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of Albuquerque
A Proud Member of Oceans Healthcare

September 10, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division – Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

RE: Public Comment on Proposed Amendments to 8.296.400 NMAC – Medicaid Community Engagement Requirements

Dear Secretary Armijo, Director Dancis, and Members of the Medical Assistance Division:

On behalf of Oceans Healthcare, thank you for the opportunity to comment on the New Mexico Health Care Authority's proposed implementation of the new Medicaid community engagement requirements, including the proposed amendments to 8.296.400 NMAC.

Oceans Healthcare provides behavioral health treatment to individuals with serious mental health and substance use disorders. We appreciate HCA's efforts to implement the new federal requirements in a way that complies with federal law and minimizes unnecessary disruption in Medicaid coverage.

Our comments focus on a relatively narrow but significant issue: making certain that Medicaid beneficiaries whose behavioral health conditions substantially impair their ability to meet community engagement requirements are identified accurately and with as little unnecessary administrative burden as possible.

The federal framework recognizes substance use disorders and disabling mental disorders as conditions that may qualify an individual for the medically frail exclusion when the condition significantly impairs the individual's ability to comply with community engagement requirements. The CMS Interim Final Rule also directs states to use reliable information already available to them, including relevant adjudicated claims and encounter data from the preceding 12 months, when verifying exclusions.

We respectfully recommend that New Mexico use the flexibility and data available to it to establish a clear, practical process for behavioral health beneficiaries.

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In several areas, the proposed New Mexico rule appears consistent with the federal framework but does not expressly identify the behavioral health services or verification pathways that will qualify. We encourage HCA to make these protections explicit in the final rule or formal implementation guidance so that eligibility does not depend on differing interpretations by beneficiaries, providers, or eligibility staff.

1. Use Intensive Behavioral Health Services as Evidence of Medical Frailty During Ex Parte Verification

We support HCA's proposed use of available data sources to verify exclusions and exceptions before requiring additional information from a beneficiary.

As HCA develops the operational criteria for medical frailty, we recommend that recent utilization of intensive behavioral health services be treated as strong evidence that an individual with a substance use disorder or disabling mental disorder meets the functional-impairment standard for the medically frail exclusion.

In particular, HCA should use Medicaid claims and encounter data from the preceding 12 months to identify beneficiaries who have received:

- inpatient psychiatric treatment;
- residential behavioral health treatment;
- partial hospitalization program services (PHP);
- assertive community treatment (ACT); or
- intensive outpatient program services (IOP).

These are not routine outpatient services. Admission to these levels of care reflects substantial clinical need and, in many cases, significant impairment in an individual's ability to perform ordinary work, educational, or other community activities.

We recommend that HCA establish recent utilization of one of these intensive levels of care as presumptive evidence of the functional impairment required for the medically frail exclusion when the individual has a qualifying substance use disorder or disabling mental disorder.

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Doing so would make meaningful use of information HCA already possesses, reduce unnecessary paperwork for beneficiaries and providers, and limit the need for eligibility staff to recreate clinical determinations that are already reflected in treatment history.

2. Provide a Time-Limited Self-Attestation Pathway When Reliable Information Is Not Yet Available

Claims-based verification will not identify every individual who qualifies for the medically frail exclusion.

A newly eligible Medicaid applicant may have been uninsured and therefore have no Medicaid claims history. Others may be experiencing new or worsening symptoms, waiting for an initial behavioral health appointment, or undergoing an evaluation before a final diagnosis can be documented.

CMS has recognized this circumstance by permitting states, when reliable information is unavailable, to use a statement provided under penalty of perjury to establish medical frailty, subject to subsequent verification requirements.

We encourage HCA to explicitly provide this pathway for individuals asserting medical frailty based on a substance use disorder or disabling mental disorder.

The process should be readily accessible to applicants and beneficiaries and should not require a person experiencing significant behavioral health symptoms to first navigate a lengthy documentation process merely to maintain the coverage needed to obtain treatment.

Once the individual is enrolled and receiving services, HCA can use subsequent claims, encounter data, or other reliable information to verify continuing eligibility for the exclusion consistent with federal requirements.

3. Explicitly Recognize Intensive Community-Based Behavioral Health Treatment for the Short-Term Hardship Exception

We appreciate New Mexico's inclusion of the short-term hardship exception in its proposed implementation.

CMS has recognized that services provided outside an inpatient institution may be comparable in acuity to institutional treatment when they are furnished to individuals who would otherwise be at significant risk of requiring institutional care.

This principle is particularly relevant in behavioral health.

Partial hospitalization programs, intensive outpatient programs, and assertive community treatment are designed to provide intensive treatment in the community and, in appropriate cases, prevent or shorten psychiatric hospitalization or residential placement.

We recommend that HCA explicitly recognize PHP, IOP, and ACT as qualifying noninstitutional behavioral health services for purposes of the short-term hardship exception when those services meet the federal acuity standard.

A categorical determination would provide clarity for beneficiaries, behavioral health providers, and eligibility staff and would avoid requiring individual eligibility workers to make complex clinical judgments about whether a particular level of behavioral health treatment is comparable to inpatient care.

We likewise ask HCA to clarify that **residential behavioral health treatment** is included within the institutional or similar-facility component of the hardship exception.

4. Create a Clear Provider-Assisted Verification Process

Individuals receiving intensive behavioral health treatment are often least able to navigate complicated eligibility procedures at the exact moment when verification may be required.

A person transitioning from an inpatient psychiatric hospital, residential program, PHP, or other intensive setting may still be experiencing substantial symptoms and may be managing medications, follow-up appointments, housing concerns, family responsibilities, and other immediate needs.

We encourage HCA to establish a simple process through which authorized behavioral health providers may assist beneficiaries in documenting medical frailty or a qualifying hardship.

This could include standardized forms, electronic submission processes, clear provider guidance, or other mechanisms that allow HCA to obtain necessary information without placing the full administrative burden on the beneficiary.

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5. Engage Behavioral Health Providers in Development of the Medical-Frailty Verification Criteria

The federal rule requires states to operationalize how medical frailty will be identified and verified. Much of the practical impact of the community engagement requirement will depend not simply on the language of 8.296.400 NMAC, but on the criteria, data sources, systems, and procedures HCA ultimately uses.

We respectfully request that HCA provide behavioral health providers and other interested stakeholders an opportunity to provide input as it develops:

- the conditions, diagnosis lists, service-utilization criteria, and other standards used to identify individuals who may be medically frail;
- the claims and encounter data used for ex parte verification;
- the treatment and utilization indicators used to demonstrate functional impairment;
- the state's community engagement verification plan;
- guidance concerning self-attestation and documentation; and
- provider procedures for assisting beneficiaries with exclusions and exceptions.

This collaboration can help New Mexico build a process that is administratively workable and clinically sound while remaining fully consistent with federal requirements.

Conclusion

Oceans Healthcare recognizes that New Mexico is implementing a federal requirement and appreciates HCA's efforts to use available data and other administrative tools to reduce unnecessary coverage disruptions.

Our recommendations do not seek to broaden the statutory definition of medical frailty or create exemptions outside the federal framework. Rather, they are intended to help New Mexico identify individuals whom federal law already protects and to do so using reliable clinical and Medicaid data already available to the state.

We respectfully ask HCA to:

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1. use recent inpatient, residential, PHP, ACT, or IOP utilization as presumptive evidence of functional impairment when determining medical frailty for individuals with substance use disorders or disabling mental disorders;
2. explicitly permit time-limited self-attestation of behavioral health medical frailty when reliable information is not yet available;
3. recognize PHP, IOP, and ACT as qualifying intensive noninstitutional behavioral health services for the short-term hardship exception and clarify the treatment of residential behavioral health services;
4. establish a practical provider-assisted verification pathway; and
5. involve behavioral health providers in the development of the state's medical-frailty criteria and community engagement verification procedures.

We appreciate the Authority's consideration of these recommendations and would welcome the opportunity to work with HCA and the Medical Assistance Division as implementation proceeds.

Sincerely,

Kathleen Dostalik

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