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Redetermination CoP Session 1: Prevent

2026 WCAG 2.1 AA Accessible

Q & A Format

Please enter your questions into the Q & A panel as we move through the presentation.
Due to time constraints, we will follow up after the session with responses.

Community of Practice at a Glance

- Build the policy and population foundation so teams can anticipate who will be affected and where the greatest disenrollment risk sits.

Prevent 1

- Be prepared to intervene the moment a client receives a renewal notice with redesigned staffing, billing, workflows, EHR alerts, and proactive outreach that keep eligible clients on coverage.

Prevent & Identify 2

- Keep renewed clients connected to care and bring back those who fell off, while ensuring adequate policies to support the work.

Intervene, Recover, & Restabilize 3

- Close the loop by quantifying and qualifying impact at every intercept point so teams can refine workflows and tell the story to policymakers.

Measure & Sustain 4

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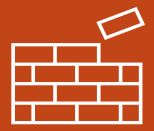
Applications due 7/20/26

Public Policy Mission Statement

National Council advocates for assertive public policies that:

Ensure
access
to high-quality
services

Build
the capacity of mental health and substance use treatment organizations



Promote
a greater understanding of mental wellbeing as a core component of comprehensive health and health care

Together, these efforts form a coordinated, bipartisan approach that advances our mission and amplifies the voices of the mental health and substance use treatment community.

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Today's Presenters

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The views expressed in this presentation are provided for informational purposes only. They do not necessarily reflect the opinions or views of the National Council for Mental Wellbeing, its employees or partners.

Session 1 Learning Objectives

- Summarize the key changes to redetermination outlined in H.R.1, including key population(s) impacted
- Understand the state-specific elements of implementation and potential sources for state-specific information
- Understand the various internal and external staff, MCOs, systems, and processes that impact and are impacted by redetermination (introduction to CCIM)
- Overview of CoP and PTC Cohort Opportunity

H.R.1: What It Is and Why It Matters

- H.R.1 carries the bulk of the current Congress's domestic policy agenda, partially offsetting tax cuts through new restrictions on Medicaid.
- The law creates significant Medicaid funding reductions, in many cases phased in over the next decade.
- The Congressional Budget Office estimates the Medicaid provisions could lead to about **10 million people losing coverage by 2034.**
- It passed through budget reconciliation — allowing Senate passage by simple majority — limited to spending, revenue, and debt-limit changes (the Byrd Rule bars "extraneous" provisions).
- For behavioral health providers, the practical impact hinges on state-level execution — the focus of this Community of Practice.

H.R.1 Key Changes to Medicaid Redetermination and Eligibility

- Frequency of redeterminations increase to once every 6 months (down from every 12 months)
  - ”Expansion adults” only
- Eligibility changes for immigrants for Medicaid/CHIP/Marketplace APTCs
- Community Engagement Requirements for Expansion Population
  - Medical frailty exemptions include people with substance use disorder or a “disabling mental disorder”
  - Requires states to verify compliance for at least one month prior to application and for up to 3 months prior to application
  - **Some states are implementing earlier than the Jan. 1, 2027, deadline: Nebraska (live May 1), Arkansas and Montana (July 1), and Iowa (Dec. 1)**
- Reduces the period of retroactive coverage for both expansion (1-month) and non-expansion (2-months) populations

Medicaid Redetermination Changes

Medicaid Redetermination Changes and Exempt Populations

- Beginning in 2027, states must implement 6-month redetermination processes for all "expansion adults" meaning:
  - Expansion population adults age 19-64
  - Adults age 19-64 in a state that provides Minimum Essential Coverage (MEC) through an 1115 demonstration
- Exempt populations include:
  - Certain American Indians and Alaska Natives
  - Individuals enrolled in other MAGI (Modified Adjusted Gross Income) based groups (e.g., pregnant women, dependent children, etc.)
  - Individuals enrolled in non-MAGI groups (e.g., disabled with Medicare, blind with Medicare, etc.)
- Redeterminations do not enjoy the same exceptions as the community engagement requirements (medical exemptions, caregiver exemptions, etc.), so someone may be subject to 6-month redetermination but not community engagement

Medicaid Redetermination Changes and Exempt Populations

Items for Provider Action

1.  **If you are in an expansion state,** identify any people you serve that may be covered under Medicaid expansion rather than traditional eligibility groups.

2.  **Make sure individuals know** that although they may be able to secure an exception for community engagement requirements, they are still likely to be subject to 6-month renewal processes (i.e., qualifies for a medical frailty exception for community engagement, does not apply for 6-month renewal).

States Subject to 6-month Redeterminations

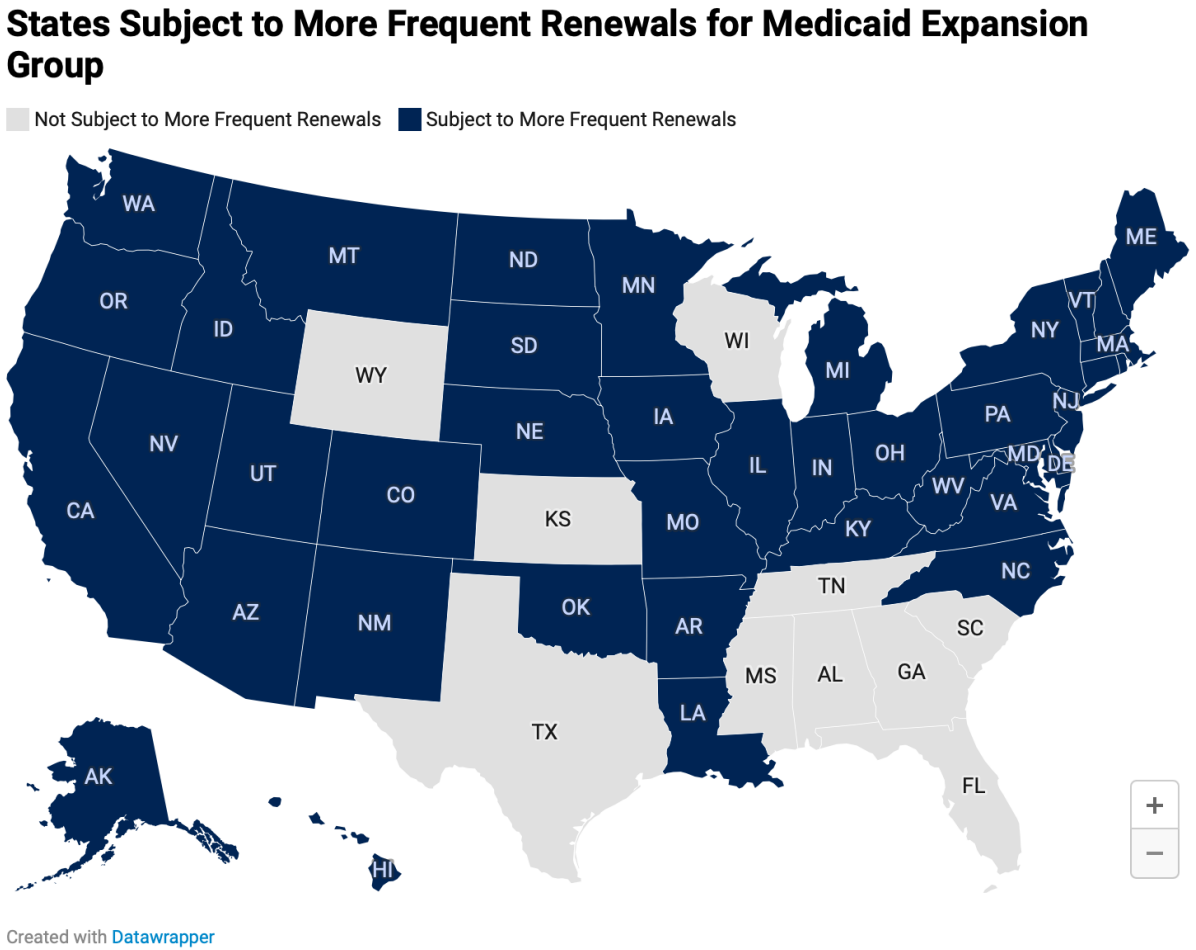

Image credit: Center on Budget and Policy Priorities. Beyond the Basics. June 2026. Retrieved from: https://www.healthreformbeyondthebasics.org/medicaid-work-requirements-and-six-month-redeterminations/.

State Redetermination Process Requirements

First Attempt *Ex Parte* Renewal

States must first attempt *ex parte* renewal without contacting the beneficiary for requested documentation.
States may use a wide variety of information sources with just a few examples among many below:

- Claims data
- Social Security Administration data
- Department of Veterans Affairs Data
- National Clearinghouse Data

If Eligibility Cannot Be Determined *Ex Parte*

States must notify the individual with sufficient time to complete the process by the end of 6 months. States may begin the process as soon as 90 days in advance.

- States must send a prepopulated renewal form and requested information providing at least 30 days to return
- States must consider eligibility on all bases before determining ineligibility
- Should a determination of ineligibility be made, individuals must be given a minimum of 10 days advance notice and fair hearing rights before termination can go into effect

Aligning Eligibility Across Household Members

States also cannot shorten OR extend eligibility to align different members in a household's redetermination timeline. However, if information comes to light that impacts another household member's eligibility (such as an income change), the state must then act on the new information.

State Redetermination Process Requirements

Items for Provider Action

1

States are not required to notify enrollees when they begin *ex parte* review, so you may not be aware when they begin processing.

2

Providers should work with participants to monitor for important notices. The timeline will vary by state. If the state cannot identify needed documentation, individuals should be notified with at least 30 days to complete and return. Should an individual be eligible, they will send a notification that the individual's eligibility is confirmed.

Now is the time to ensure enrollee addresses and contact information are up to date with the state!

Medicaid Redetermination: State-Specific Impacts

States have two options for implementing Medicaid Redetermination processes in 2027:

OPTION 1:

States may choose to move an individual's previously set 2027 renewal to an earlier date.

- States may not do this before 6 months (i.e., if Sally has 2 months of coverage as of January 1, 2027, they may not initiate.)
- However, if Sally is 7 months into her previous 12-month period, the state may choose to initiate in January rather than her original date in May.

OPTION 2:

States may use the existing renewal dates scheduled for 2027 and, following the first renewal, move to a 6-month period moving forward.

Note: States have varying timelines for initiating redetermination processes. Some may begin **90 days in advance** while other may begin **60 days in advance**.

Medicaid Redetermination Example Scenarios: Option 1

Example - Jill : Jill is enrolled in the adult expansion group as of May 1, 2026 and an eligibility period through April 30, 2027. The state Jill lives in selected Option 1: to immediately move eligible expansion adults in 2027. Because Jill will have had more than 6 months of eligibility on January 1, 2027, the state will initiate her redetermination on January 4, 2027 (the first business day of the year). From this point on, pending eligibility, Jill receives 6 months of eligibility each period.

Example - Max: Max is also enrolled in the adult expansion group, but his eligibility period began November 1, 2026 and ends October 31, 2027. The state elects to immediately move eligible expansion adults in 2027. However, because Max has not had 6 months of eligibility on January 1, 2027, the state adjusts his eligibility period to end on April 30, 2027. The renewal is initiated on March 1, 2027 to be complete by April 30, 2027.

Example - James: James' original eligibility period is September 1, 2026 to August 31, 2027. His state opts for immediate movement to 6-month redeterminations. His eligibility period now ends February 28, 2027, and it takes his state two months to complete the renewal. His renewal is initiated on January 4, 2027, to be completed by February 28, 2027.

Examples retrieved from CMS letter to State Medicaid Directors, March, 2026

Medicaid Redetermination Example Scenario: Option 2

Example - Jane: Jane's eligibility period is August 1, 2026 through July 31, 2027. The state Jane lives in opted to use Option 2 and retain previously scheduled 2027 renewal dates. She becomes subject to community engagement requirements on January 1, 2027. Her state elects to verify one month of community engagement at renewal. The state's renewal process takes about 90 days, so Jane's renewal is initiated in May 2027. Her eligibility is renewed for August 1, 2027. Her next renewal is January 31, 2028.

Examples retrieved from CMS letter to State Medicaid Directors, March, 2026

Community Engagement Requirements & Exemptions

Community Engagement Requirements

- Beginning January 1, 2027, all eligible Medicaid expansion adults are subject to community engagement requirements to retain eligibility.
- There are Specified Excluded Individuals, Mandatory Exceptions, and, at the option of the state, short-term hardship exceptions, which we will review today.
- States may allow self-attestation for certain exceptions through 2027, expiring January 1, 2028.
- For individuals not falling under any exception, they must meet 80 hours of qualifying community engagement activities or lose coverage.
- States must implement a “lookback” period of 1-3 months (at least 1 month, not longer than 3 at state option).

States Subject to Medicaid Community Engagement Requirements

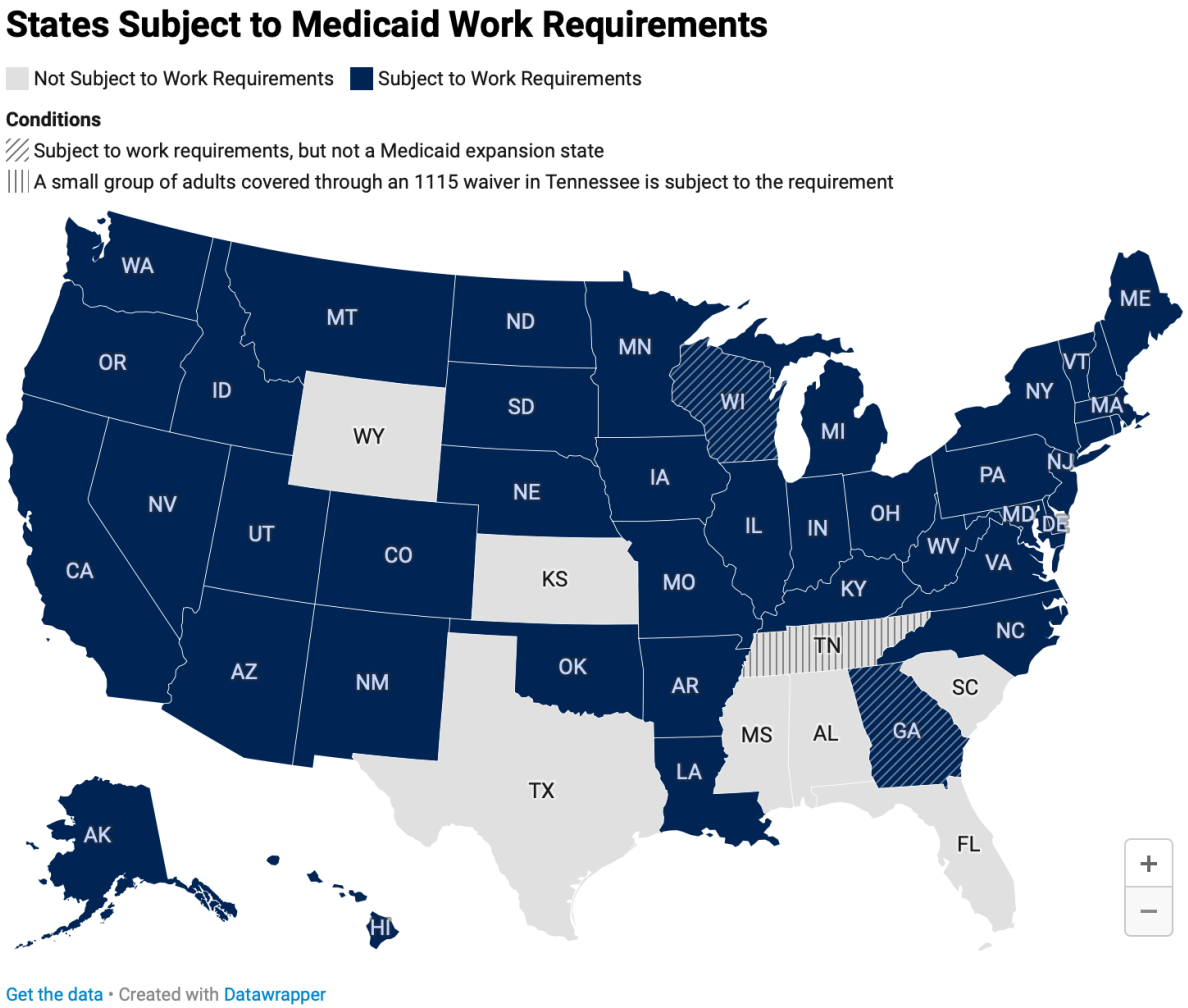

Image credit: Center on Budget and Policy Priorities. Beyond the Basics. June 2026. Retrieved from: https://www.healthreformbeyondthebasics.org/medicaid-work-requirements-and-six-month-redeterminations/

Applicable and Specified Excluded Individuals

Specified Excluded Individuals* (NOT applicable individuals)

- Former foster care youth (under age 26);
- American Indians and Alaska Natives;
- Parents, guardians, caretaker relatives, or family caregivers of a dependent child 13 years of age and under, or a disabled individual;
- Veterans with a total disability rating;
- **Medically frail or otherwise have special medical needs that significantly impair their ability to comply with the requirement;**
- Meet the TANF work requirements or are a member of a household receiving SNAP benefits and are not exempt from the SNAP work requirements;
- Participants in a public or non-profit drug or alcohol rehabilitation or treatment program;
- Inmates of a public institution; and
- Pregnant or eligible for postpartum coverage in their state.

***Full definitions for Specified Excluded Individuals can be found in the appendix**

Applicable Individuals with Exceptions

Mandatory Exemptions:

- Under age 19
- Entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B
- Described in a mandatory eligibility group
- Incarcerated at some point in the 3-month period prior to the relevant month
- Specified excluded individuals

Short-term Hardship Exemptions:

(Optional for State)

- Receiving inpatient or institutional care
- Travel outside one's community for medical care for themselves or a dependent
- Living in a county with a federal emergency or disaster declaration
- Living in a county with high local unemployment

Note: we will do a deeper dive into this in **Session 2**!

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Medical Frailty Exception

The IFC also clarifies five qualifying categories for the **Medical Frailty Exception*** from Community Engagement Requirements:

1. Blindness or disability
2. Substance use disorder
3. Disabling mental disorders
4. Physical or intellectual disabilities
5. Serious or complex medical conditions

Note: CMS interprets the statute to require consideration of the severity of an individual's condition as relevant to whether they can meet the community engagement requirement. This means a lengthy list of applicable conditions with blanket exemptions is likely not allowable for states.

***Full details for each of the Medical Frailty Categories can be found in the appendix**

Medical Frailty: Illustrative Qualifying Conditions

- CMS does not fully define these categories and defers to states, but names non-exhaustive examples and points states to ISMICC, DSM-5, and ICD-10.
- **Disabling mental disorder —** CMS names schizophrenia, schizotypal and delusional disorders, other non-mood psychotic disorders, moderate or severe bipolar disorder, major depressive disorder, and panic disorder.
- **Substance use disorder —** CMS names alcohol use disorder (AUD), opioid use disorder (OUD), and stimulant use disorder; the exemption is not conditioned on active treatment and can apply to those in recovery for less than five years.
- In every case, the condition must **substantially limit the individual's ability to meet the community engagement requirement.**

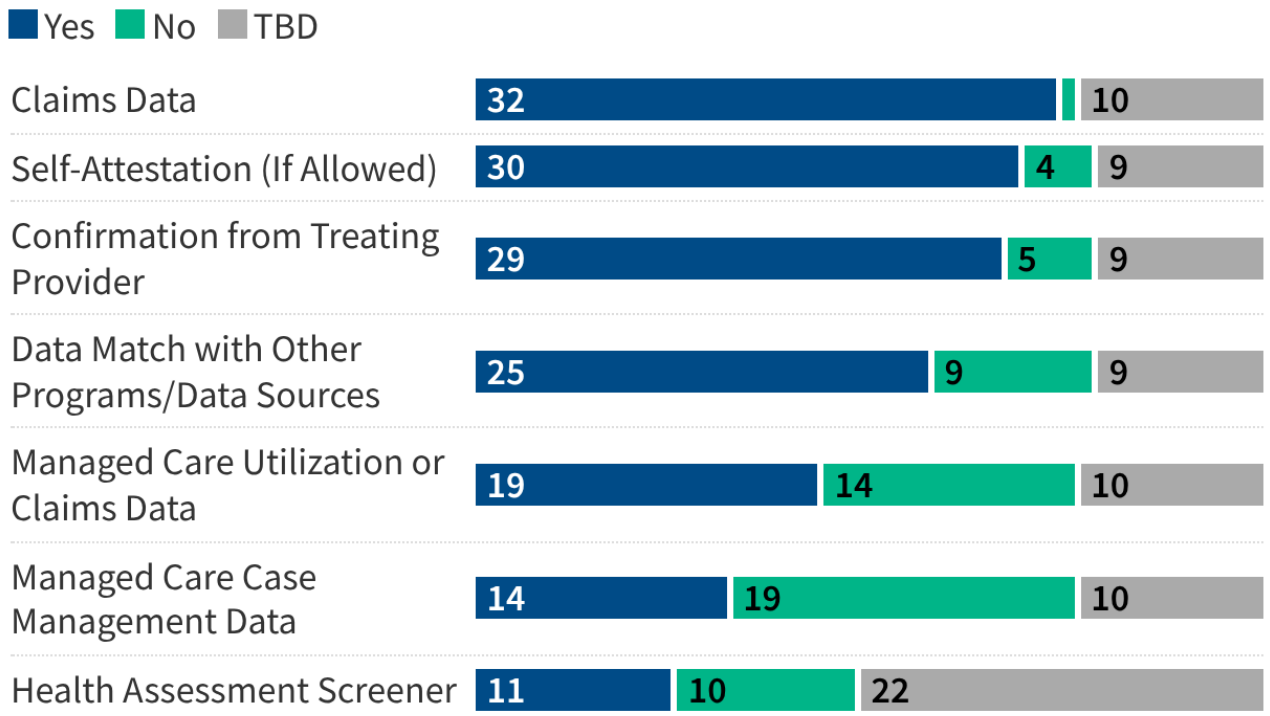
Confidentiality: 42 C.F.R. Part 2 Still Applies

- Regardless of which exclusion a state applies, federal confidentiality protections for SUD treatment records under **42 C.F.R. Part 2 must be followed.**
- Most individuals in a qualifying drug or alcohol treatment program have an SUD, but the treatment-program exclusion is distinct from the medically frail exclusion.
- Verifying an exemption should never disclose protected Part 2 records without proper consent.
- Build consent and record-handling steps into redetermination workflows so exemption documentation stays compliant.

Figure 8

Verification Sources States Plan to Use for Medical Frailty Exemptions, March 2026

Number of states using each verification source



Note: Number of states reporting: 43

Source: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2025

KFF

Planned State Information Sources for Medical Frailty Exceptions

Most states plan to use claims data, allow self-attestation in 2027, confirmation from HCPs, and data match with other programs.

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Image credit: KFF. An early look at policy decisions as states get ready to implement work requirements.
Retrieved from: https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/#55330424-e204-48ad-a344-5eeaf24a4d10

Mandatory Exceptions

- Under the age of 19
- Entitled to or enrolled for benefits under Medicare Part A
- Enrolled in Medicare Part B
- In a mandatory categorically needy eligibility group
- Was an inmate in a public institution at any point during a 3-month period preceding community engagement applicability
- CMS notes that states may also choose to apply short-term hardship exceptions

Short-Term Hardship Exceptions

Short-term hardship exceptions that states may choose to allow
Receives inpatient hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity
Resides in a county in which an emergency or disaster has been declared
Resides in a county in which unemployment is at or above 8% or 1.5 times the national unemployment rate (the lesser of)
Must travel outside of their area for medical services not available in their community to treat a serious or complex medical condition

This is “all or nothing.” If states choose to allow short-term hardship exceptions, they must allow all. The state selected review (lookback) period also applies. If an applicable individual was not working or meeting another exception in the review period prior to the qualifying hardship, they could still lose coverage temporarily. Individuals also must request a short-term hardship exception; it is **not automatic**.

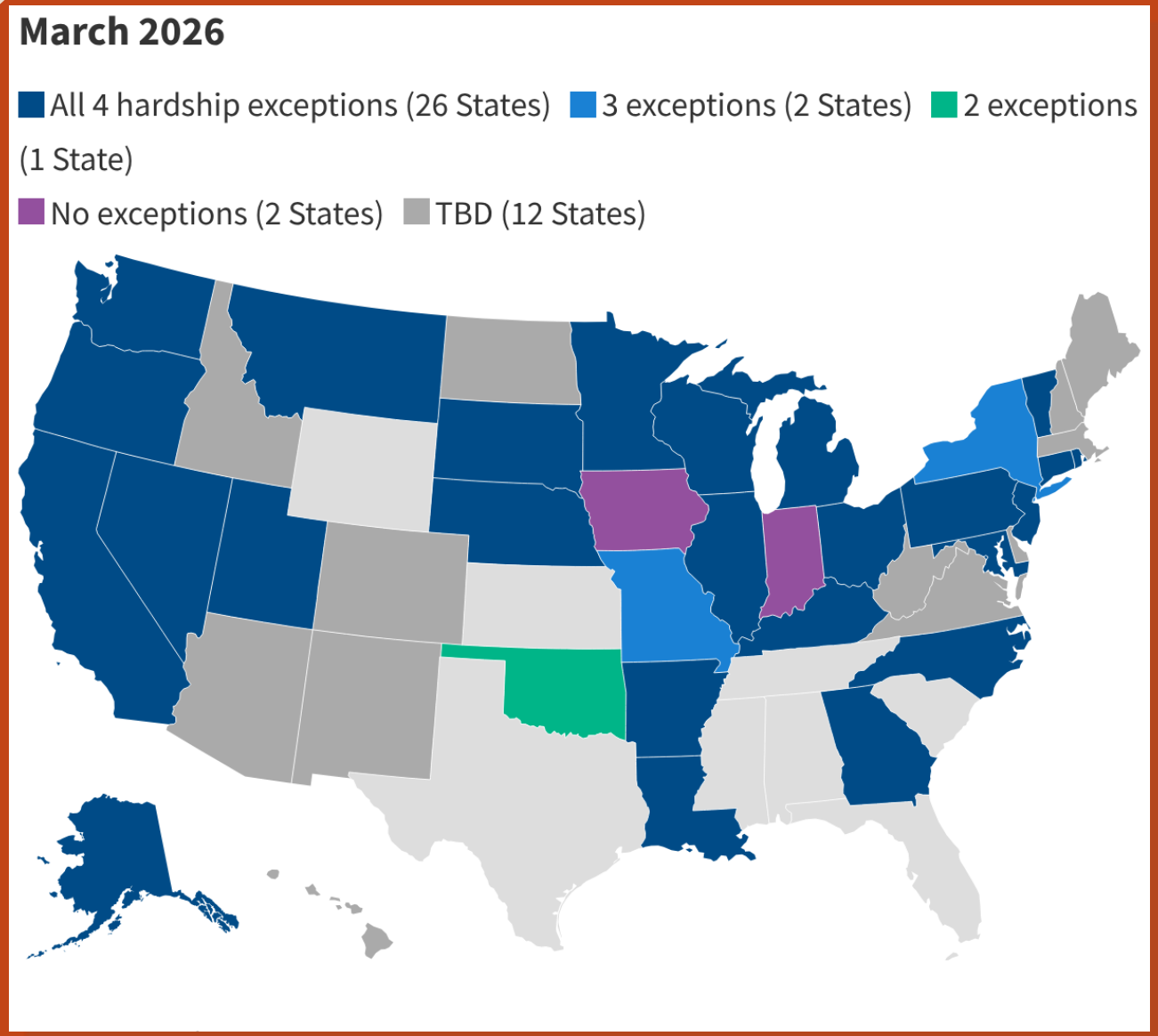
Short-Term Hardship Exceptions

Inpatient Hardship Notes

- Other services of similar acuity may include other inpatient/institutional levels of care not listed (e.g., VA hospital, CAH)
- Outpatient/home-based care may be included when it is a service that would otherwise be in the hospital or you can demonstrate it would prevent hospitalization

Travel for Medical Care Hardship Notes

- Services must not be available within your community
- Individuals can qualify if they or their "dependent" needs to travel, even if not accompanying the dependent, but in that case must verify why it is a hardship



State Plans for Hardship Exemptions, March 2026

This data was collected before CMS clarified that states must make all or none of the exemptions available.

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Image credit: KFF. An early look at policy decisions as states get ready to implement work requirements.
Retrieved from: https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/#55330424-e204-48ad-a344-5eeaf24a4d10

Specific Excluded Individuals vs Mandatory Exceptions

If the state determines the individual is a “specified excluded individual”, they must **not** determine whether the individual met the community engagement requirement or evaluate exceptions.

If the state determines the individual is an applicable individual in the month of application, they must then evaluate mandatory exceptions.

If the state determines the individual is an applicable individual and is not excepted, then they must evaluate and determine whether the individual has complied with community engagement requirements.

Qualifying Activities to Meet Community Engagement Requirements

For applicable individuals not found to be excepted from the requirements, they must demonstrate compliance by providing evidence that they have met **at least one of the following criteria:**

1. Worked at least 80 hours a month
2. Completed at least 80 hours a month of community service
3. Are enrolled at least half time in a qualifying education or training program
4. Engaged in any combination of activities 1-3 which must total at least 80 hours a month
5. Has a monthly income that is not less than the applicable minimum wage requirement multiplied by 80 hours ($580)
6. Is a seasonal worker with an average monthly income over the preceding 6 months that is at least the minimum wage multiplied by 80 hours (or using reasonably predictable changes methodology for relevant states)

Note: States may choose to verify community engagement requirements more frequently than once every 6 months (discussed later in presentation).

Beneficiary Outreach and Notice Requirements for States

States are required to:

- Conduct initial outreach to members from **June 30 to August 31, 2026**
  - Must occur 3 months prior to the state's community engagement effective date plus the number of months the state requires an individual to demonstrate compliance (a total of 4-6 months prior to implementation)
  - Must occur through regular mail (or an electronic format if an individual elected), and states must also use one additional format of outreach (phone, text, etc.). **Now is the time to monitor for initial communications!**
- Send notices on a "periodic basis thereafter" when certain events occur, including:
  - Following a determination or redetermination of eligibility at application;
  - At renewal;
  - Upon a change in circumstances (income change or other event);
  - When the state elects or deselects short-term hardship exceptions; or
  - Upon the loss of a beneficiary's specified excluded individual status
- Include information on their public website

Additional Considerations

- CMS notes that states should notify *all* enrollees in the adult group, not just applicable individuals since exceptions can change. **As a result, not everyone who receives a notice is required to comply with community engagement requirements.**
- CMS encourages public outreach activities and partnerships with other entities for dissemination efforts.

Beneficiary Outreach and Notice Requirements for States

Outreach notices must include the following information:

1. How to comply with and demonstrate community engagement
    - An explanation of exceptions
    - Who is an applicable individual and exclusions
    - The number of months an individual must demonstrate compliance during the review period
    - How frequently the state will verify engagement between renewals (if applicable)
2. The consequences of non-compliance on both Medicaid coverage and APTC/PTC availability
3. How to report change in an individual's status to the state

Notice of Non-Compliance

- If a state is unable to verify compliance, an exception, or an exclusion using available "reliable" data, it must send a notice of non-compliance and provide individuals with 30 calendar days of notice to show their compliance or exception.
- If the individual does not make a "satisfactory showing" in 30 days, the state must deny the application or disenroll them by the end of the month following the month in which the 30-day period ends.
- States may choose to send a concurrent or sequential notice.
  - **Concurrent notice:** The individual will receive a notice of non-compliance at the same time that they receive the prepopulated information form requesting information that could not be verified during *ex parte.*
  - **Sequential notice:** The individual will first receive their prepopulated form requesting additional information. If that information is insufficient, they will then receive a notice of non-compliance with a 30-calendar day period to respond.

Additional Considerations for Providers

- Some states provide MAGI beneficiaries with more than 30 days to respond to a renewal form.
- These notices may cause some confusion for beneficiaries so it's important to support with monitoring and education
- Individuals are entitled to fair hearing right

Notice of Non-Compliance

The notice of non-compliance must include the following information:

1. How to make a satisfactory showing of compliance with the community engagement requirement including:
    - Which months will be assessed
    - How to show the individual demonstrated or should be deemed to have demonstrated compliance
    - **How to make a satisfactory showing that the requirement does not apply to the individual due to being a specified excluded individual**
2. The deadline for providing the information
3. A description of the consequences for non-compliance including loss of Medicaid coverage and ineligibility for APTC/PTCs
4. How to reapply if the application is denied or individual is disenrolled
5. If the state has elected short-term hardship exceptions, information about short-term hardships

State-Specific Implementation Flexibilities & Considerations

State Option: Verifying Community Engagement More Frequently than 6 Months

States have the option to verify community engagement compliance for the expansion population more frequently than at renewal every 6 months.

- States electing this option may add verification processes between the most recent verification and the date the next verification is due.
  - States must first confirm the individual is not a specific excluded individual. If they are, they may not reverify.
  - If the state determines this is an applicable individual:
    - And is unable to verify, noncompliance procedures would be followed.
    - And is able to verify, the eligibility period continues.
- This option makes it more likely states will have overlapping processes with the 6-month renewal processes.

State Option: Good Faith Waivers

States may request a good faith waiver to delay their implementation of community engagement requirements but CMS is **not** required to award it.

- For states that receive a waiver, there are additional significant reporting requirements demonstrating progress toward milestones.
- Waivers are approved for 6 months and can be extended, not to exceed December 31, 2028.
- Waivers can also be revoked at any time.

Providers and affected individuals should proceed assuming their state will *not* receive a waiver and will be implementing community engagement requirements in 2027.

State Limits on Self-Attestation

- Through 2027, states **may** (but are not required to) accept self-attestation to confirm medical frailty when corroborating documentation is unavailable — with no cap on frequency, if the state allows it at all.
- Beginning in 2028, states may accept self-attestation for a given individual **only once**; corroborating documentation is required at the next scheduled renewal.
- **Some states have already moved to prohibit ANY use of self-attestation:**
  - Utah — HB 471
  - Indiana — SB 1
  - North Carolina — HB 696
- Providers in these states should prepare clients to supply documentation up front — attestation alone will not preserve coverage.

Anticipated Challenges for States and Health Systems

States will have varying readiness for their electronic systems and infrastructure to implement these verifications

Medicaid offices and county assistance offices will have significant administrative burden as they work to launch these new systems

CMS does have money available to states to support implementation

Physicians and other healthcare professionals may face increased demands for paperwork attesting to functional status

What to Watch: Litigation and Pending Guidance

- Litigation over the community engagement rule is likely, though its success is uncertain.
- CMS may issue additional guidance on medical frailty directly to states in the coming weeks.
- States may look to existing SNAP work-requirement standards and forms when assessing functional impairment.
- Because this is an interim final rule with comment period (IFC), some specifics may change after the comment period — though provisions set directly in H.R.1 will not.
- Plan for implementation as written while monitoring for state-specific interpretations and updates.

Questions to Ask Your State

Redetermination Frequency

- Will the state use Option 1 (moving to an earlier redetermination date) or Option 2 (using existing 2027 redetermination dates) for redetermination?
- What will the review/lookback period be for redeterminations (1-3 months)?
- Is the state prepared or preparing to use *ex parte* review processes?
- What information sources will be used during *ex parte* review processes?

Community Engagement Requirements

- Will the state choose to verify community engagement only at application and renewal, or more frequently?
- Will the state elect short-term hardship exceptions?
- Will the state request a "good faith waiver" for community engagement requirements?

Medical Frailty

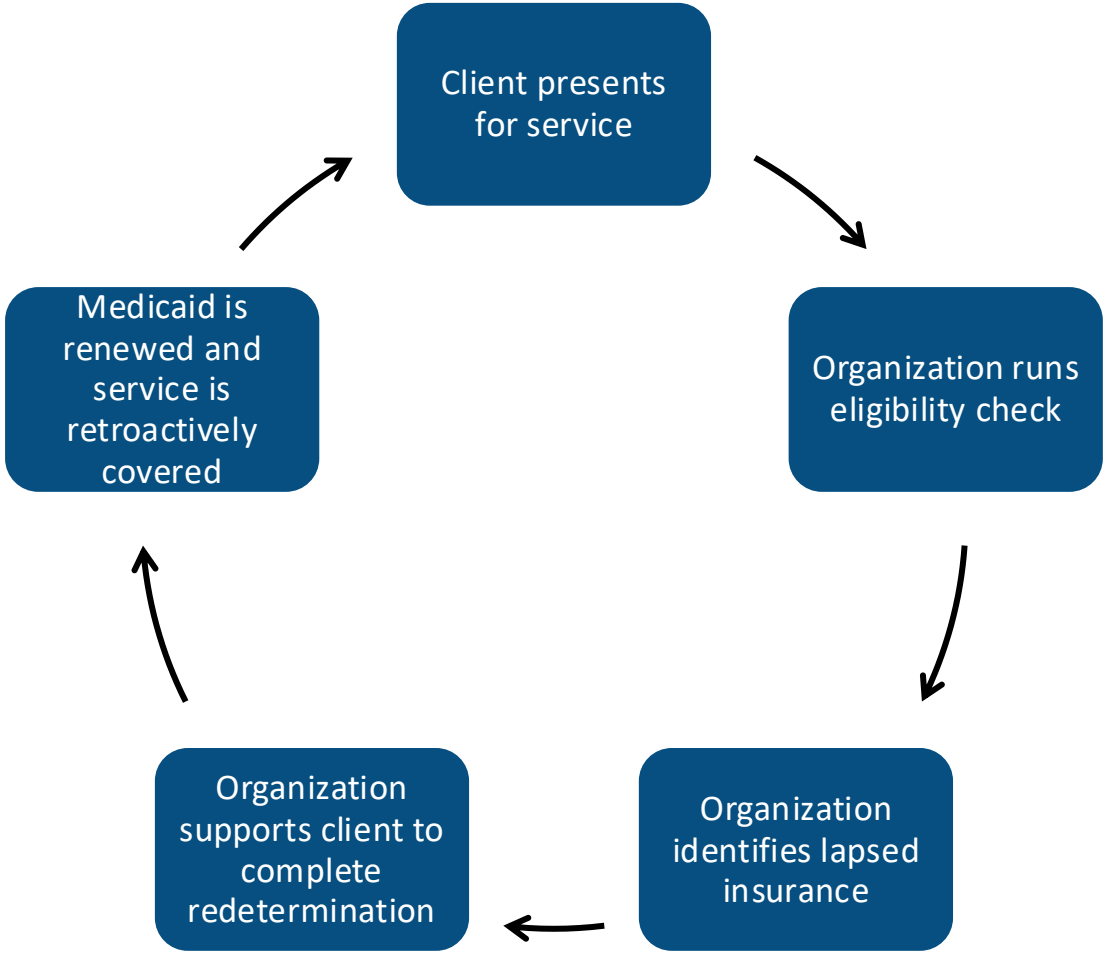
- Will the state exempt any specific diagnoses under the "disabling mental disorder" exemption category?
- What information sources will be needed to verify an exemption?
- What diagnoses will be exempted for the SUD exemption and what classification sources will be used?
- Will the state allow attestation throughout 2027?

Communication and Notification

- What communication modalities will the state use to notify enrollees?
- Will the state elect concurrent or sequential notification for notice of non-compliance?

Coverage Continuity Intercept Model

The Traditional Redetermination Cycle



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Coverage Continuity Intercept Model (CCIM)

0. PREVENT

Capacity Building & Pre-Redetermination

Key Partners: CBOs, MCOs, housing providers, schools, faith-based orgs

Key Activities: develop communication plans, outreach campaigns, update contact info, educate individuals affected and staff on requirements, identify and build relationships with work/volunteer opportunities and related relationship building, develop workflows, establish tracking tools, plan for financial impact, develop policies

01. IDENTIFY

Renewal Notification & App Support

Key Partners: State vendors, case managers, care coordinators, community health workers

Key Activities: assist with application/renewal assistance, support with document gathering/ interpretation/ literacy, prompt individuals to check mail/texts, track application completeness and renewal status

Client receives renewal notice

02. INTERVENE

Coverage Loss/Gap

Key Partners: Pharmacies, hospitals/Eds, crisis services, legal aid

Key Activities: engage rapid re-enrollment workflows, engage bridge programs (charity care, sliding scale), support access to emergency medication

03. RECOVER

Re-enrollment & Coverage Recovery

Key Partners: Medicaid staff, MCOs, navigators

Key Activities: support community engagement, leverage presumptive eligibility, support transition to marketplace (if income change)

04. STABILIZE

Restabilization

Key Partners: Peer support, social services, care coordinators

Key Activities: track renewals and community engagement, maintain updated contact info, address SDoH

workforce, text reminders, technology (e.g., EHR alerts, shared referral platforms)

Readiness Scorecard

Red — Not started

Yellow — In progress

Green — Established

Readiness Domain	Domain Description	Status (R / Y / G)	Current Gaps	Next Steps & Owner
People	Individuals to support direct client support, partnerships, and infrastructure-building			
Policy	Defining task ownership, outreach and documentation standards, partnerships, and escalation pathways			
Workflow	Identifying impacted workflows, documenting changes, and training staff			
Data	Identifying risk (individuals and financial), monitoring progress, and prioritizing outreach			
Technology	EHR, eligibility verification, reporting, care management, interoperability, and automation opportunities (reminders, work lists, dashboards)			

Please Complete the Session Evaluation

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Register for Session 2
Tuesday, August 18 at 12pm ET

https://us06web.zoom.us/webinar/register/WN_pKomwAwfRqGZ93aqqiHPow

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Please contact Kimberly@bowlingbiz.com with any questions!

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Applications due 7/20/26

National Council Engagement

How we engaged:

- Engage key offices
- Grasstops alliances
- Grassroots advocacy

Successes:

- Inclusion of CCBHCs, OTPs, and CMHCs in RHTP
- Exemptions in cost sharing and work requirements

H.R.1 Hub: Your Source for all Things H.R.1 Implementation!

- **Journey Map**
- **Work Requirements White Paper**
- **Baseline Survey and Results**
- **Direct Service Provider Talking Points**
- **Summaries:**
  - Detailed Summary, High-Level FAQ on Work Requirement Final Rule
  - New State-Directed Payment Rule
  - Noncitizen Eligibility

Check out the H.R.1 Hub here!

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Appendix

Definitions for Specified Excluded Individuals

Category	Definition in Interim Final Rule with Comment Period (IFC)
Former foster care youth	Individuals who were enrolled in Medicaid while in foster care and then exited foster care or ”aged out” without an adoption or other permanency and are under age 26.
American Indians or Alaska Natives	CMS has previously adopted a definition and chooses to use the existing definition in CMS regulation. CMS also notes that unlike other exclusions which may change, states will not be required to re-verify this exception once established.
Parents, guardians, caretaker relatives, or family caregivers of a dependent child 13 and under, or a disabled individual	Defines parent, guardian, caretaker relatives, or family caregivers. CMS adopts the Americans with Disabilities Act definition of disability to determine who qualifies as a disabled individual. An individual need not be eligible for Medicaid or other federal programs on the basis of a disability to be a disabled individual under this definition. This definition applies to any age, including older adults who require assistance of varying scope in performing activities of daily living.

Definitions for Specified Excluded Individuals

Category	Definition in IFC
Veterans with a total disability rating	Note: this exclusion includes total disability based on individual unemployability, as well as veterans with a combined rating of 100%.
Meet the TANF work requirements or household receiving SNAP and are not exempt from SNAP work requirements	States should confirm if an individual meets TANF work requirements according to states, recognizing state requirements will vary. Additionally exempts individuals in households receiving SNAP only when subject to SNAP work requirements (not exempt from). CMS interprets statutory language in H.R.1 saying "not exempt from" SNAP work requirements to mean "subject to" SNAP work requirements.
Participant in a Drug or Alcohol Rehabilitation Program	**Any individual participating in a drug addiction or alcoholic treatment and rehabilitation program. Programs include any such program conducted by a private non-profit organization or institution or a publicly operated community mental health center to provide treatment that can lead to rehabilitation. States may establish a minimum time commitment requirement.**

Definitions for Specified Excluded Individuals

Category	Definition in IFC
Inmates of a Public Institution	An individual that is in custody and held involuntarily by law enforcement. Individuals in correctional institutions such as state and federal prisons, local jails, detention facilities, or other penal settings.
Pregnant or entitled to postpartum coverage	A pregnant woman or a woman who is receiving Medicaid under either the mandatory postpartum period or the 12-month postpartum extension.
Medically Frail or otherwise have special medical needs that significantly impair their ability to comply with the requirement	**CMS notes that this exception should not be determined by a diagnosis alone, but rather by the impact of the condition on an individual's ability to comply with community engagement requirements. See following slides for detail.**

Definitions of Medical Frailty Categories

Category	Definition in IFC
Blind or Disabled	Blind: An individual has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. Disabled: A person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.
Substance Use Disorder	**Excludes individuals in recovery for 5 or more years. CMS believes the exception applies whether someone is in active treatment or not. CMS declines to further define SUD in regulation but directs states to DSM-5 and ICD-10 as useful resources.**
Disabling Mental Disorder	**CMS declines to fully define a disabling mental disorder and directs states to consider whether the disorder significantly impairs an individual's ability to comply with the community engagement requirements. CMS further notes states may find ISMICC, DSM-5, and ICD-10 to be useful resources. CMS notes states may also consider including specific conditions as disabling mental conditions.**

Definitions of Medical Frailty Categories

Category	Definition in IFC
Physical, intellectual, or developmental disability	The physical, intellectual, or developmental disability must impair the individual from performing at least one or more activity of daily life (ADL). CMS again notes it may be reasonable for states to consider including specific conditions.
Serious or complex medical condition	A medical condition that is life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments. CMS notes there may be variance in acuity even within the same condition and throughout the course of illness. As such, CMS directs states to evaluate and verify an individual's condition according to the impact on their ability to comply with community engagement requirements.

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