Coalition Comments on Medicaid Community Engagement Requirements

Interim Final Rule with Comment Period (CMS-2454-IFC)

July 31, 2026

The Honorable Mehmet Oz, M.D., Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244
Attention: CMS-2454-IFC

RE: Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026), as corrected, 91 Fed. Reg. 39028 (June 29, 2026); File Code CMS-2454-IFC; Docket No. CMS-2026-2047

Submitted electronically through the Regulations.gov docket.

Dear Administrator Oz:

These comments are submitted on behalf of a statewide coalition that includes rural and urban hospitals, physicians, a children's hospital, Federally Qualified Health Centers, long-term care and nursing facility providers, and behavioral health providers. Our members care for Arizonans across the health care continuum and will be directly affected by how states implement the new Medicaid community engagement requirement.

We recognize that Congress established the requirement and that CMS must provide a national implementation framework. Our comments focus on the areas in which CMS retains discretion to prevent avoidable coverage losses, protect continuity of care, and ensure that Medicaid eligibility administration remains the responsibility of state agencies. Physicians, hospitals, and other health care providers may supply clinical information, but they are not eligibility workers and should not be required to make legal, vocational, or benefit determinations on behalf of the state.

Our central concern is not whether qualifying activities may be verified. It is whether eligible people will lose AHCCCS coverage because a database is incomplete, a claim has not yet been adjudicated, a provider cannot complete an additional form, or a patient in active treatment cannot respond to a notice. CMS should not create a system in which coverage depends on a clinician's willingness or ability to serve as a de facto eligibility adjudicator. Coverage should turn on eligibility, not paperwork capacity.

Coalition position. CMS should establish a data-first, patient-protective framework that uses automatic exclusions and exceptions wherever possible, minimizes individual and provider documentation, preserves attestation when reliable data are unavailable, and prohibits coverage termination while a medical-frailty, hardship, or appeal determination is pending. States—not health care providers—must remain responsible for applying the law, resolving conflicting information, and making final eligibility determinations.

1. Central Themes Identified Across All Sectors

1.1 Prevent procedural coverage losses and require operational readiness

All sectors expect the rule to increase the number and complexity of eligibility touchpoints for applicants and beneficiaries. The Interim Final Rule (IFC) requires states to assess compliance at application and renewal and permits more frequent verification at state option[1]. It also requires most affected beneficiaries to undergo eligibility renewal every six months. In practice, multiple verification cycles can create coverage churn even among people who are working, participating in qualifying activities, or eligible for an exclusion or exception.

Coverage loss has immediate system consequences: interrupted medications and treatment, delayed care, greater emergency department use, higher uncompensated care, and additional work for hospital eligibility teams, FQHC navigators, physicians, health plans, nursing facilities, and behavioral health providers. These effects are especially serious for people with complex conditions, limited literacy, unstable housing, limited broadband, or no reliable transportation.

Requested revisions

- CMS should provide administrative funding to states to complete and publicly document a CMS-approved operational readiness review before any denial or termination based on community engagement. The review should address staffing, systems testing, data accuracy, notice readability, language access, appeals, call-center capacity, provider training, and continuity-of-coverage procedures.
- Limit state verification to the minimum one-month review period at application and renewal, and prohibit more frequent verification during at least the first implementation year.
- Require coverage to remain in effect while an exclusion, hardship request, good-cause request, or appeal is pending, including when verification depends on information from a provider, employer, school, volunteer organization, or another government agency.
- Require good-cause extensions when a person cannot respond within the standard notice period because of illness, hospitalization, disability, language barriers, displacement, or lack of access to records.
- Prohibit denial or termination when the only missing element is a third party's failure or delay in responding.

1.2 Revise the medical frailty standard so that it does not become an individualized work-capacity test

The most consistent concern across the coalition is the requirement in 42 C.F.R. § 435.554(c)(5) that a condition significantly impairs the person's ability to comply with community engagement. For serious or complex medical conditions, the rule turns a medical exclusion into a functional and vocational determination. The standard is undefined, highly subjective, and likely to produce inconsistent results across states, health plans, clinicians, and patient populations. It is also inconsistent with the statutory framework identified by Congress that did not require this additional functional limitation except for individuals with a physical, intellectual or developmental disability[2].

[1] Federal Register 33388, Section II.H

[2] Pub. L. 119-21, § 71119(a) (amending SSA § 1902 to add subsection (xx)); codified as SSA § 1902(xx)(9)(A)(ii)(V)

A diagnosis alone should not always be dispositive, but the rule should permit diagnosis, severity, treatment intensity, utilization, and expected course to establish medical frailty without requiring a treating clinician to predict whether the person can work, volunteer, or attend school for 80 hours in a particular month. The rule preamble itself recognizes that states should consider multiple domains, including intensive outpatient services and utilization patterns, and that the absence of claims cannot establish that a person is not medically frail.

Requested revisions

- Delete the significant-impairment-to-comply standard for individuals with a serious or complex medical condition, substance use disorder, or disabling mental disorder when the statute does not expressly impose that standard.
- At a minimum, define objective federal criteria and establish rebuttable presumptions for diagnoses, treatment courses, and utilization patterns that ordinarily demonstrate medical frailty.
- Clarify that a state's diagnosis or code list is a screening floor, not a ceiling, and that no person may be denied an exclusion because a diagnosis is absent from a code list.
- Permit a diagnosis combined with evidence of active treatment, significant medication burden, repeated acute care, intensive outpatient services, or specialist management to establish medical frailty without a separate work-capacity opinion.
- Prohibit states from requiring proof that a person is unable to perform every type of qualifying activity.

1.3 Do not make healthcare providers and institutions Medicaid eligibility agencies

Medicaid eligibility determinations are a governmental responsibility. CMS should not implement the medical-frailty exclusion in a manner that transfers responsibility for interpreting or applying Medicaid eligibility standards to physicians, hospitals, health systems, nursing facilities, Federally Qualified Health Centers, behavioral health providers, or other healthcare institutions.

The central problem is the requirement in 42 C.F.R. § 435.554(c)(5) that an individual's condition significantly impairs the individual's ability to comply with community engagement requirements. As explained in Section 1.2, the Coalition's primary recommendation is that CMS remove this requirement. Congress identified medically frail individuals and individuals with special medical needs for exclusion from the community engagement requirements. CMS should not convert that exclusion into an individualized vocational-capacity determination that must be supported by a treating provider.

Clinicians are trained to diagnose illness, assess clinical functioning, recommend treatment, and describe medically relevant limitations. They are not trained or positioned to decide whether a patient can work, volunteer, participate in a work program, or attend school for 80 hours each month. Those questions extend beyond clinical medicine. They may depend on the nature of available work, the physical or cognitive requirements of particular activities, transportation, scheduling, accommodations, symptom variability, treatment side effects, and other vocational and environmental factors.

The AAMC[3] correctly observes that neither claims data nor diagnosis codes resolve this problem. Claims and clinical codes may demonstrate diagnoses, comorbidities, treatment intensity, and clinical severity, but they do not reliably show whether an individual can sustain the particular community engagement activities reasonably available to that person. Two patients with the same diagnosis may experience

[3] AAMC Medicaid Program; Medicaid Community Engagement Requirements for Certain Individuals

markedly different symptoms and functional limitations. The absence of a reliable administrative data source, however, does not justify shifting the determination to treating clinicians. It demonstrates that the ability-to-comply standard itself is unworkable.

Requiring a provider attestation would place physicians and other healthcare professionals in the position of making decisions that directly affect whether a patient retains Medicaid coverage. A provider's assessment could later be challenged by the state, a managed care organization, an auditor, a court, or a patient who disagrees with the conclusion. Providers could face allegations that they supported an exclusion for a patient who was capable of satisfying the requirement or failed to support an exclusion for a patient who subsequently lost coverage and experienced harm. CMS has not addressed whether these disputes would be covered by professional liability insurance or whether they could increase malpractice exposure and insurance costs.

The requirement would also create substantial inconsistency. In the absence of objective federal standards, two clinicians reviewing similarly situated patients could reasonably reach different conclusions. Access to Medicaid could therefore depend on the individual provider's interpretation of an unfamiliar eligibility standard, the amount of time available during a clinical encounter, or the patient's ability to obtain an appointment and secure completed paperwork.

This is not an appropriate use of limited clinical capacity. Providers already devote significant time to prior authorization, appeals, disability forms, medical-record requests, and other administrative requirements. Requiring recurring medical-frailty evaluations would divert additional time from diagnosis, treatment, chronic-disease management, and preventive care. AAMC notes that reliance on physician attestations could increase appointment delays not only for individuals seeking medical-frailty documentation, but also for other patients competing for limited clinical capacity.

Recurring documentation requirements are particularly unnecessary for conditions that are permanent, progressive, or unlikely to improve. Advanced heart failure, dementia, persistent post-stroke impairment, end-stage renal disease requiring dialysis, and comparable conditions should not require a new provider certification every year in the absence of evidence of meaningful improvement. Repeated documentation creates work for providers and state agencies without necessarily generating new information, while exposing eligible individuals to coverage loss when an appointment or form is delayed.

CMS must preserve a clear division of responsibility. Healthcare providers may supply factual clinical information when that information is unavailable through claims, encounters, medical records, or other ex parte sources. The state must remain responsible for evaluating the information, applying the federal standard, resolving disputes, and making the final eligibility determination.

Requested revisions

- Clarify that the state Medicaid agency retains sole responsibility for determining Medicaid eligibility and medical-frailty status. Physicians, clinicians, hospitals, health systems, nursing facilities, Federally Qualified Health Centers, and behavioral health providers may furnish factual clinical information, but they may not be required to determine whether an individual is legally eligible, medically frail, or capable of satisfying the community engagement requirement.
- Prohibit states, managed care organizations, contractors, and auditors from requiring healthcare providers to perform vocational or work-capacity evaluations for Medicaid eligibility purposes. Providers should not be required to determine whether a patient can work, volunteer, participate in training, or attend school for 80 hours per month.

- Prohibit requirements that healthcare providers conduct a new examination or create a separate work-capacity assessment solely to support a Medicaid eligibility determination. Any request for provider information must be limited to factual clinical information ordinarily available in the medical record, including diagnoses, treatment, symptoms, functional limitations, prognosis, and expected duration.
- Establish a federal good-faith safe harbor for healthcare providers and institutions. A provider or institution that supplies accurate clinical information in good faith through an authorized process should not be subject to liability, recoupment, sanctions, adverse audit findings, or program-integrity allegations based on the state's subsequent eligibility determination.
- Clarify that the state bears responsibility for applying the legal standard and resolving conflicting information. The state may not shift responsibility to the treating provider by requiring the provider to certify that the patient does or does not qualify for the medical-frailty exclusion.
- Require states to consult healthcare professionals with relevant clinical expertise when designing medical-frailty processes. This consultation should include the development of diagnosis lists, clinical presumptions, documentation requests, review criteria, and processes for conditions that are episodic, progressive, or highly variable.

1.4 Use ex parte data first, preserve self-attestation, and prohibit negative inferences from missing data

The corrected verification regulation at 42 C.F.R. § 435.557 appropriately requires states to use reliable information available to the state before requesting information from an individual. That protection must be strengthened in the final rule and implementation guidance. Claims and encounter data can lag, may not reflect services delivered outside a managed care network, and may be incomplete for a newly diagnosed or newly enrolled person. Payroll and education data also may fail to capture seasonal, gig, cash, part-time, or multiple-employer work.

Requested revisions

- Require states to exhaust all relevant ex parte sources before contacting an applicant or beneficiary, including eligibility data, claims and encounters, payroll and wage data, SNAP and TANF data, education data, unemployment data, and information already held by managed care organizations where legally available.
- State expressly that missing, delayed, incompatible, or incomplete data may not be treated as evidence of noncompliance or ineligibility.
- Continue to require acceptance of self-attestation when documentation is not reasonably available and permit self-attestation beyond 2027 for medical frailty, qualifying activity, and hardship circumstances, subject to reasonable program-integrity safeguards.
- Require states to accept multiple forms of proof and information from authorized representatives, caregivers, providers, and community organizations rather than mandating a single form or source.
- Limit reverification of medical frailty to no more than once every 12 months unless the individual reports a material improvement or the state has reliable evidence of a material change.

1.5 Expand and simplify short-term hardship protections

Section 435.555 recognizes hardships related to institutional and similar-acuity services, disasters, high unemployment, and extended travel for medical care. These protections are important, but they are

optional at the state level and, for some medical circumstances, require an individual request. Patients in active treatment may not know that a hardship exists or may be unable to request it while managing an acute illness.

Requested revisions

- Make the medical-service, disaster, unemployment, and travel protections a federal minimum rather than optional protections, or, at a minimum, require states to opt out affirmatively and explain how eligible people will otherwise be protected.
- Allow states to individually elect hardship categories to the fullest extent permitted by law. If CMS continues its all-or-nothing stance, simplify the election process and strongly condition implementation approval on adoption of the complete package.
- Apply medical hardships automatically when claims, encounter, admission, treatment, or authorization data show that the criteria are met.
- Recognize intensive outpatient treatment, partial hospitalization, repeated infusion, dialysis, outpatient surgery, transplant evaluation, cancer treatment, and other comparable services as services of similar acuity.
- Expand disaster protection to people whose workplace, school, treatment site, or caregiving location - not only residence - is in an affected area.
- Require self-attestation for travel-related hardship when documentation is not readily available.

1.6 Fund and authorize navigation, outreach, and beneficiary assistance

The rule creates a new, recurring eligibility process that will be difficult to understand even for people who are working and otherwise eligible. Hospitals, FQHCs, health plans, physicians, long-term care providers, and behavioral health providers will become default sources of assistance. Without dedicated funding and clear authority, this work will displace patient care and other enrollment functions.

Requested revisions

- Establish dedicated Navigator funding for Medicaid community engagement education, exemption screening, documentation assistance, and appeals.
- Clarify that Medicaid managed care organizations may contract with FQHCs, hospitals, and community-based organizations for outreach and navigation, and explain how such spending may be included in the medical loss ratio numerator or otherwise recognized as a quality-improvement activity.
- Require plain-language, multilingual, accessible notices delivered by mail, electronic message, telephone, and other modalities selected by the beneficiary.
- Require states to test notices and workflows with beneficiaries, providers, disability organizations, Tribal partners, rural communities, and people with limited English proficiency before implementation.

1.7 Protect privacy and create a centralized, standardized verification process

Verification requests can involve health information, behavioral health and substance use information, employment records, school records, and volunteer participation. A fragmented process increases privacy risk and produces inconsistent results. One Arizona hospital already has experience with telephone-based volunteer verification for SNAP eligibility that illustrates the operational problem: a single organization may manage hundreds of volunteers, and each request requires record location, staff time, interpretation, and documentation.

Requested revisions

- Require a secure, centralized state verification portal with standardized data elements and audit trails rather than ad hoc calls and emails.
- Require written authorization or another legally sufficient basis before a state seeks information from a third party, and limit requests to the minimum information necessary.
- Establish standard response timeframes that do not jeopardize the beneficiary when a third party is unavailable.
- Clarify that behavioral health and substance use information remains subject to HIPAA, 42 C.F.R. Part 2, and other applicable confidentiality protections.

2. Sector-Specific Issues and Requested Revisions

2.1 Rural hospitals

Rural hospitals will face the same eligibility responsibilities as larger systems but often with fewer eligibility staff, fewer specialized financial counselors, and less information-technology capacity. Rural patients also are more likely to travel long distances for specialty care and may have seasonal or irregular employment patterns that are not accurately reflected in a single month of payroll data. Limited broadband, limited cellular service, and transportation barriers can make electronic reporting and repeated documentation especially difficult.

The IFC acknowledges several rural realities: it permits a six-month income average for seasonal workers, identifies critical access hospital inpatient services as a qualifying medical hardship, and recognizes high unemployment, disasters, and extended medical travel. Those protections will not be effective if they depend on a patient knowing to request them or on a state making a discretionary county-level request after coverage problems arise.

Requested revisions

- Require states to apply the six-month seasonal-worker income average whenever it is more favorable than a single-month calculation and accept employer attestation, pay records, or self-attestation when electronic wage data are incomplete.
- Automatically apply unemployment and disaster hardships using federal and state data, without requiring an individual request or additional proof.
- Treat medically necessary travel outside a rural community as a hardship whenever travel, treatment, or recovery affects any part of the month; do not require travel for the entire month.
- Include critical access hospital swing-bed care, observation services, outpatient infusion and oncology care, dialysis, outpatient surgery, and other intensive outpatient services within similar-acuity protections when clinically appropriate.
- Require telephone, paper, in-person, and low-bandwidth reporting options and prohibit an online-only process.
- Provide enhanced federal implementation funding and standardized eligibility-support tools for rural and critical access hospitals.

2.2 Physicians and other treating clinicians

Treating physicians are trained to diagnose and treat disease, not to determine eligibility for public benefit programs or to perform vocational capacity evaluations. A requirement that the physician decide whether a patient can work, volunteer, participate in a work program, or attend school for 80 hours per

month creates legal, ethical, and practical problems. Symptoms can fluctuate substantially, particularly in oncology, autoimmune disease, behavioral health, pain conditions, and other episodic illnesses. Two reasonable clinicians may reach different conclusions about the same patient.

The eligibility role also threatens the patient-physician relationship. Patients may view the treating clinician as the gatekeeper to health coverage, physicians may feel pressured to write exemption letters, and disagreements may become intertwined with clinical care. Physicians already complete extensive prior authorization, disability, leave, and insurance paperwork; a new recurring category of uncompensated forms will reduce time for patient care.

Requested revisions

- Explicitly state that treating clinicians are not the ones who determine whether a condition significantly impairs compliance with community engagement.
- Require the state to make the eligibility determination through a trained administrative process using objective standards and available data.
- If clinical information is necessary, use a brief standardized form that permits the clinician to describe diagnosis, treatment, limitations, variability, and duration without making the final eligibility decision.
- Accept information from physicians, nurse practitioners, physician assistants, psychologists, counselors, therapists, clinical social workers, and other qualified professionals acting within state scope-of-practice laws.
- Provide liability protection and prohibit audits or recoupments against a clinician who supplies information in good faith.
- Limit recurring certification and require payment when the documentation burden is substantial.

2.3 Children's hospitals and adult patients with congenital, rare, or pediatric-onset conditions

Most patients in a children's hospital system are minors and therefore outside the applicable adult population. Children's hospitals, however, also care for adults with congenital and pediatric-onset diagnoses, including sickle cell disease, hemophilia, congenital heart disease, and other rare or complex conditions. These patients may require highly specialized services that are not readily available in adult community settings and may remain clinically dependent on pediatric specialists after age 19.

The IFC gives clearer protection to people receiving inpatient services than to those receiving intensive outpatient care. Adults undergoing outpatient surgery, cancer treatment, transplant evaluation, infusion therapy, or treatment while immunosuppressed may be medically unable to maintain 80 hours of activity even though they are not admitted. A gap in Medicaid coverage can interrupt specialty medications, blood products, laboratory monitoring, and coordinated care.

Requested revisions

- Establish presumptive medical frailty for adults with serious congenital, rare, blood, transplant-related, or pediatric-onset conditions when diagnosis and active specialty treatment are documented.
- Clarify that sickle cell disease, hemophilia, active cancer treatment, transplant evaluation and post-transplant care, immunosuppression, and comparable conditions may qualify without a separate activities-of-daily-living limitation.

- Treat intensive outpatient treatment and recovery periods as similar-acuity medical hardships and apply the protection for the full month in which treatment occurs.
- Accept documentation from pediatric and subspecialty clinicians who continue to treat the adult patient.
- Require continuity of coverage while a medical frailty or hardship determination is pending and during transition from pediatric to adult systems of care.

2.4 Long-term care and individuals awaiting disability-based eligibility determinations

Arizona's Medicaid eligibility structure illustrates the importance of distinguishing individuals already enrolled in a long-term services and supports eligibility category from those still awaiting a determination. Individuals enrolled in the Arizona Long Term Care System (ALTCS) are assigned a distinct eligibility code and are not enrolled in the Proposition 204 Restoration or ACA adult expansion categories to which the community engagement requirement applies.

The more significant concern arises during the period in which an individual remains enrolled through the adult expansion pathway while an application for ALTCS or another disability-based eligibility category is being evaluated. For example, an adult under age 65 may already reside in a nursing facility, have a traumatic brain injury, require extensive assistance with activities of daily living, or otherwise appear to require an institutional level of care, but may remain coded as an adult expansion member until the ALTCS application, financial review, and Pre-Admission Screening (PAS) process are completed. AHCCCS requires both a financial determination and a PAS assessment before ALTCS eligibility is approved, and the PAS process determines whether the individual requires a nursing-facility or intermediate-care-facility level of care[4].

Individuals whose ALTCS applications or PAS assessments are still pending also need temporary protection. A pending application alone may not establish permanent medical frailty in every case, but it should automatically trigger a provisional medical-frailty review and suspend community engagement notices and adverse action. The IFC requires states to use reliable information already available in the eligibility system and case record and to use relevant adjudicated claims and encounter data when evaluating medical frailty. It also requires states to attempt ex parte verification before requesting additional information from the individual. CMS therefore should direct states to treat an ALTCS application, PAS referral, scheduled PAS assessment, completed PAS result, nursing-facility claim, institutional placement record, or other state-held long-term-care information as an automatic trigger for this protection.

The same transition problem affects individuals applying for Supplemental Security Income (SSI). Once SSI is approved, an individual is no longer subject to the community engagement requirement, but the disability-determination process frequently takes longer than the Medicaid eligibility and renewal timelines. KFF reports that, in 2023, more than 106,000 new SSI enrollees had previously been covered through the ACA expansion pathway, and 42% of new SSI enrollees in expansion states had expansion coverage before their SSI entitlement. The average initial disability-application processing time was approximately 184 days as of May 2026. During that period, applicants may face two concurrent

[4] AHCCCS Medical Assistance Eligibility Policy Manual, 1001 General Provisions

assessments of their ability to work—one through the Social Security disability process and another under Medicaid's medical-frailty standard—using different standards and timelines[5].

CMS should ensure that individuals awaiting ALTCS, SSI, or comparable disability-based eligibility determinations do not lose Medicaid coverage while the government is still deciding whether they qualify for an eligibility pathway that is categorically outside the community engagement requirement.

Requested revisions

- Prohibit termination based solely on a resident's failure to respond when the state knows the person is institutionalized, cognitively impaired, or represented by an authorized representative.
- Send all notices to the beneficiary and any authorized representative, guardian, or responsible party identified in the case record.
- Require a pending-determination indicator. Direct states to establish an electronic indicator when an ALTCS application, PAS assessment, SSI application, state disability determination, or comparable eligibility review is pending. The indicator should suppress community engagement notices and adverse actions until the determination and any timely appeal are completed.
- Treat a favorable PAS medical determination as conclusive evidence of medical frailty. Once the state determines that an individual meets nursing-facility or intermediate-care-facility level-of-care criteria, no additional "ability to comply" determination should be required, even if financial eligibility or enrollment processing remains pending.
- Provide provisional protection while the PAS or disability determination is pending. Require states to treat a pending ALTCS, PAS, SSI, or comparable disability application as a trigger for an expedited ex parte medical-frailty review. Coverage should continue while the state reviews its eligibility records, claims, encounter data, facility information, provider documentation, and information supplied by the individual or authorized representative.
- Allow attestation when state data are incomplete or delayed. The IFC permits states, through 2027, to accept information provided under penalty of perjury when reliable data are unavailable or insufficient. CMS should require states to make that option readily available to individuals awaiting ALTCS or disability determinations, particularly when claims lag prevents automatic verification.
- Prohibit retroactive noncompliance. If the ALTCS, SSI, or disability-based application is ultimately denied, the state should apply community engagement requirements prospectively only, after issuing an individualized notice and providing a reasonable opportunity to demonstrate compliance or another exclusion.

2.5 Behavioral health and substance use disorder services

Behavioral health conditions are often episodic, and functional capacity may vary substantially over time. People with serious mental illness may experience periods of relative stability followed by crisis, hospitalization, or significant loss of executive functioning. However, many individuals with severe mood disorders, anxiety disorders, post-traumatic stress disorder, obsessive-compulsive disorder, and other serious psychiatric illnesses experience substantial occupational and functional impairment without meeting their state's administrative criteria for Serious Mental Illness (SMI). SMI is not a clinical diagnosis. It is an administrative designation established under state law or policy to determine eligibility

[5] Abby Sachar, Amaya Diana, Alice Burns & Jennifer Tolbert, *What Could Medicaid Work Requirements Mean for SSI Applicants?*, KFF (July 29, 2026), https://www.kff.org/medicaid/what-could-medicaid-work-requirements-mean-for-ssi-applicants

for certain public behavioral health services. In Arizona, an SMI determination is based on state-established criteria that include diagnosis, duration, and functional impairment. As a result, an individual may have a severe psychiatric illness that substantially limits their ability to maintain consistent employment while not qualifying for the state's SMI designation. Making medical frailty contingent on an administrative designation rather than an individual's actual functional capacity could unintentionally exclude Medicaid beneficiaries whose behavioral health conditions genuinely prevent them from consistently meeting community engagement requirements. This distinction is particularly important because SMI eligibility criteria vary considerably from state to state, creating the potential for similarly situated beneficiaries to receive different treatment based solely on where they live.

Similarly, people with substance use disorder often move through different phases of treatment and recovery, including outpatient counseling, intensive outpatient treatment, partial hospitalization, medications for opioid use disorder and other FDA-approved pharmacotherapies, residential treatment, peer recovery support services, and periods of relapse or remission. Participation across this continuum reflects active engagement in evidence-based treatment and recovery and should not be interpreted as evidence that an individual is capable of meeting community engagement requirements.

The IFC recognizes disabling mental disorders and substance use disorder within the medical frailty framework and excludes participants in drug or alcohol treatment programs. However, the rule does not clearly recognize the full continuum of evidence-based behavioral health and substance use disorder treatment. Requiring disclosure of detailed treatment information also raises significant confidentiality concerns.

Requested revisions

- Remove the five-year stable recovery cutoff as a categorical basis for denying medical frailty, or clarify that duration of recovery does not create a presumption of work capacity.
- Clarify that qualifying participation in substance use disorder treatment includes the full continuum of evidence-based care, including outpatient counseling, intensive outpatient programs, partial hospitalization programs, medications for opioid use disorder and other FDA-approved pharmacotherapies, residential treatment, peer recovery support services, and other evidence-based recovery support services, regardless of whether services are furnished by certified community behavioral health clinics, community mental health centers, opioid treatment programs, office-based prescribers, or other qualified providers.
- Clarify that individuals with significant mood disorders, anxiety disorders, post-traumatic stress disorder, and other serious behavioral health conditions may qualify for medical frailty or an exclusion based on clinical severity and functional impairment, even if they have not been designated as having Serious Mental Illness under state-specific criteria.
- Recognize the episodic nature of behavioral health conditions and substance use disorders and permit an exclusion based on expected variability, relapse risk, cognitive impairment, treatment intensity, or other clinically documented functional limitations.
- Treat intensive outpatient programs, partial hospitalization programs, crisis stabilization, assertive community treatment, residential treatment, medications for opioid use disorder, and other evidence-based behavioral health and substance use disorder services as indicators of medical frailty or comparable-acuity services.
- Accept documentation from behavioral health clinicians, counselors, therapists, peer support specialists where appropriate, and other qualified professionals acting within their scope of practice.

- Apply exclusions and hardships automatically when claims, encounter, or authorization data establish participation in qualifying behavioral health or substance use disorder treatment.
- Require minimum necessary verification and full compliance with HIPAA, 42 C.F.R. Part 2, and applicable state confidentiality laws.
- Prohibit termination during a behavioral health crisis, active treatment episode, inpatient or residential discharge transition, or while a medical frailty determination, hardship request, or appeal is pending.

2.6 Urban hospitals and high-volume hospital systems

Urban hospitals and health systems will face this rule frequently through emergency departments, financial counseling, discharge planning, specialty clinics, and uncompensated care. Even a small increase in procedural denials can produce thousands of additional patient contacts, billing corrections, applications, appeals, and self-pay balances. Coverage churn also makes it more difficult to coordinate follow-up care and maintain medication access after discharge.

Urban systems may also be asked to verify employment, training, or volunteer activity. Large urban hospitals manage hundreds of volunteers. A manual verification model would require staff to locate records, answer questions, document responses, interpret whether volunteer activities qualify, and manage privacy and consistency. Hospitals are not eligibility determination agencies, and a beneficiary should not lose coverage because the state cannot reach a volunteer office.

Requested revisions

- Create a secure, standardized verification portal and prohibit reliance on unrecorded telephone calls to hospital departments.
- Require written beneficiary authorization, standard data fields, clear record-retention rules, and a safe harbor for good-faith responses by hospitals and volunteer programs.
- Prohibit denial or termination when a hospital or other third party does not respond before the eligibility deadline.
- Require states to fund training, workflow changes, and system modifications for qualified hospitals before implementation.
- Prohibit recoupment or sanctions when the hospital reasonably relied on the applicant's attestation.

2.7 Federally Qualified Health Centers and community health centers

Federally Qualified Health Centers (FQHCs) will be central to educating patients, identifying potential exclusions, helping patients obtain documentation, and restoring coverage after procedural loss. These tasks will fall on clinics already facing workforce shortages and high administrative demands. Every hour spent on an individualized work-capacity certification or repeated eligibility paperwork is time unavailable for diagnosis, treatment, chronic disease management, and preventive care.

FQHC patients are also more likely to face language, transportation, technology, housing, and health-literacy barriers that make repeated reporting difficult. If patients lose coverage, FQHCs will continue providing care while absorbing additional uncompensated costs and helping patients reapply.

Requested revisions

- Eliminate the significant-impairment requirement for serious or complex medical conditions or, if retained, issue detailed objective guidance and require multiple verification options, including self-attestation.

- Require operational readiness before coverage terminations and suspend terminations when state systems, data matches, or notices are not functioning reliably.
- Restore or create Navigator funding for FQHC enrollment and community engagement assistance.
- Clarify that Medicaid managed care organizations may contract with FQHCs to provide outreach, education, navigation, documentation assistance, and referrals.
- Clarify how managed care spending on these activities is treated for medical loss ratio and rate-setting purposes.
- Limit clinician forms and recurring certifications and ensure that community engagement administration does not reduce access to clinical appointments.

3. Conclusion

CMS can implement the statutory community engagement requirement without converting Medicaid eligibility into a paperwork test. The final framework should identify exclusions and exceptions automatically, use reliable state data before asking patients for documentation, preserve self-attestation when records are unavailable, and keep eligibility adjudication with the state. It should also protect patients receiving intensive outpatient care, recognize existing long-term care and disability determinations, and prevent coverage loss when a provider or other verification source does not respond.

Arizonans for Better Healthcare respectfully requests that CMS revise the IFC and issue implementation guidance consistent with the recommendations above. We would welcome the opportunity to provide additional operational detail and to work with CMS and Arizona officials on beneficiary-centered implementation.

Sincerely,

Appendix A. Consolidated Regulatory Revision Crosswalk

This crosswalk summarizes the principal regulatory changes requested in the coalition comments. It is intended to make the requested revisions easy to locate and does not replace the detailed discussion above.

Provision	Issue	Requested revision
42 C.F.R. § 435.554(c), including (c)(5)	**Medical frailty definition**	Remove the generalized ability-to-comply requirement and the five-year stable-recovery cutoff; adopt objective presumptions based on diagnosis, treatment, utilization, severity, and expected course; make state code lists non-exhaustive; recognize episodic conditions and the full behavioral health and substance use disorder treatment continuum.
42 C.F.R. § 435.555	**Short-term hardship**	Make protections a federal minimum or strongly condition implementation on state adoption; apply medical, disaster, and unemployment hardships automatically; include intensive outpatient and comparable services; accept self-attestation for travel.
42 C.F.R. § 435.556	**Review periods**	Use the minimum one-month review at application and renewal; prohibit more frequent checks during initial implementation; apply favorable seasonal-worker averaging.
42 C.F.R. § 435.557, as corrected	**Verification, data, and privacy**	Require exhaustive ex parte review before contacting individuals or providers; prohibit negative inferences from missing or delayed data; accept multiple forms of proof and ongoing self-attestation when records are unavailable; limit frailty reverification; use secure, minimum-necessary verification that protects HIPAA and 42 C.F.R. Part 2 information.
42 C.F.R. § 435.558, as corrected	**Noncompliance and termination**	Continue coverage during pending exclusion, hardship, good-cause, or appeal determinations; provide good-cause extensions; prohibit adverse action based on a provider's or other verification source's failure or delay in responding.
42 C.F.R. § 435.561	**Outreach**	Require plain-language, multilingual, accessible, multimodal notices; fund navigators; require user and stakeholder testing before implementation.
42 C.F.R. §§ 431.10, 435.554, 435.557 and implementation guidance	**State responsibility and healthcare-provider role**	Confirm that state Medicaid agencies alone determine eligibility and medical-frailty status; prohibit provider vocational or work-capacity determinations and new examinations solely for eligibility; limit requests to factual clinical information; establish a good-faith liability safe harbor; require clinical consultation in process design.
42 C.F.R. §§ 435.554, 435.557, 435.558 and implementation guidance	**Pending ALTCS, PAS, SSI, and disability determinations**	Require pending-determination indicators that suppress community-engagement notices and adverse actions; treat a favorable institutional-level-of-care finding as conclusive medical frailty while final enrollment is pending; continue coverage through the determination and any timely appeal; apply requirements prospectively if the application is denied.
Managed care guidance under 42 C.F.R. Part 438	**Navigation and outreach support**	Clarify that MCOs may fund hospital and FQHC outreach, education, navigation, documentation assistance, and referrals, and identify appropriate medical loss ratio and rate-setting treatment.
CMS readiness and oversight guidance	**Implementation safeguards**	Require public readiness assessments, systems testing, notice testing, call-center capacity, appeals, continuity procedures, and corrective action before any coverage termination.