July 31, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2454-IFC, Medicaid Program; Community Engagement Requirement for Certain Individuals

Dear Administrator Oz,

Thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid (CMS) Interim Final Rule, CMS-2454-IFC: Medicaid Program; Community Engagement Requirement for Certain Individuals.

We are writing in our individual capacity to express significant concerns regarding the impact community-engagement requirements will have on individuals with substance use disorder (SUD). We are attorneys and former government officials with expertise at the local, state, and federal levels specializing in the area of addiction law and policy.

We write with great concern that this interim final rule will, upon implementation, undermine the federal government's strategy to address the addiction and overdose crisis in our country and risks reversing the downward trend of overdose deaths.

We appreciate the important role work and community engagement play in sustaining long-term recovery from substance use disorder (SUD). However, several provisions of the interim final rule implementing the medical-frailty exemption for individuals with substance use disorder effectively narrow Congress's express inclusion of individuals with SUD within the medically frail exclusion and impose additional limitations which Congress did not include in the final legislation. In addition, rather than encouraging employment and recovery, these provisions risk interrupting treatment and increasing avoidable coverage losses among eligible individuals, ultimately making it more difficult for people with SUD to obtain and maintain employment and remain engaged in their community.

Given the breadth and implications of this interim final rule, we urge CMS to carefully consider the public comments it receives and make substantive revisions before this rule is implemented. Doing so reduces the risk that eligible Medicaid beneficiaries will lose coverage as a result of provisions that could be modified without undermining the Administration's broader policy objectives.

1. **CMS Lacks Authority to Narrow the Statutory Medical Frailty Exclusion (§ 435.554(c)(5))**

Based on current law and regulations defining the term “medically frail”, Congress included SUD as eligible for the medically frail exemption in Public Law 119-21 (H.R. 1). However, the interim final rule adds a new requirement and states that individuals with SUD qualify for the medically frail exemption only if they demonstrate that their condition “significantly impairs” their ability to meet the 80-hour per month community engagement requirement. As such, an SUD diagnosis alone is not sufficient. Instead, eligibility depends on a separate determination regarding the individual's functional ability to comply with community engagement activities.

This additional requirement substantially narrows that statutory protection by imposing an additional functional-impairment requirement that does not appear in the statutory language. Congress did not condition eligibility for the medically frail exemption on a separate showing that the individual's condition significantly impairs the ability to satisfy community engagement requirements. CMS should reconsider whether this additional limitation is consistent with the authority granted by Congress and revise the rule accordingly.

2. The Functional Impairment Standard for Medical Frailty (§ 435.554(c)(5))

Apart from the statutory concerns discussed above, the functional impairment standard is poorly suited to the clinical realities of SUD and should be removed on that basis.

SUD does not progress in a predictable linear fashion. Functional status may improve substantially over several weeks because treatment is working, yet individuals often remain clinically vulnerable and require uninterrupted treatment to maintain that progress. Medicaid coverage should support recovery through periods of improvement rather than place continued access to care at risk because treatment has begun to succeed.

More broadly, the proposed standard requires states to devote substantial administrative effort to answering a narrow question: whether an individual's SUD impairs functioning enough to qualify for an exemption. That determination is inherently subjective and likely to vary among reviewers. Moreover, a determination made using information from a single point in time may not accurately reflect an individual's clinical needs over the duration of a certification period. For individuals with SUD, temporary improvement may reflect successful treatment rather than resolution of the underlying condition, while short-term instability may not accurately predict future functioning. CMS should consider whether the administrative cost and complexity of this process is justified by any demonstrated improvement in program integrity or beneficiary outcomes.

These requirements also create significant administrative complexity for state Medicaid agencies. Determining whether an individual with SUD is functionally unable to satisfy the community engagement requirement is not a simple yes-or-no inquiry. It requires individualized clinical judgment, collection and review of medical documentation, evaluation of data sources that may not adequately capture functional status, and coordination with providers. These activities consume state administrative resources while increasing the likelihood of inconsistent determinations across beneficiaries and across states. If CMS’s goal is to promote efficient program administration and program integrity, a simpler and more durable medical-frailty determination would better achieve those objectives.

CMS should remove the functional-impairment requirement and rely on Congress's statutory definition of medically frail. If CMS retains the functional-impairment standard, it should provide additional guidance regarding what constitutes a condition that "significantly impairs" an individual's ability to satisfy the community engagement requirement in order to promote greater consistency across states.

3. Certification and Reverification Requirements (§ 435.557(f)(1)(ii))

Even if CMS retains the proposed functional-impairment standard, the certification and reverification framework should be re-designed to minimize administrative barriers to treatment and coverage. For individuals with SUD, continuity of care is essential to recovery, and interruptions in coverage can have immediate consequences for treatment engagement, health outcomes, and workforce participation.

CMS should limit reverification of medical frailty to annual eligibility renewal except in cases involving fraud, material error, or a reported change in circumstances, rather than permitting states to reverify medical frailty more frequently than annual renewal. For individuals with SUD, more frequent reverification is unlikely to improve accuracy while creating additional opportunities for eligible individuals to lose coverage despite continuing clinical need. Temporary improvements in functioning often reflect successful treatment rather than resolution of the underlying condition, and additional reverification requirements increase administrative burden for beneficiaries, providers, and state agencies alike.

CMS should minimize documentation and verification requirements associated with medical-frailty determinations. Individuals with SUD often experience treatment transitions, unstable housing, transportation barriers, changing employment circumstances, and interactions with multiple health care and social service systems. Additional paperwork and documentation requirements increase the likelihood that eligible individuals will lose coverage for procedural rather than substantive reasons. For individuals with SUD, treatment is often the pathway to employment and stability, not an alternative to it.

CMS should permit self-attestation whenever reliable information is unavailable rather than limiting its use to a single occasion during a period of enrollment. Individuals receiving treatment for SUD may experience disruptions in provider relationships, changes in insurance status, relocation, or other circumstances that make documentation difficult to obtain. When reliable information is unavailable, self-attestation provides an important safeguard against unnecessary interruptions in coverage while states obtain additional information.

CMS should maximize flexibility regarding who may certify or verify medical frailty. Many individuals with SUD receive ongoing care from addiction specialists, office-based buprenorphine prescribers, certified peer recovery specialists, recovery support providers, and other professionals who are well positioned to assess the impact of SUD on functioning and treatment needs. Restricting certification authority unnecessarily may create delays in access to exemptions for otherwise eligible individuals.

Recent Medicaid experience demonstrates the risks associated with complex eligibility verification systems. During the post-COVID Medicaid unwinding, nearly two-thirds of

disenrollments occurred due to paperwork or administrative reasons rather than true ineligibility, demonstrating how easily eligible individuals can lose coverage when verification demands intensify (KFF, 2024). The unwinding demonstrated that even well-intentioned eligibility processes can result in substantial coverage losses when administrative requirements become too complex. Similar barriers in the context of SUD treatment would interrupt care without advancing program integrity or reducing inappropriate enrollment. The concern is particularly significant given CMS's own estimate that the interim final rule will result in the disenrollment of 2.3 million individuals in FY 2027 and between 3.1 million and 3.3 million individuals in subsequent years (CMS, 2026, p. 312). Similar administrative barriers in the context of SUD treatment would interrupt care without advancing program integrity or reducing inappropriate enrollment.

CMS should adopt the least burdensome certification and reverification framework permitted under the statute in order to preserve continuity of care, reduce procedural disenrollment, and support successful recovery and workforce participation.

4. The Five-Year Recovery Limitation (§ 435.554(c)(5)(i)(B))

CMS should eliminate the five-year recovery limitation from the medically frail definition. The interim final rule excludes individuals with SUD who are in "stable recovery," defined as five or more years in recovery (CMS, 2026, p. 87).

Recovery is measured by continued engagement, stability, and long-term management of a chronic illness, not by the simple passage of time. Individuals who have achieved several years of recovery often remain engaged in medication treatment, counseling, recovery support services, and routine medical care. Eliminating eligibility based on an arbitrary benchmark risks disrupting precisely the supports that helped them achieve stability.

The evidence cited by CMS does not support using a five-year threshold as a categorical marker of stable recovery for all individuals with SUD. Much of the research relied upon by CMS is alcohol-focused and does not reflect the different relapse patterns associated with opioids, stimulants, or polysubstance use (Frone et al., 2022; Moe et al., 2022). Recovery from SUD is not always a linear process, and periods of remission do not guarantee continued stability or consistent functional capacity over time. A fixed five-year cutoff therefore risks excluding individuals who continue to experience significant clinical needs while relying on a benchmark that is not supported across substance types.

Conclusion

CMS can preserve the goals of community engagement while reducing unnecessary administrative complexity and avoiding procedural coverage losses among individuals who remain eligible for Medicaid.

To achieve this, we respectfully urge CMS to:

- remove the functional-impairment requirement from the medical-frailty definition for individuals with SUD and rely on Congress's definition of medically frail;

- limit reverification of medical frailty to annual eligibility renewal except in cases involving fraud, material error, or a reported change in circumstances;
- permit self-attestation whenever reliable information is unavailable and maximize flexibility regarding who may certify or verify medical frailty;
- remove the arbitrary five-year recovery limitation; and
- adopt implementation standards that minimize procedural coverage losses among otherwise eligible beneficiaries.

These changes would better advance CMS's stated goals by preserving access to evidence-based treatment, supporting long-term recovery, strengthening workforce participation, reducing avoidable overdose deaths, and ensuring that program integrity efforts focus on individuals who are truly ineligible rather than those who encounter unnecessary administrative barriers while seeking treatment and recovery support.

Thank you for the opportunity to comment on CMS-2454-IFC and to share our concerns regarding several provisions. Please contact us with any questions about our comments.

Sincerely,

Regina LaBelle, JD

Shelly Weizman, JD

References

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