loss among people at heightened risk of adverse health consequences.

CMS should permit broader use of self-attestation for exclusions and exceptions to the greatest extent permitted by law, including beyond 2027. Individuals with mental illness or SUD face substantial difficulty obtaining timely documentation, particularly if they are between clinicians, experiencing housing instability, facing transportation barriers, or already at risk of losing coverage. The consequences for noncompliance should not be punitive or disproportionate. Temporary bans, lockouts, or other barriers to re-enrollment will interrupt access to preventive, primary, psychiatric, and SUD treatment services. For patients with serious mental illness or active SUD, even short coverage gaps can destabilize treatment and increase crisis risk, while the associated costs of care make it harder to engage in work, education, volunteer service, or caregiving.

CMS should minimize administrative burdens associated with specified exclusions and mandatory exemptions. The IFC requires states to identify, verify, and adjudicate numerous exclusions and exceptions. CMS should provide states with flexibility to use existing data sources, presumptive eligibility logic, reasonable self-attestation, and streamlined renewal processes. Without this flexibility, eligible individuals may lose coverage simply because state systems cannot reliably identify their exclusion status or because beneficiaries cannot navigate complex reporting requirements.

It is especially important that CMS avoid shifting excessive administrative responsibility onto behavioral health clinicians. Psychiatrists and other behavioral health professionals should not be required to complete burdensome forms, make legal eligibility determinations, or repeatedly document functional limitations in ways that disrupt care. CMS should encourage states to create a clear, comprehensive list of diagnoses and clinical circumstances that qualify as disabling mental disorders or otherwise support medical frailty, while preserving clinician judgment and beneficiary self-attestation where appropriate. States should also be encouraged to incorporate psychiatrists and other behavioral health clinicians, beneficiaries with lived experience, and other relevant stakeholders in the decision-making bodies. This will ensure a transparent and thoughtful process that encompasses all mental health conditions that can be disabling at times throughout the disease.

Although the IFC describes community engagement requirements as a pathway to employment and self-sufficiency, coverage loss is more likely to produce instability, uncertainty, and crisis for people with mental illness and SUD. Access to psychiatric care, therapy, medications and SUD treatment often enables individuals to work, attend school, care for family members, and participate in their communities. Policies that interrupt that care will undermine, rather than advance, the stated goals of community engagement. Thank you for the opportunity to comment on the IFC. APA strongly urges CMS to revise the rule before finalization so that it more closely follows the plain language of the statute, protects people with mental illness and SUD from inappropriate coverage loss, and avoids unnecessary burdens on states, beneficiaries, and clinicians. If you have any questions, please contact Brooke Trainum, Senior Director, Practice Policy, at btrainum@psych.org.

Sincerely,

Marketa Wills, MD, MBA, FAPA
CEO and Medical Director
American Psychiatric Association