H.R.1 Community Engagement Requirements and the Community Service Pathway: Best Practices for Behavioral Health Clinics and Providers

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Beginning Jan. 1, 2027, members of the Medicaid expansion population will need to complete 80 hours per month of qualifying activities to maintain coverage. One of the qualifying activities under the interim final rule with comment period (IFC) released by the Centers for Medicare and Medicaid Services (CMS) is completion of at least 80 hours of community service per month. The IFC provides a fairly broad definition of community service, and some clinics may be well-positioned to help clients use this pathway to maintain coverage, depending on state approval. This document describes the community service flexibilities in the IFC and offers high-level recommendations for community-based behavioral health organizations specifically as they relate to compliance with community engagement requirements via community service.

How the IFC Defines Community Service

Under the IFC (42 CFR § 435.552(b)), community service is defined as **"unpaid work that is part of a structured program, performed for the direct benefit of the community, under the auspices of a public or nonprofit organization."** Some important flexibilities to note include the following:

- Community service does not need to be voluntary. Hours completed to satisfy a probation condition or other mandate count toward the 80-hour requirement. This can be particularly useful for justice-involved clients attempting to navigate community engagement requirements.
- Time spent in training necessary to perform a given community service activity **may** count toward the monthly requirement. As a result, programs intended to build skill development are likely to qualify, but you will need to confirm whether specific programs qualify with your state Medicaid office.
- Community service hours can be combined with work, work program participation, and less-than-half-time education to reach eighty total hours in a month (§ 435.552(e)).
- CMS did not restrict qualifying host organizations to 501(c)(3) entities. Local government agencies, religious and other nonprofit organizations, and smaller community-based programs can all host qualifying community service activities.

Considerations Related to Unpaid Work

Separately from community service, the IFC's definition of work includes unpaid work that is not community service. Unpaid work does not require a structured program or explicit community benefit. Unpaid internships, informal work arrangements, and caregiving that does not meet a specified excluded individual category can count as unpaid work hours. Clients who cannot readily connect to a structured program may find this option to be particularly useful.

The Role of Behavioral Health Clinics and Providers

Nonprofit community-based behavioral health organizations can host structured volunteer programs through which clients may be able to accrue qualifying hours in a familiar, supportive environment. Examples include volunteer peer support activities, clubhouse-model program participation, facility and grounds projects, community outreach and education events, food and supply drives, and front-desk or

administrative volunteering. **It will be important to check with your state Medicaid program to confirm that specific programs will comply with federal and state requirements.**

It will be important for clinics to keep volunteer activities distinct from Medicaid-billed services. The IFC explicitly states: "[W]hile some States partner with managed care plans to provide a range of supported employment services to individuals receiving home and community-based services under section 1915(c) waivers or as part of section 1915(i) State plan services, these Medicaid-covered employment services are different from work programs as defined at § 435.552(b) and do not independently satisfy the work program community engagement requirement."

Because supported employment and other Medicaid-covered services do not count as qualifying activities, you may wish to ensure that clinic-based volunteer program are organized and documented separately from services billed to Medicaid, and time spent receiving treatment is not considered "community service."

Additionally, it is important to keep in mind that depending on your state's resources, community service may not readily appear in the data sources states check first, including payroll, wage, and claims data. If hours are not documented, clients may be routed into the noncompliance process and asked to produce evidence after the fact. Therefore, it will be critical for any programs used for this purpose to track activity type, dates, hours, and a point of contact who can confirm participation.

What Can I Do Now to Prepare?

The following are high-level recommendations designed to help behavioral health clinics and providers make effective use of the community service pathway.

→ Screen for Medicaid Expansion Eligibility and Exclusions

Only individuals enrolled in Medicaid expansion programs will need to comply with community engagement requirements. As a result, one of your first steps should be verifying whether someone is enrolled in Medicaid expansion or traditional Medicaid. If someone is enrolled in Medicaid expansion, note that people with a disabling mental disorder or substance use disorder (SUD) who meet the medical frailty standard (classified as specified excluded individuals under the IFC), and individuals participating in qualifying SUD treatment programs do not need to complete qualifying activities at all. With this in mind, incorporate exclusion screening into clinical touchpoints before routing an individual toward qualifying activities. The community service pathway is for clients who are subject to the requirements and not otherwise compliant through work, income, or education.

Example: Amy, 34, arrives at a clinic for an assessment. She's uninsured until staff help her enroll in Medicaid, and she lives in Ohio, an expansion state.

- **Step 1 — Coverage pathway:** A benefits specialist confirms Amy is enrolled through the adult expansion group (she isn't pregnant, doesn't receive SSI, and qualifies solely on income). Because she's an expansion adult aged 19–64, the community engagement requirement applies to her by default. If she had instead qualified through SSI or another disability pathway, the assessment would end here.
- **Step 2 — Exclusion screening:** During the clinical assessment, Amy is diagnosed with opioid use disorder and begins receiving buprenorphine treatment at the clinic. That triggers two potential exclusions: (a) participation in a qualifying SUD treatment program, and (b) if her condition causes functional impairment such that she can't meet community engagement requirements, the medical frailty standard for people with a disabling mental disorder or substance use

disorder. The clinician documents the diagnosis and treatment participation in terms that map to the state's exclusion verification process. Amy does not need to log 80 hours of any potentially qualifying activities, and staff capture this at the clinical touchpoint instead of waiting for her to receive a compliance notice and ultimately experience a denial of coverage.

- Contrast this with another case: Amy's neighbor Mark, 28, is also an expansion enrollee at the same clinic, in treatment for mild anxiety. His anxiety is managed, not disabling in a way that would categorize him as medically frail, and he is not enrolled in an SUD treatment program. No exclusion applies to him and he must meet community engagement requirements. Staff proceed to check compliance by looking at whether Mark is engaged in any qualifying activities. He works part-time stocking shelves (if he works 80 hours/month or earns $580/month, he will be compliant through work alone). If he does not work 80 hours for some required months, at this point the community service pathway becomes relevant. Staff then proceed to connect him with an organization where he can provide community service to cover the gap.

→ Stand Up/Formalize a Structured Volunteer Program at Your Organization

Because of the way the IFC defines community service, an informal arrangement may not satisfy the "structured program" element of the definition. With this in mind, clinics might consider adopting the following:

- A written program description
- Defined volunteer roles
- A designated program coordinator
- Standardized hour logs.

Formalizing existing activities may allow hours clients who are already engaged in some way to count toward their compliance with community engagement through community service. Peer-led groups' volunteer components, clubhouse work-ordered day participation, and community events are all examples of activities that **may** qualify, but again **you will want to obtain confirmation of compliance with state Medicaid programs.**

Example: Clinic A runs a psychiatric rehabilitation day program and a peer-run drop-in center. Clients do work including staffing the front desk, preparing the community lunch, and maintaining the garden. None of that work is currently documented in a way that would survive a state verification request because no program description exists, "volunteering" means whatever a client happened to help with that day, and no one logs their hours.

Here is an example of how Clinic A could leverage this program in accordance with the recommendation above:

Written program description: A two-page "Clinic A Community Volunteer Program" document stating the program's purpose (community benefit through the drop-in center and clubhouse), the sponsoring nonprofit entity (Clinic A itself, a 501(c)(3)), eligibility, and supervision structure. The program description should explicitly state that activities serve the community and do not have a partisan purpose.

Defined volunteer roles: Instead of just someone who "helps out," the program lists discrete positions with duty statements. Front Desk Greeter (reception coverage, visitor log), Community Kitchen Assistant

(meal prep for the free community lunch), Grounds & Garden Volunteer, Events Setup Crew. Program work-ordered day tasks are mapped into these roles rather than left as undifferentiated participation.

Designated coordinator: The peer support supervisor is named program coordinator and point of contact. This person should be available for a state verifier or the client's eligibility worker to contact. Their name and contact information should appear in the program description and on every hour log.

Standardized hour logs: A single log template that includes the client's name, role, date, hours, task performed, and coordinator initials. In this instance, everything is logged on the same day, signed monthly, and formatted around the state's reporting cadence so a client can provide the required documentation through their Medicaid eligibility portal. Clinic A keeps copies, because clients subject to the requirement might lose paperwork and the clinic may need to reproduce it at redetermination.

Example of Results: James, an expansion enrollee subject to the requirement with no exclusion, already spends roughly 20 hours a week in the program, half of it doing kitchen and front-desk work. Before formalization, those hours were invisible. After, his logged Community Kitchen Assistant and Front Desk Greeter hours count toward the 80-hour monthly threshold. He is performing the same activity, but it is now documented in a form that may (if the state approves) satisfy the structured-program element.

Other Recommendations

→ Utilize Peer Support Programs and Services

Volunteer peer support roles may potentially count as qualifying activities that also build recovery capital and a pipeline into the peer workforce. These **may** include co-facilitating groups, mentoring, outreach, and warmline support. **However, when a client's peer support activity is delivered as a Medicaid-billable service, or the individual is a paid peer specialist, those hours should be counted as work instead of being counted as community service.** It will be important to document which category applies in these cases. Note also that hours a client spends **receiving** peer support services are treatment, not community service.

→ Documentation and Attestation Infrastructure

Develop standard forms and workflows for logging volunteer hours, issuing verification letters, and responding to state or client requests for confirmation. Align documentation with what your state will accept before the requirements take effect, and retain records so clients contacted through the noncompliance process can respond within required timeframes. Where states permit self-attestation, ensure clients understand what they are attesting to and retain supporting records.

→ Partner with Community Organizations, Courts, and Reentry Programs

Mandated service still qualifies as community service under the IFC; as a result clinics serving justice-involved populations should coordinate with probation offices, drug courts, and reentry programs so that court-ordered community service hours are documented in a form usable for Medicaid compliance. Similarly, you may wish to maintain a referral list of local government and nonprofit volunteer opportunities for clients who prefer placements outside the clinic.

→ Educate Clients on Combination/Unpaid Work Options

Although less common in practice, some clients will meet the requirement by stacking part-time work, volunteering, and education. Case managers and peer staff should be trained to help clients map their

existing activities against the qualifying categories. This includes activities like unpaid work and caregiving.

→ Engage Your State Medicaid Agency and State Association

States are currently in the process of making implementation decisions. These decisions include how community service hours will be reported and verified and whether short-term hardship exceptions will be offered. Staying in close contact with your state Medicaid agency and/or your state association can help ensure you are informed of decisions being made on these fronts as implementation dates for various H.R.1 Medicaid provisions approach.