HMA

NYS Council for Community Behavioral Healthcare

Community Engagement Interim Final Rule

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Today's Agenda

- Overview of the interim final rule
- Implications for the people you serve
- Implications for you
- Discussion

Interim Final Rule

HIGH LEVEL OVERVIEW

- On June 3, HHS/CMS published in the Federal Register an Interim Final Rule with Comment Period **"Community Engagement Requirements for Certain Individuals"** implementing Public Health Law 119-21, Section 1902 (xx)
- Section 1902 (xx) requires individuals to engage in **qualifying community engagement activities** like work, volunteering, or education **at least 80 hours per month**.
  - The law requires disenrollment of noncompliant individuals from Medicaid.
- States that provide Medicaid coverage must comply with community engagement requirement no later than **January 1, 2027**
  - Self-attestation is permitted until December 31, 2027
- Every six months as part of the Medicaid renewal process the State must verify whether applicable individuals have met the community engagement requirements
- **Because this is an Interim Final Rule with Comment Regulations, comments are due the same date that the regulations take effect - July 31, 2026**

Who Does Community Engagement Apply To?

- Applies primarily to adults in Affordable Care Act Medicaid expansion group
- Impacted individuals, generally, must show at least 80 hours per month of qualifying work, education, or community service
- The rule also establishes exemptions and state responsibilities for verifications, notices, reporting, appeals and oversite.
- **The rule temporarily allows self-attestation in limited circumstances to verify work or exemption status, including medical frailty**
- Starting January 2028, states must request documentation from individuals when the state does not have current data on file. In the case of medical frailty, states are permitted to accept self-declaration of medical frailty one-time during the enrollment period.
  - For example, if self-declaration for medical frailty is accepted at application, individuals must provided documentation renewal, six months later.

Key exempt groups include:

Medically frail individuals
Certain caregivers
Former foster youth
AI/AN individuals
Certain veterans
People in SUD treatment
Other statutory groups

New vocabulary:

Exclusion: individuals not subject to CE requirement
Exception: individuals subject to CE requirement deemed compliant for certain months
Hardship: limited circumstantial exception to CE requirements

Medical Frailty Definition

- Individuals are excluded from CE if their condition **significantly impairs ability to meet CE requirements.**
- Included conditions:
  - **Substance Use Disorder (SUD)**
  - **Disabling mental disorder**
  - **Serious or complex behavioral/medical conditions**
- Functional impairment test is **required**
  - Diagnosis alone is insufficient
  - Must impair capacity to complete required activities
- Individuals with BH/SUD may:
  - Be **excluded entirely** (medically frail)
  - Be **temporarily excepted** (hardship)
  - Or must comply if condition does not impair function

Medical Frailty Criteria for BH Clients

SUD

Individuals with SUD are excluded unless in "stable recovery" (≥5 years in recovery)

Early or sustained recovery still qualifies as SUD-based exclusion

Not limited to active treatment

Includes:

- Alcohol-use disorder
- Opioid-use disorder
- Stimulant-use disorder

DSM-5/ICD-10 may be used by States

Disabling Mental Disorder

Condition must significantly impair ability to engage in CE activities

Examples CMS deems reasonable:

- Schizophrenia
- Bipolar disorder (moderate/severe)
- Major depressive disorder
- Panic disorder

Must be "disabling" (functional impairment required)

No fixed national definition; states must operationalize

Additional Pathways

Separate from medical frailty, individuals participating in drug/alcohol treatment programs are excluded (applies for duration of participation)

Short term hardship exception (individual deemed compliant for affected month(s):

- Inpatient psychiatric care
- Crisis stabilization/ institutional services
- Travel for treatment

BH/Justice Involved Overlap

- Automatic exclusion during incarceration
- Automatic exception for 3 months post-release
- After 3-month hardship exception, individuals who are justice-involved may trigger an exclusion or hardship exception based on a specified diagnosis (SUD or MH/BH disabling condition) or short-term hardship (acute treatment or crisis event)

The Challenge for States

1. Broad income-based compliance pathway

CMS allows states to use existing MAGI-based household income methodologies, including earned and unearned income, to evaluate compliance.

This is broader than many stakeholders expected and may let states integrate compliance into current eligibility workflows.

Potential upside: less reliance on manual activity reporting and more opportunity to automate compliance checks.

2. Rigorous end-to-end verification framework

Verification requirements extend beyond employment and income to exemptions, hardship exceptions, notices, and monitoring.

States must build processes to validate both compliance and exemption status.

The evidentiary burden for exceptions may become a bigger operational issue than demonstrating compliance.

Verification Requirements Become the Central Challenge

Medical frailty

The rule appears to require more than diagnosis-based exemptions and points toward a functional assessment of ability to meet the requirement.

Many states may lack standardized, scalable processes for these determinations.

This area is difficult to automate and could become one of the most resource-intensive parts of implementation.

Caregiver exemptions

Caregiving responsibilities often sit outside formal data systems.

States will need documentation standards that satisfy oversight without creating undue family burden.

The requirement to verify both the caregiving relationship and level of care creates a more subjective review process.

Hardship exceptions

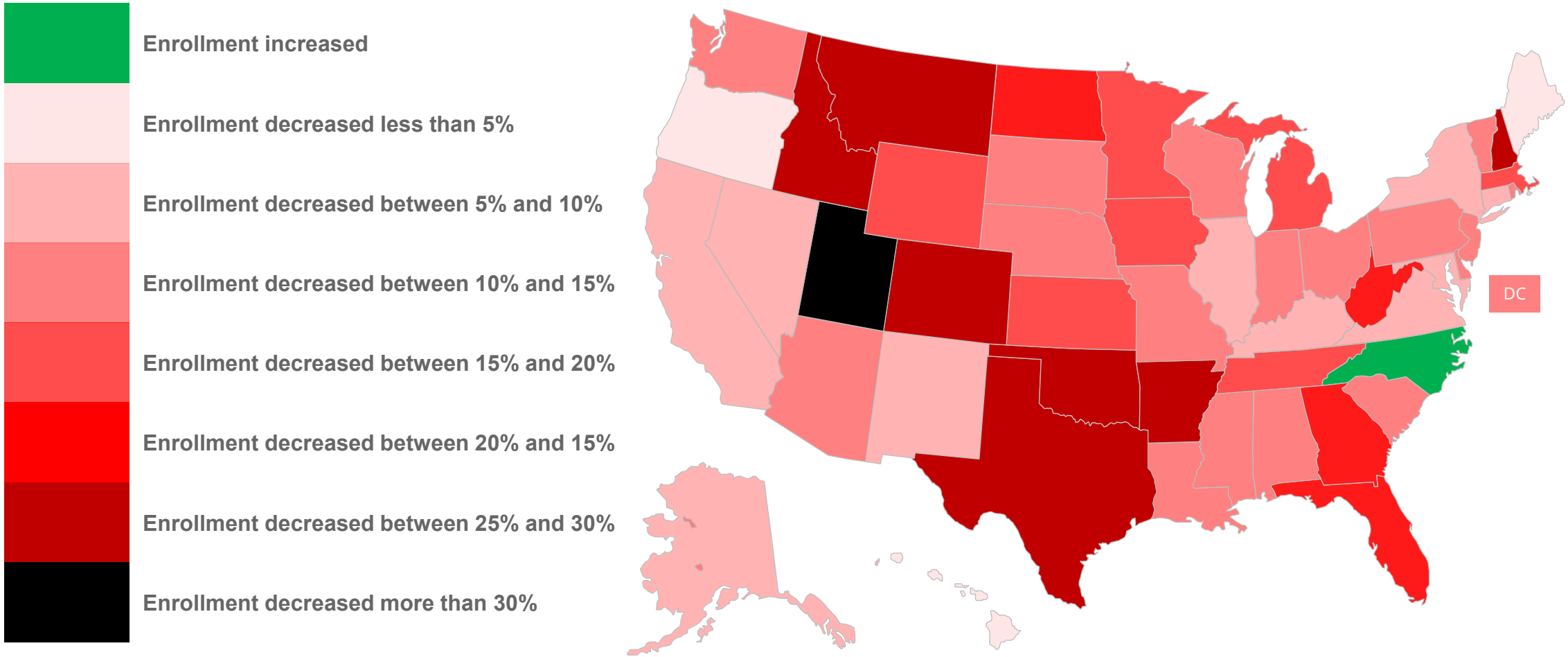
Hardship relief is case-specific, documented, and time-limited.

Without broad categorical protections, individualized reviews may create substantial manual workload.

States will need clear policies for eligibility, documentation, duration, renewal, and consistency.

States can mitigate or exacerbate CE's coverage losses

LOOK AT THE PANDEMIC MEDICAID UNWINDING TO SEE THE IMPORTANCE OF STATE PERFORMANCE



Data as of March, 2024 as reported on https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/

Impact on BH Consumers

- Stressor during their recovery
- Makes it more difficult to maintain continuity of care
- Requires significant effort/executive function for them to maintain their coverage
- Perverse incentives for people who have been in SUD recovery for 4+ years
- The whole process does not account for the relapsing/remitting nature of some behavioral health conditions

Implications for NYSCCBH members

- **Every** stakeholder is on team New York
  - Everyone's interest is aligned around helping people maintain their coverage
- Voc/psychosocial rehab programs will be ever more important
  - Leverage CCBHC if you have that designation
- Systems for tracking which clients need what documentation and when to maintain coverage will be essential
- Clients will require a tremendous amount of education
- Many clients will need documentation that you will have to provide without remuneration
  - Need to document functional impairments

What Can You Do Right Now

- **State Advocacy**: help NYSCCBH provide input to the State as they build out processes for clients subject to CE, particularly processes that will create burden or further limit who may qualify for exceptions/exclusions (i.e., MH diagnoses)
- **Education/Outreach**: begin working with clients and their families to understand these requirements and the pathways for securing exceptions or meeting 80-hour CE obligations
- **Data Systems:**
  - ***Documentation/data sharing:*** qualifying diagnoses/functional impairment documentation will likely be sourced from existing data sharing/records like Qualified Entities/RHIOs; ensuring that your EHR and documentation demonstrate exception/exclusion criteria for Ex Parte state process, will be critical
  - ***Medicaid enrollment:*** tracking and understanding when individuals are subject to reenrollment or exception/exclusion expiration becomes a new critical task in maintaining coverage for clients; tracking this will be essential for proactive intervention and planning to prevent coverage lapses
- **CE Workflows:** safety net providers will be disproportionately impacted by individuals looking for CE exclusion/exception documentation; new workflows and staffing will be needed to provide functional impairment assessments to determine if a BH diagnosis prevents someone from participating in CE activities (unfunded mandate)
- **Vocational Rehabilitation:** programs can be reoriented to support individuals looking to satisfy the new 80-hour CE requirement; Voc Rehab provided by BH providers are uniquely positioned to understand the cyclical nature of recovery and treatment to support individuals throughout their journey
- **Volunteer Opportunities**: create and/or partner with other community organizations (for-profit and non-profit) to identify available volunteer opportunities for clients subject to CE

Contact Us.

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