AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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July 31, 2026

Administrator Mehmet Oz, MD
Centers for Medicare and Medicaid Services
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 Administrator Oz:

The American Academy of Child and Adolescent Psychiatry (AACAP) is the professional home to 11,000 child and adolescent psychiatrists, fellows, residents, and medical students, some of whom also treat adults and transitional age youth (ages 18-26 years). Our mission includes promoting the healthy development of children, adolescents, and families. AACAP's child and adolescent psychiatrist members spend their careers caring for children, adolescents, and families affected by mental illness. As such, we are committed to increasing access to mental health and substance use disorder care for all who need it and feel uniquely qualified to comment on the negative impact that the IFC will have on children and families.

Unworkable Definition of "Medical Frailty"

The Medicaid program is the single largest payer of mental health services in the nation. Medicaid expansion has allowed the nearly 24 percent of enrollees with mental health and substance use disorders (SUDs) to receive the care they need.[i] Continuous Medicaid coverage is essential to the ongoing treatment of mental health and substance use disorders, yet only 50 percent of Medicaid enrollees with a disabling mental health condition receive this care, with many currently

struggling to stay enrolled in Medicaid.[ii] The new definition of "medically frail" in the IFC which adds the need to demonstrate "significant impairment," goes beyond what was included in the H.R. 1 statute and may be outside of the agency's discretion. This additional test will make a difficult situation even more untenable for the most vulnerable Medicaid enrollees, contrary to the stated mission of the U.S. Department of Health and Human Services (HHS), which emphasizes its commitment to the health and well-being of all Americans.

Ironically, the need to demonstrate "significant impairment" as part of meeting the definition of "medically frail" will only make it more difficult for those who are living with a significant impairment and are most in need of stable Medicaid coverage. Medicaid enrollees who have a disabling mental health condition, receive treatment for a SUD, or who are living with an intellectual or developmental disability, already experience significant stress and, in many cases, are unable to perform activities of daily living. Navigating the redetermination process and scheduling the necessary medical appointments to gain proof of medical frailty would be difficult, if not impossible, for many enrollees. The inability to access psychiatrists or other mental health professionals who can document both their medically frail condition and their inability to work due to significant impairment, year after year, or worse, every six months, will put those most in need of medical care at significant risk of losing their health coverage. **For the foregoing reasons, we urge the agency to remove the additional requirement that a medically frail enrollee demonstrate that their condition "significantly impairs" their ability to meet community engagement requirements.**

Unworkable Short-term Optional Hardship Exception

AACAP is concerned with the current IFC provision related to the short-term optional hardship exemption for inpatient or institutional care, which includes inpatient psychiatric care. As written, a prospective Medicaid enrollee hospitalized during the application or renewal month may not qualify for a hardship exception if the hospitalization did not occur during the lookback period, even though the hospitalization directly affects the person's current ability to satisfy community engagement requirements. Conversely, a hospitalization during the lookback period may qualify for a hardship exception even if the individual has fully recovered by the time eligibility is determined. Either way, the applicant would be unable to meet the community engagement requirement and therefore be ineligible for coverage. To ensure that an eligible individual can access necessary inpatient care at the time of illness and be eligible for the short-term hardship exception**, AACAP recommends that CMS amend the IFC to require states to evaluate whether a short-term hardship exists at the time of eligibility determination. States could also allow**

time spent under observation, e.g., time spend boarding in the emergency department, to count toward the "lookback" period.

Impact on Psychiatrists and Other Mental Health and SUD Providers

Inevitably, psychiatrists and other mental health and SUD providers will be called upon to certify that an individual meets the medically frail exclusion, as described in the IFC. The lack of clarity on what data or documentation would allow an enrollee to prove a medical frailty exemption raises numerous questions for physicians. Additionally, time spent attempting to document "significant impairment" competes with time for patient care. **CMS should recognize and minimize the administrative burden this will place on psychiatrists and other mental health professionals, while taking steps to ensure that Medicaid programs provide specific guidance, and reimbursement, for assessing and documenting functional limitations for the purposes of certifying exclusion from community engagement requirements.** CMS should also recognize that these additional documentation requirements will be for Medicaid applicants who may be uninsured at the time of application and therefore access to certain data and documentation may not be available. Further, this amounts to uncompensated work for physicians, if not reimbursed, will create a disincentive to participate in the Medicaid program, which will only exacerbate the access issues discussed above.

States Will Face Burdens with Implementation

Moreover, the new requirements are imposing additional burdens on states, which must implement new processes by January 2027, now less than six months away. States are making significant changes to the processes they have developed, given the changes in the IFC from earlier guidance which did not include demonstration of significant impairment. As mentioned above, the situation is compounded by limited access to physicians, especially psychiatrists, and other mental health professionals, a well-documented challenge for patients with mental health and SUDs. The shortage of psychiatrists and other behavioral health professionals providing mental health and substance use disorder (SUD) treatment is well documented. Approximately 40 percent of the U.S. population lives in a Mental Health Professional Shortage Area, with rural communities experiencing the greatest shortages.[iii] All of these factors create a nearly impossible system for the nation's most vulnerable enrollees to navigate and will place undue pressure on states to implement. The required administrative changes will also be costly at a time when federal investments in Medicaid are severely restricted. **CMS should provide states with the flexibility to permanently allow self-attestation when data and documentation is not readily available.**

States Should Develop and Utilize Comprehensive Lists of Debilitating Diagnoses for the Purposes of Determining Medical Frailty and Have More Time to Do So

To ensure people with disabling mental health conditions or SUDs have access to Medicaid coverage, states should develop comprehensive lists of diagnoses with input from psychiatrists and other mental health professionals for use in determining medical frailty. Doing so would align with the H.R. 1 statute, intended to protect individuals who are at elevated risk of experiencing adverse effects from loss of coverage, by granting them an exclusion from community engagement requirements. Time is scarce for states to develop effective administrative processes for determining that a disabling mental condition or SUD is also significantly impairing. The Congressional Budget Office estimates that millions of individuals could lose Medicaid coverage, not because they are ineligible, but because compliance cannot be verified.[iv] Accordingly, the agency should encourage states to put in place administrative processes that will minimize this outcome, and provide the opportunity for states that need more time to implement the unexpected additional requirement that they determine whether a condition significantly impairs an individual's ability to work, such as granting good faith waivers and approving them without requiring states to prove "extraordinary or unexpected issues that would hinder their progress." **States are already facing significant implementation challenges and good faith waivers should be made readily available to states when needed.**

Medicaid Coverage Increases Family Stability and Benefits the Nation's Youth

Lastly, research consistently shows that when parents gain Medicaid coverage, their children benefit and can access needed health care at a higher rate. Evidence from Medicaid expansion states under the Affordable Care Act shows that parental coverage supports children in several ways, including greater family financial security; healthier mothers, babies, and caregivers; reduced school absenteeism and dropout rates; fewer reported cases of child neglect; improved children's mental health; and better outcomes for children receiving cancer treatment.[v] Conversely, the opposite is true; as parents lose Medicaid eligibility and experience increased economic and health instability, their children are more likely to lose coverage.

Alarmingly, the child uninsured rate, including the loss of Medicaid coverage for children, is currently accelerating even before the H.R. 1 Medicaid community engagement requirements are implemented. Ensuring that children remain covered by Medicaid or the Children's Health Insurance Program, if eligible, should be a national priority. To prevent unintentional loss of coverage for children and youth whose parents or caregivers lose coverage, **we recommend that CMS work with states to develop guidance to**

disenrolled parents/caregivers that emphasizes that their loss of coverage does not impact on children in their care.

In closing, we appreciate your consideration of the issues outlined above. We also ask the agency to consider the impact of these complex policies on families and the indirect impact on the nation's children. HHS has a solemn duty to protect all citizens of the United States and should come back to that foundation when promulgating regulations implementing H.R. 1's community engagement requirements to enable the smoothest possible path for states and for Medicaid enrollees. Should you have questions, you may contact Karen Ferguson, Deputy Director of Clinical Practice, at kferguson@aacap.org.

Sincerely,

John T. Walkup, MD
President

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[i] Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders | KFF
[ii] How Will States Implement the Behavioral Health Exemption? | Commonwealth Fund
[iii] State of the Behavioral Health Workforce, 2025
[iv] Inseparable-MedicaidMHandHR1Guide-04.21.26_0806.pdf
[v] Research Shows Medicaid Expansion Beneficial to Child Health and Family Financial Security – Center For Children and Families