National Alliance on Mental Illness
MINNESOTA

July 22, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comments on Interim Final Rule with Comment Period – Medicaid Community Engagement Requirements

Dear Administrator Oz,

On behalf of NAMI (National Alliance on Mental Illness) Minnesota, we appreciate the opportunity to comment on the Interim Final Rule (IFR) implementing Medicaid community engagement requirements. NAMI Minnesota is a nonprofit organization dedicated to improving the lives of children and adults with mental illnesses and their families. For over 40 years, NAMI Minnesota has worked to promote the development of community mental health programs and services, change public attitudes about mental illnesses, improve access to services, and increase opportunities for recovery.

Approximately one in five adults in Minnesota live with a mental illness – and Medicaid is the backbone of Minnesota's mental health system, covering around 20 percent of all mental health treatment and half of all substance use disorder treatment in the state. Providing access to Medicaid coverage is essential to ensuring that Minnesotans living with mental illnesses can access the services they need to achieve and maintain stability.

We are deeply concerned that the framework provided in the interim final rule for determining if a person meets the definition of "medically frail" will exclude individuals with serious behavioral health conditions whom Congress intended to protect. We recommend several key changes before the rule is finalized to protect access to Medicaid for qualified individuals and to honor the congressional intent of the law.

The definition of "Medically Frail" should account for the unique and dynamic nature of serious mental illnesses and eliminate the two-part test.

Many psychiatric conditions are characterized by fluctuating symptoms rather than permanent incapacity. Individuals living with schizophrenia, bipolar disorder, major depressive disorder, post-traumatic stress disorder, obsessive-compulsive disorder, eating disorders, and substance use disorders may experience periods of stability followed by episodes that substantially impair

their ability to consistently work, participate in education, or comply with administrative reporting requirements.

We strongly encourage the Centers for Medicare and Medicaid Services (CMS) to eliminate the vague and practically unimplementable standard for states to demonstrate that a person's condition impairs a person's ability to meet community engagement requirements. In addition, by severely limiting self-attestation, the IFR effectively shifts the administrative burden of verifying exemptions to providers. While the IFR indicates that states – not providers – are responsible for making this determination, states do not possess the necessary information and will be forced to rely on health care professionals to inform their ability to make an accurate determination. This creates a massive, unfunded burden for providers and will further strain a system already lacking capacity.

CMS should also clarify that medical frailty includes conditions that are intermittent, or fluctuate. Functional limitations such as cognitive impairment, executive dysfunction, impaired concentration, severe anxiety, medication side effects, or recurrent psychiatric crises should be considered alongside diagnosis. CMS should also clarify that co-occurring behavioral and physical health conditions should be evaluated collectively rather than independently.

CMS should support states to maximize ex parte processes and provide the greatest degree of flexibility to determine medically frail individuals.

The greatest barrier posed by these new requirements and the processes outlined in the IFR for many individuals with serious mental illnesses is not eligibility but navigating administrative processes. Requiring beneficiaries experiencing psychiatric symptoms to self-identify, obtain documentation, and submit forms will inevitably result in eligible individuals losing coverage despite qualifying for an exemption.

CMS should require states to make every reasonable effort to identify medically frail individuals using existing information before requesting additional documentation. At a minimum, states should be expected to review:

- Medicaid claims, including diagnoses appearing in any diagnosis position;
- Electronic health record information available through state health information exchanges where available;
- Behavioral health assessments and managed care care-management data;
- Prior disability determinations;
- Prescription drug utilization indicating treatment for serious behavioral health conditions; and
- Recent inpatient psychiatric, residential treatment, or intensive outpatient utilization.

An effective ex parte process will reduce administrative burden for beneficiaries while improving program integrity and reducing unnecessary coverage disruptions. CMS should support states in building out systems and processes to collect the necessary information without putting the burden on individuals seeking coverage – or providers serving them.

Participation in intensive behavioral health treatment should be evidence of medical frailty.

Individuals actively receiving intensive behavioral health treatment are often engaged in treatment precisely because their conditions substantially limit daily functioning. CMS should recognize participation in services such as Assertive Community Treatment (ACT), intensive outpatient treatment, partial hospitalization, residential behavioral health treatment, medication-assisted treatment, psychiatric rehabilitation, or other intensive community-based behavioral health services as strong evidence supporting a medical frailty determination. These services are designed for individuals with significant functional impairment and should be considered accordingly.

The rule should clarify which settings meet the definition of "drug and alcohol treatment and rehabilitation program."

The statute and IFR both allow that a person who is "participating in a drug and alcohol treatment and rehabilitation program" is considered a "specified excluded individual" and therefore is not subject to work and community engagement requirements. Further clarity is needed around which specific treatment settings qualify. We encourage CMS to clarify that this definition includes certified community behavioral health clinics, community mental health centers, all licensed substance use disorder treatment programs, as well as substance use disorder treatment provided in non-behavioral health specific settings – such as inpatient and outpatient hospitals, federally qualified health centers, and other primary care settings.

Conclusion

We respectfully request these adjustments to the rule so that Minnesotans living with mental illnesses can continue accessing the therapy, medications, case management, and other supports that help them live independently and successfully. When people lose health care coverage, they often lose access to the very treatment that keeps them healthy enough to work, care for their families, and contribute to their communities.

Sincerely,

Marcus Schmit, Executive Director

NAMI Minnesota