REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

July 30, 2026

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 431, 435, 438, 457, and 600
Attn: CMS-2454-IFC
RIN 0938-AV9

Submitted via regulations.gov

RE: Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period (IFC) addressing Medicaid community engagement requirements, at 91 Federal Register ("FR") 33348 Medicaid Program

On behalf of the Rehabilitation & Community Providers Association of Pennsylvania (RCPA), thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period (IFC) addressing Medicaid community engagement requirements, at 91 Federal Register ("FR") 33348. This IFC interprets and implements the community engagement requirement in Medicaid under section 1902(xx) of the Social Security Act. States are required to implement the new requirement no later than January 1, 2027.

RCPA is a statewide association representing more than 400 human services providers in Pennsylvania. Our provider network includes thousands of licensed programs and facilities, and serves more than two million vulnerable Pennsylvanians annually. The RCPA comments to the CMS Medicaid IFC addressing Medicaid community engagement requirements reflect the position of our membership and our partnership with the National Council for Mental Wellbeing, whose visions, missions, and most importantly those individuals they serve, will be deeply impacted by the implementation of this and several of the proposed changes as a result of the H.R. 1 Bill.

We respectfully submit our comments below:

Exclusionary Criteria for Individuals with Mental Health and Substance Use Conditions

In alignment with statute, RCPA supports CMS's inclusion of individuals with mental health and substance use conditions who are medically frail and may qualify for exclusion from the community engagement requirement, though the indirect impacts of these proposed stands have collateral consequences for other vulnerable individuals in the Commonwealth.

Impacts for Individuals with Mental Health and Substance Use Conditions

CMS also notes that it would be reasonable for states to consider certain conditions, when such conditions are disabling and significantly impair an individual's ability to comply with the community engagement requirement, such as disabling mental disorders, including schizophrenia, schizotypal disorder, delusional disorder, other non-mood psychotic disorders, moderate or severe bipolar disorder, major depressive disorder, and panic disorder (91 FR 33375). RCPA has been in engagement with the PA Department of Human Services (DHS). Managed care partners and a host of oversight and advocacy stakeholder groups are collaboratively seeking pathways to ensure coverage specific to the medical fragility and intersects with capacity to meet the work requirements. Pennsylvania, while it continues the work of defining the medical fragility exceptions codes, seeks clarification that if a list of such conditions is identified by states, whether such conditions identified as severe and resulting in functional impairment would be sufficient to demonstrate meeting the functional impairment component of the medical frailty exclusion.

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Pennsylvania has clearly outlined several of the barriers associated with meeting compliance with the community engagements standards, including antiquated technology infrastructure, systems interoperability challenges, the incorporation of disparate electronic health records across provider communities, as well as depleted and historically understaffed County Assistance Offices, who at this point in the planning hold a significant role in both eligibility redeterminations and the community engagement tacking. Pennsylvania has yet to finalize this plan with less than six months to go before implementation.

Pennsylvania preliminary projections are as follows:

- Cost to the Commonwealth to re-determine eligibility every six months:
  - Increased staff by about 500 people; and
  - Estimated cost of $37 million per year.
- Cost to implement and track new work requirements:
  - Increased staff by 250 people; and
  - Estimated cost of $18 million per year.

If the state is unable to verify medical frailty with information already available to the state, RCPA seeks clarification on whether provider attestation or an individual's self-attestation may serve as acceptable evidence that an individual meets the medical frailty exclusion. Such flexibility is particularly important for individuals experiencing acute, or newly emerging, mental health or substance use conditions or disruptions in care, who may not yet have extensive claims history or readily available documentation. However, doing so should be permitted in the least administratively burdensome and efficient way possible for the provider. RCPA offers greater detail on recommendations on the verification process later in this document.

RCPA appreciates CMS's discussion of qualifying activities that fulfill demonstrating community engagement, inclusive of the broad definitions for activities that constitute work and community service.

The Interim Final Rule dealt a secondary yet more critical challenge in the determination of diagnosis to capacity to achieve the 80 hours per month community engagement standards. RCPA seeks clarification on whether data such as code modifiers that indicate condition severity may be sufficient to demonstrate that an individual's condition meets the functional impairment component of the medical frailty exclusion without requiring additional documentation. The ability to add a code modifier to demonstrate compliance with the functional impairment component would be empirical, improve clarity, and reduce administrative burden for both the state and providers.

Furthermore, an individual's functional capacity is often highly individualized and often depends on the nature of the work being considered, the individual's symptoms, workplace accommodations, treatment status, and the physical, cognitive, or interpersonal demands of a particular occupation or community engagement activity. Consider the variation that can exist and role that providers will play in assessment and determination of an individual's functional impairment or ability. While RCPA provider members and stakeholders await guidance from DHS on the role providers will play in both eligibility redeterminations and/or the community engagement tracking process, RCPA strongly suggests CMS clarify liability protections for providers, acting in good faith and using their professional clinical judgement, in determining the functional impairment standard that an individual might meet in cases where there could be varying interpretations across parties.

With regard to clarifying how individuals can demonstrate that they have engaged in qualifying activities, RCPA urges CMS to confirm that individuals may use statements made under penalty of perjury to demonstrate compliance with fulfilling qualifying community engagement requirement activities. The IFC requires states to attempt to verify that applicable individuals have met the community engagement requirement using reliable information available to the state before requesting additional information from

the individual or initiating noncompliance procedures, and permits states to request documentation or additional information only when there is no reliable information available to the state, or the reliable information is not reasonably compatible with information provided by or on behalf of the individual. Regarding 42 CFR § 435.557(b)–(c), as corrected at 91 FR 39028 (June 29, 2026). We seek to clarify that individuals participating in nontraditional work arrangements, for example, as recognized by the IFC (91 FR 33354), may rely on statements under penalty of perjury when conventional documentation is unavailable.

Verification of Compliance with and Exceptions and Exclusions from the Community Engagement Requirement

RCPA seeks clarification regarding the verification processes and application of self-attestation. As we understand the provisions under the IFC, states are permitted, but not required, to accept statements made under penalty of perjury as evidence supporting an individual's eligibility for the medical frailty exclusion through calendar year 2027. We seek to confirm whether this interpretation is correct. Such clarification is particularly important for individuals whose disabling conditions may not be immediately reflected in available electronic data sources or claims records. See 42 CFR § 435.557(f)(1), as corrected at 91 FR 39028 (June 29, 2026).

More generally, as discussed earlier in this comment, we seek clarification that statements made under penalty of perjury are permitted for purposes of establishing compliance in fulfilling qualifying community engagement activities. For example, individuals engaged in nontraditional work arrangements, caregiving activities, or other qualifying activities may have limited documentation available despite meeting the requirements established by the IFC. Allowing attestations under penalty of perjury, with no time limit, to certify having engaged in such qualifying activities could reduce unnecessary administrative burden while preserving program integrity.

Overall, RCPA strongly suggests that CMS amend the IFC to permanently allow use of self-attestation for purposes of meeting components of the medical frailty exclusion, and fulfilling community engagement requirements more broadly. Doing so is particularly important for individuals whose disabling conditions may not be immediately reflected in available electronic data sources or claims records – such as when individuals face new onset of mental health or substance use conditions or disruptions in care – as well as individuals who may have nontraditional work arrangements and are engaged in qualifying community engagement activities.

RCPA further requests clarification regarding what types of information would constitute acceptable "reliable information" when a state is unable to verify medical frailty through available data sources. Specifically, in situations where an individual has submitted a statement under penalty of perjury but additional verification is required, RCPA seeks clarification on whether provider attestation or self-attestations or attestations from family members or other individuals familiar with the beneficiary's functional limitations may be considered reliable evidence. It has been suggested by the PA DHS that, in the first year of implementation, that self-attestation will meet this burden of verification.

RCPA appreciates CMS's acknowledgment that some individuals who qualify for the medical frailty exclusion may not identify themselves as having a qualifying condition, even after having completed a screening assessment (91 FR 33406). Given the unique challenges faced by individuals with SMI and substance use conditions, we seek clarification on whether providers, family members, legal representatives, caregivers, or other individuals familiar with the beneficiary's functional limitations may submit information on behalf of a beneficiary when the beneficiary lacks the capacity to complete reporting requirements independently. Many individuals who may qualify for the medical frailty exclusion experience periods of impaired functioning, psychiatric crisis, cognitive limitations, or other circumstances that may prevent them from effectively navigating administrative processes. For example, someone experiencing bipolar disorder may undergo severe depressive episodes causing impaired

concentration, memory problems, indecisiveness, and loss of motivation. Responding to a state notice can require understanding a deadline, gathering documents, and navigating a portal or phone tree, many of which are multi-step executive-function tasks that become difficult during an episode. Allowing appropriate third-party individuals to submit documentation on their behalf would help ensure that eligible beneficiaries are supported and able to complete necessary reporting requirements when they are unable to do so themselves.

In addition, RCPA suggests that CMS permit states to not require repeated re-verification of an exclusion when eligibility is based on a condition that is permanent or not reasonably expected to change. Requiring beneficiaries with lifelong disabilities, such as a chronic SMI, to repeatedly submit documentation when the condition is lifelong or unlikely to change would create unnecessary burden for beneficiaries, providers, and state agencies while contributing little value to improving program integrity.

Similarly, CMS should not limit acceptable documentation to records generated within the preceding 12 months when evaluating conditions are lifelong or chronic in nature. Some beneficiaries may have well-documented histories of SMI, severe substance use conditions, traumatic brain injuries, or other chronic cognitive conditions for which older clinical records may provide the most complete evidence of functional impairment. States should be permitted to rely on historical documentation, where appropriate, and beneficiaries should not be required to obtain new evaluations solely to re-establish the existence of a condition that has not materially changed. Providing this flexibility would reduce administrative burden, promote continuity of care, and better align implementation of the medical frailty exclusion with the realities of chronic severe mental health and substance use conditions.

RCPA remains concerned by the IFC's discussion of supported employment services provided through sections 1915(c) and 1915(i) authorities. Specifically, the IFC states that, “while 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.” Supported employment services furnished under these authorities, including job development/coaching and ongoing follow-along supports, are individualized services designed to help individuals obtain and maintain competitive, integrated employment consistent with the home-and-community-based settings requirements.

This issue is particularly important for individuals with serious mental illnesses (SMI) and substance use disorders (SUDs), many of whom rely on evidence-based supported employment services to participate successfully in the workforce. Supported employment services should count toward satisfying the community engagement requirement, where consistent with the statute. RCPA accordingly urges CMS to clarify that hours of employment obtained or maintained with the assistance of supported employment services count toward satisfying the community engagement requirement.

Additionally, RCPA recommends that CMS provide to the states resources and guidance on specific functional assessment and screening tools that may be used to evaluate functional impairment and meet this criterion if the results demonstrate significant functional impairment for purposes of the medical frailty exclusion. If CMS intends to permit the use of standardized assessments, it should identify specific tools, characteristics of acceptable tools, and clarify whether assessments already used by behavioral health providers would satisfy this requirement when the results demonstrate substantial limitations in functioning. Doing so would improve clarity throughout the process and ameliorate burden for both states and providers.

Impacts Relative to Substance Use Conditions

RCPA commends the Centers for Medicare and Medicaid Services (CMS) for specifically excluding from the H.R. 1 work requirement individuals in a drug or alcohol rehabilitation or treatment program as well as, separately, those with a substance use disorder (SUD) who, by CMS's definition, are considered to be medically frail.

That said, the interim final rule (IFR) has further narrowed the SUD exclusion in multiple ways, creating additional burden on not only the individual in need of service but on the broader healthcare system that will ultimately need to spend significant resources supporting this population as it navigates the complexity of work requirements. As a result, healthcare access is jeopardized for a population of people who can, literally and figuratively, least afford it.

SUD Treatment Exclusion: Applicable Only to Treatment at Nonprofit Providers

The original exclusion in H.R. 1 for those in a drug or alcohol rehabilitation or treatment program is in itself narrow, as it limits those treatment programs to private nonprofit organizations or publicly operated community mental health centers. Many individuals with SUD receive treatment from for-profit providers. An individual receiving treatment at a for-profit entity would fall through this crack. And although on its face the medical frailty SUD category would seem to catch that individual, the severity qualifiers and limitation on years in recovery create yet another fracture.

Medical Frailty Severity Qualifier: Additional Burden, Subject to Interpretation

The process for determining whether an individual has an SUD and therefore is medically frail is flawed. Although self-attestation is an initial option, beyond that, claims data are a primary determinant of medical frailty. This presumes that those with an SUD diagnosis are in fact receiving treatment, when, in fact, less than one in five individuals who need substance use disorder treatment receive it[1]. Someone with untreated or newly relapsed SUD who has not yet entered treatment may need to satisfy the work requirement or, more likely, lose their Medicaid coverage, unless another exemption applies.

Further, IFR has placed qualifying conditions on the SUD population considered to be medically frail. Under the medical frailty definition, SUD diagnosis in and of itself is not sufficient — the condition must significantly impair an individual's ability to comply with the community engagement requirements. This qualifying condition stipulation weakens the exclusion and adds yet another burden and barrier, not to mention its subjectivity in assessing severity, to an already onerous process. To ensure integrity to the definition of medically frail and its SUD exclusion, diagnosis alone should be the determining factor in excluding an individual with SUD from the work requirement.

Additionally, IFR does not allow for exclusion from the work requirement for those with an SUD who are "in stable recovery," defined by CMS as five or more years. The issue with this definition is that it is time-based. Recovery is not linear, nor is there a widely agreed upon definition[2]. CMS cites the arbitrary five-year milestone as the point at which relapse risk approximates the general population. But according to the Legal Action Center, the research used to justify this claim is drawn from a series of studies ranging

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[1] *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health*," SAMHSA 43 (July 2025), https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduhannual-national-report.pdf.

[2] Snyder, Jason, "SAMHSA Report Elicits Questions About Definition of Recovery, Purpose of Addiction Treatment," *Rehabilitation and Community Providers Association*, Nov. 27, 2023, https://www.paproviders.org/samhsa-report-elicits-questions-about-definition-of-recovery-purpose-of-addiction-treatment.

from 1989–2007 that only focused on alcohol use disorder and defined recovery as abstinence.[3] This suggests that these findings may not in fact be generalizable.

SUD is a chronic disease requiring long-term management, including:

- Medication for opioid use disorder (MOUD);
- Counseling;
- Peer recovery support;
- Recovery housing services; and
- Relapse prevention.

If individuals lose Medicaid because they no longer qualify for an exclusion per CMS's IFR—or because of administrative burdens—they may lose access to these services, potentially increasing the risk of relapse, overdose, hospitalization, or involvement with the criminal legal system. Although IFR seeks to preserve coverage for many people with active SUD, it does not fully reflect the chronic, relapsing nature of addiction.

SUD Related Recommendations

To ensure that individuals with SUD—regardless of whether they are in a treatment program or their stage of recovery or severity of impairment—are not denied access to healthcare, CMS should revise its categorical definition of SUD as part of the medical frailty definition by eliminating both the five-year "stable recovery" distinction and the assessment of severity and instead rely on clinical judgment about whether continued treatment or recovery support is medically necessary.

Impacts on the IDD Community in Pennsylvania

Understanding that community engagement and work requirements established under the One Big Beautiful Bill (OBBB) Act primarily target non-disabled adults enrolled through Medicaid Expansion, there is a significant risk of creating blind spots with unintended consequences that impact the intellectual and developmental disabilities (IDD) community. However, the proposed implementation will trigger indirect consequences that threaten the stability, health, and community inclusion of Pennsylvanians with IDD. These include destabilizing the direct support professional (DSP) workforce, imposing administrative burdens on transition-age youth, misidentifying individuals who lack formal SSI determinations, and diverting state administrative capacity from working to reduce PA's HCBS waiting list. CMS must establish safeguards, automatic administrative exemptions, and clear guidance to mitigate these unintended problems.

Increasing Pressure on the Direct Support Professional (DSP) Workforce

Pennsylvania is already amidst a severe long-term care workforce shortage. DSPs, who provide essential, daily support to individuals with IDD are predominantly low-wage workers, many of whom rely on Medicaid Expansion for their own healthcare coverage. DSPs frequently work variable, hourly, or per-diem schedules across multiple agencies. Mandatory 80-hour monthly reporting creates unnecessary administrative hurdles. If DSPs lose healthcare coverage due to reporting errors or administrative red tape, they are more likely to exit the field entirely. Even a small increase in DSP turnover directly leads to service reductions, unstaffed service hours, and heightened risk of negative outcomes for individuals with IDD in PA.

Vulnerability During Youth-to-Adult Transition (Ages 18–26)

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[3] *Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011*. Philadelphia Department of Behavioral Health and Intellectual disability Services, March 2012, https://www.naadac.org/assets/2416/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf

Young adults with IDD who age out of children's services often face a "service cliff." Many may not yet have an established SSI determination due to Social Security Administration (SSA) backlog delays, nor do they immediately receive an HCBS waiver slot. During this interim phase, transition-age youth rely heavily on Medicaid Expansion for access to behavioral health, therapies, and medical care.

Requiring a transition-age youth with autism or intellectual disability to navigate monthly 80-hour work/volunteering verifications or apply for exemptions will result in frequent procedural disenrollment, cutting off critical health services when they are needed most.

Inefficiencies in the "Medically Frail" & Disability Exemption Process
The statute exempts individuals with physical, intellectual, or developmental disabilities that impair daily functioning. However, as designed, the operational burden of proving an exemption falls on the individual. Individuals with mild-to-moderate IDD, fetal alcohol spectrum disorders (FASD), or autism who do not receive SSI may have significant functioning deficits that make tracking and documenting 80 hours per month of work or education activities nearly impossible, yet they may struggle to obtain the requisite clinical documentation from a physician to prove "medical frailty."

Customized employment and supported job placements for individuals with IDD often involve work schedules in small blocks of time (e.g., 5–10 hours/week). Rigid 80-hour monthly benchmarks fail to accommodate integrated, competitive employment models that fit an individual's capacity.

Burdens on Family Caregivers and Natural Supports
Unpaid family members are key caregivers in PA's IDD support system. While the rule provides an exemption for caregivers of individuals with disabilities, the administrative verification mechanism poses a significant risk. Family caregivers, who are often juggling full-time care, medical appointments, and employment, will face duplicative annual or semi-annual paperwork to verify their caregiving status. Loss of Medicaid coverage for a family caregiver directly reduces their capacity to provide home care, inevitably driving up demand for expensive emergency placements.

IDD Recommendations to CMS
To protect individuals with IDD, their families, and the workforce that supports them, CMS should incorporate the following binding provisions into the Final Rule:

Automate Exemption Verification via Data Matching:
Require states to automatically exempt individuals using existing state data interfaces including Special Education (IEP/504) records, Vocational Rehabilitation (OVR) open cases, state-funded IDD registration lists, and SNAP disability tags without requiring separate enrollee application forms.

Institute a "Deemed Exempt" Category for Transition-Age Youth:
Provide a universal exemption for youth with documented special healthcare needs or formal IDD diagnoses while their SSA or state waiver applications are pending.

Broaden and Streamline Caregiver & Supported Worker Protections:
Allow self-attestation or single-third-party attestation (e.g., from a case manager or supports coordinator) to satisfy caregiver exemption proof. Deem any individual participating in a state Vocational Rehabilitation or Supported Employment program as meeting the engagement standard regardless of total hours worked.

Protections for the HCBS Workforce:
Exempt direct care workers (DSPs, personal care assistants, home health aides) who work part-time or irregular hours in Medicaid HCBS settings from disenrollment due to month-to-month hour fluctuations.

Mandatory 90-Day Resolution Periods & Expedited Reviews:

Prohibit disenrollment of any individual who claims a disability or caregiver exemption until an administrative review is completed and a 90-day resolution period is provided.

Work requirements designed for the Medicaid Expansion population cannot be viewed in a vacuum. In Pennsylvania, the direct care crisis, the youth transition pipeline, and state administrative systems are deeply interconnected. Without proactive safeguards from CMS, the administrative barriers imposed by the OBBB will disproportionately harm Pennsylvanians with IDD and destabilize the community-based infrastructure that keeps them independent.

Noncompliance Procedures

RCPA appreciates the protections built into § 435.558, including the requirement to exhaust reliable information available to the state before issuing a notice of noncompliance, the 30-calendar-day opportunity to make a satisfactory showing with continued coverage during that period, the requirement to consider all other bases of Medicaid eligibility before denial or disenrollment, advance notice and fair hearing rights, and the reconsideration period for individuals disenrolled for failure to respond.

We remain concerned, however, that the procedures as outlined thus far by PA DHS will depend heavily on mail-based notice. A notice is presumed received five days after its date, yet individuals with serious mental illness and substance use conditions disproportionately experience housing instability and homelessness and are, in many cases, unlikely to receive and act on mailed notices within 30 days.

We urge CMS to require states to attempt notice through multiple modalities before taking adverse action, to establish good-cause extensions of the 30-day period (including for hospitalization, residential treatment, incapacity, and crisis episodes), and to clarify that a satisfactory showing may be submitted by a provider or other individual acting on the beneficiary's behalf, consistent with our comments above.

Finally, we request that CMS clarify that individuals who demonstrate compliance or specified excluded individual status during the reconsideration period must be reinstated without a gap in coverage, and specify the effective date of coverage upon reinstatement.

Implementation Timing

The January 1, 2027 implementation deadline requires states to stand up new data connections, verification plans, notice processes, and outreach campaigns on a compressed timeline. RCPA supports the good faith effort exemption process at § 435.560 and urges CMS to review good faith exemption requests expeditiously, to apply the criteria flexibly, and to publish approved exemptions and their durations so that providers and beneficiaries know when the requirement takes effect in their state. We further request this based upon the six-month delay in CMS issuing the Interim Final Rule guidance.

We also request that CMS confirm that where a state receives a good faith effort exemption, the associated outreach timing requirements adjust to the state's revised implementation date, and that CMS provide template state plan amendment materials, model notices, and sustained technical assistance to support consistent implementation.

Lastly, several states including Pennsylvania have made clear that the IFR does not represent the final standards and that additional guidance is pending from CMS. If this is the case, it is our contention that this be provided as soon as possible as there is less than six months to projected implementation.

Communications, Outreach, and Engagement

RCPA appreciates and supports the outreach requirements at § 435.561, including the initial notice timing formula, the required content elements, and the plain language, language access, and disability accessibility requirements. As noted under Noncompliance above, because individuals with serious

mental illness and SUDs are less likely to be reached by mail-only strategies, we urge CMS to encourage states to conduct outreach through the PA HealthChoices Medicaid Managed Care Organizations, County Human Services, and providers and community-based organizations through a coordinated and transparent plan.

Strictly from a provider involvement perspective, these individuals they serve already know and trust these agencies. Model notices and outreach materials developed by CMS, available for state adaptation, would meaningfully improve the consistency and accuracy of beneficiary-facing communications, but timing is of the essence, as letters and communications from states either have been completed or are in the final phase of development.

Additional Recommendations for Considerations

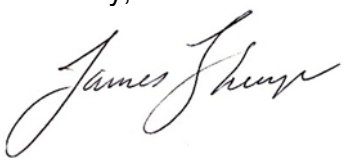
Many Medicaid beneficiaries, as well as the providers and community-based organizations that serve them, may not clearly understand whether an individual is enrolled in the Medicaid expansion population or an applicable section 1115 demonstration population and is thus subject to community engagement requirements. RCPA would suggest CMS provide clear, accessible, and patient and provider-facing educational and assessment resources that help individuals determine whether they are part of a population subject to community engagement requirements.

Additionally, we urge CMS to consider the operational challenges facing mental health and substance use providers that practice across multiple states. As states implement the community engagement requirement, providers may be required to navigate different state verification processes, reporting systems, documentation standards, outreach requirements, and exclusion determinations – thus creating substantial administrative burden, which could further strain providers that already run on tight and efficient margins. As a part of ameliorating such burden on providers, we suggest CMS establish a centralized repository of state-specific implementation information, including eligibility criteria, reporting mechanisms, documentation standards, timelines, and contact information for beneficiary assistance. Providing such a resource as well as additional technical assistance will help improve efficiency for providers who may need to comply with varying requirements across states.

Conclusion

In closing, RCPA appreciates the opportunity to provide these comments. We welcome any questions or further discussion about our comments outlined above. Please contact RCPA COO and Mental Health Division Director Jim Sharp for further clarification. Thank you for your time and consideration.

Sincerely,



James Sharp
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