Global Health Advocacy Incubator

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VIA ELECTRONIC SUBMISSION

July 29, 2026

Mehmet Oz
Centers for Medicare and Medicaid Services
7500 Security Boulevard,
Woodlawn, MD 21244

Docket No. CMS-2454-IFC

RE: Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period

Dear Administrator Oz,

Thank you for the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule (IFR), *Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period* [CMS-2454-IFC].

The Overdose Prevention Initiative at the Global Health Advocacy Incubator (GHAI) works to identify and advance federal solutions that ensure individuals, families and communities affected by substance use disorders (SUDs) have access to the resources, treatment and support needed to prevent overdose deaths and achieve long-term recovery. Our comments reflect our commitment to evidence-based policymaking, continuity of care and ensuring that Medicaid policies support, rather than disrupt, access to evidence-based treatment and recovery services.

Medicaid is the nation's single largest payer of SUD services, and uninterrupted coverage is essential for individuals seeking treatment, maintaining recovery and reducing their risk of overdose.[1] While the IFR includes several exemptions to the Medicaid community engagement requirements intended to protect high-risk populations, explicitly including those with a SUD, aspects of the implementation framework may create significant administrative barriers that place eligible individuals at risk of losing coverage. These barriers are particularly concerning for people with SUD, whose treatment and recovery often involve periods of instability, changing care needs and engagement across a broad continuum of clinical and community-based services.

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Preserving continuous Medicaid coverage is especially important for individuals transitioning from incarceration, for whom Medicaid is also the primary source of coverage, and those actively engaged in treatment or recovery.[2] Interruptions in coverage can delay access to medications for opioid use disorder (MOUD), mental health care, peer recovery support services (PRSS) and other evidence-based interventions that are critical to preventing relapse and overdose.[3] Implementation of the new community engagement requirements should reinforce the goals of improving health outcomes and supporting long-term recovery, not working against them.

Our comments address each of these gaps in turn: the SUD-related exemptions under the "medically frail" category; the participation in treatment exemption; the post-incarceration exemption; and the mechanisms for assessing impact.

One procedural point applies across all four issues. Although this is an interim final rule, it has significant negative implications for current Medicaid recipients. We therefore urge CMS to revise the interim final rule in response to the concerns raised in this and other comments before issuing a final rule. Addressing these concerns before the rule is finalized is essential to reducing the risk that eligible beneficiaries will lose coverage.

Specifically, we ask CMS to:

- Revise the rule before it is issued as a final rule.
- Define "significantly impairs" in the medically frail exemption using clinically grounded, SUD-specific guidance.
- Expand the list of authorized provider types for medically frail verification to include peer specialists, certified recovery coaches and SUD prescribers in non-specialty settings.
- Preserve self-attestation protections for people with SUD beyond 2027 and establish alternative verification pathways that do not rely solely on claims and encounter data.
- Establish a federal minimum standard for the treatment participation exemption broad enough to encompass the full continuum of SUD care, including harm reduction, peer support and recovery housing.
- Extend the implementation timeline for the post-incarceration data verification requirement and provide explicit guidance on compliant state data systems.

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- Require states to publicly report disaggregated data on exemption determinations by condition type, coverage disruptions and downstream health outcomes, including treatment gaps and overdose events.

We appreciate CMS' consideration of these comments and look forward to continued engagement on policies that promote access to evidence-based SUD treatment, recovery supports and overdose prevention services. Should you have any questions, please contact Daniel Diana, Research Manager, Overdose Prevention Initiative, at ddiana@advocacyincubator.org.

Sincerely,

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Background

Medicaid is the single largest payer for substance use disorder (SUD) services in the United States.[1] For millions of Americans with opioid use disorder (OUD), stimulant use disorder and other SUDs, Medicaid coverage is not a safety net of last resort. It is the primary mechanism through which they access medications that prevent overdose, treatment that supports recovery and services that allow them to stabilize their lives.

This interim final rule (IFR) implements the Medicaid community engagement requirements established under H.R.1,[i] which represents a significant change to the Medicaid program. Among other Medicaid-related changes, H.R.1 establishes new eligibility verification and reporting requirements and limits states' flexibility to use Section 1115 demonstrations to provide coverage and services.[4] The Congressional Budget Office (CBO) estimates that these provisions will result in millions of Americans losing Medicaid coverage in the coming years, with administrative barriers around work requirements – or "community engagement" requirements – accounting for a substantial share of those losses.[5] Because Medicaid is such a critical source of coverage for many people with SUD, the rule's implementation will have significant implications for access to evidence-based treatment and overdose prevention services.

The United States has recently made historic progress against the overdose crisis. In 2024, national overdose deaths declined by nearly 27% - the largest single-year reduction ever recorded by the Centers for Disease Control and Prevention (CDC).[6] That progress reflects years of sustained, bipartisan investment in evidence-based treatment, harm reduction and recovery supports, the majority of which flow through Medicaid. Coverage continuity is central to that progress. Research consistently shows that interruptions in Medicaid coverage disrupt treatment, increase emergency department utilization and raise the risk of relapse and overdose death.[7]

Community engagement requirements, if poorly designed or inadequately implemented, create exactly those disruptions. People with SUD are among the Medicaid enrollees least likely to be able to navigate complex administrative requirements, most likely to experience gaps in documented treatment history and most likely to suffer serious health consequences, including overdoses, when coverage is interrupted.[8] At the same time, individuals with SUD also face greater barriers to obtaining and maintaining the stable employment required to meet the community engagement requirements due to potential gaps in employment history, criminal records, stigma and a lack of

[i] Section 71119 of the One Big Beautiful Bill Act (H.R.1) mandates that non-exempt, able-bodied adults ages 19 through 64 who are enrolled in Medicaid through the ACA expansion (or expansion-like coverage) must complete at least 80 hours per month of qualifying work, education, job training or community service to maintain their coverage.

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skills/education.[9] The IFR's exemption framework is intended to protect this population. However, as written, it does not do so reliably for the millions of Americans with SUD.

GHAI's Response

The Overdose Prevention Initiative at GHAI highlights four areas in which the IFR, as written, would undermine access to SUD care and increase the risk of coverage loss for one of Medicaid's highest-risk populations: the medical frailty exemption, the participation in treatment exemption, the post-incarceration exemption and mechanisms to assess the impact of the community engagement requirements on health outcomes.

Sec. II, Part E.5: Medical Frailty Exemption

The IFR exempts people with SUD from community engagement requirements under the "medically frail" category,[ii] but with two significant limitations. First, individuals in "stable recovery," which is defined as five or more years of sustained recovery, are explicitly excluded. Second, a person's condition must "significantly impair" their ability to comply with community engagement requirements to qualify for exemption, a standard the IFR introduces beyond what H.R.1 requires but does not define or operationalize.

Verification of medically frail status must draw first on reliable state data, including claims and encounter data from the past 12 months. States may accept provider documentation from a range of practitioners and, during 2027, may accept self-attestation. Beginning in 2028, self-attestation is limited to once per continuous enrollment period, after which states must verify using available data or documentation. "Medically frail" status must be reverified at least every 12 months. The IFR also bars states from adding new categories to the medically frail definition beyond those enumerated federally.

These standards are vague, clinically unsupported and likely to be applied inconsistently. The five-year "stable recovery" carve-out does not have sufficient clinical basis; recovery is not linear, and people with five or more years of sustained recovery can experience relapse and remain at elevated risk.[10] Likewise, the undefined "significantly impairs" standard invites inconsistent determinations, overly restrictive state interpretations and unnecessary administrative burden

[ii] Section 71119 of H.R.1 creates an exemption from the Medicaid community engagement requirements for "medically frail" individuals, defined as having at least one of five categories of conditions: (aa) blindness or disability; (bb) SUDs; (cc) disabling mental disorders; (dd) physical, intellectual, or developmental disabilities that significantly impair their ability to perform one or more activities of daily living (ADL); or (ee) serious or complex medical conditions.

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without clear implementation guidance. It also departs from the statute. Congress exempted individuals with SUDs based on their condition, not whether they can demonstrate a particular level of impairment. Medicaid already has a long-standing definition[iii] of "medically frail" that includes individuals with SUD and is not conditioned upon an individual's ability to work or function. By introducing a new functional impairment status, the IFR narrows an exclusion that Congress intentionally made status based.

The verification framework compounds these problems. Claims and encounter data may not reliably capture SUD diagnoses for individuals who have been uninsured or experienced coverage lapses, received care in non-traditional settings or whose treatment has been episodic.[11] The proposed approach is particularly problematic during relapse, when individuals are most likely to need coverage but least likely to be able to obtain documentation or respond to notices. Although the IFR acknowledges that individuals may relapse, it provides no clear process for reestablishing an exclusion, leaving one of the highest-risk periods without adequate protection.[12] The list of authorized providers also likely excludes peer support and recovery specialists, certified recovery coaches and buprenorphine prescribers in primary care.[13] These provider types often have the most consistent relationships with individuals with SUD.

The proposed framework also assumes that eligible individuals will know that they qualify for an exclusion. The Centers for Medicare and Medicaid Services (CMS) acknowledges elsewhere in the IFR (Sec. III, Part D) that some individuals may not realize an exclusion applies to them. For people with SUD, many will simply see a "work requirement" and reasonably assume they must comply, rather than recognizing they qualify for the medically frail exemption. As a result, eligible individuals may attempt to satisfy unnecessary requirements or lose coverage without knowing they were exempt.

These barriers risk coverage loss, not because individuals fail to qualify for an exemption, but because the system fails to identify them or communicate eligibility. Clear, proactive notice and

[iii] H.R.1's exemption for "medically frail" individuals is based on the term's use in the Affordable Care Act, as defined in 42 C.F.R. § 440.315(f), which exempted medically frail individuals from mandatory enrollment in Medicaid Alternative Benefit Plans (ABP). Medical frailty is defined as having at least one of six categories of conditions: 1) disabling mental disorders; 2) chronic SUDs; 3) serious and complex medical conditions; 4) physical, intellectual or developmental disabilities that significantly impair their ability to perform 1 or more ADL; 5) those with a disability determination based on Social Security criteria; or 6) children under 19 who meet requirements under 42 C.F.R. § 438.50(d)(3) — none conditioned on work status.

Five of these six criteria — all but the children's category — mirror the five categories later adopted in Section 71119 of H.R. 1 for the medically frail exemption from Medicaid community engagement requirements.

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outreach regarding the SUD exemption should therefore be a core component of implementation, alongside a streamlined verification process. Avoiding unnecessary coverage disruptions is essential to maintaining access to Medications for Opioid Use Disorder (MOUD), preserving continuity of care and reducing the risk of relapse and overdose.[14]

Recommendation: CMS should define and operationalize "significantly impairs" under the medical frailty exemption with explicit recognition that impairment for people with SUD may be episodic, may not appear in recent claims data and does not require total inability to work.

Recommendation: CMS should expand authorized provider types to include peer specialists, certified recovery coaches and SUD prescribers in primary care and non-specialty settings to assess medical frailty for people with SUD.

Recommendation: CMS should preserve self-attestation protections for people with SUD exempted because of medical frailty beyond 2027 or establish a clear alternative verification pathway that does not rely solely on claims and encounter data.

Sec. II, Part E.7: Participation in Treatment Exemption

The IFR exempts individuals actively participating in SUD treatment from community engagement requirements. Unlike the medically frail exemption, this exemption does not require that a person's SUD significantly impair their ability to comply. Participation in treatment alone is sufficient. However, the IFR gives states broad discretion to define what qualifies, including the authority to set minimum time commitments, with no federal floor.

Without a federal minimum standard, states will define "participation in treatment" inconsistently and, in some cases, restrictively. A person receiving MOUD in a primary care setting, engaging with a peer recovery coach or residing in recovery housing, may be fully engaged in their care but fail to meet a state's narrow definition. This creates a patchwork in which the same person is protected in one state and at risk of coverage loss in another based solely on where they live. Effective SUD care encompasses harm reduction, peer support, recovery housing and medication management, not just formal outpatient or residential treatment. A standard that fails to account for the full continuum of evidence-based SUD care will exclude people who are actively engaged in recovery.

Recommendation: CMS should establish a federal minimum standard for the treatment participation exemption broad enough to encompass the full continuum of evidence-based SUD care, including harm reduction services, peer support, recovery housing and MOUD in non-specialty settings. States

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may expand beyond this floor but should not be permitted to define participation in ways that exclude evidence-based modalities or impose unrealistic time commitments.

Sec. II, Part E.8: Post-incarceration Exemption

The IFR exempts previously incarcerated individuals from community engagement requirements for a month following their release from incarceration if, at any point during the three-month period prior to the month during which the state reviews for compliance, the individual was an inmate of a public institution. States must establish procedures to verify incarceration status, using reliable data from correctional systems whenever possible and requesting documentation from individuals only when necessary.

The exemption is a meaningful protection, but its value depends entirely on whether states can accurately and timely identify who qualifies. The IFR provides no definition of what a compliant state data system looks like, no guidance on acceptable data sources and no realistic timeline for states that lack existing data-sharing infrastructure with corrections agencies. For many states, the turnaround time is too short to implement this requirement reliably.[15] Most states do not currently maintain automated data-sharing arrangements with jails and prisons and building them takes time the rule does not allow. Without a defined and compliant system, a list of acceptable sources and a workable build period, states will default to requesting documentation from individuals during the exact weeks when contact is least stable and the risk of a fatal overdose is highest.[16]

People leaving incarceration are 40 times more likely to die of an overdose in the first two weeks after release.[17] Coverage continuity during this window is a life-or-death issue. If states cannot operationalize the exemption, this population will face coverage loss at precisely the moment they are most vulnerable.

Recommendation: CMS should extend the implementation timeline for the post-incarceration data verification requirement and provide explicit guidance to states on compliant data systems, including acceptable sources, minimum standards and a definition of "ready." States that cannot meet the current timeline should receive a structured remediation pathway with technical assistance.

Recommendation: CMS should clarify that coverage must be maintained through the full completion of due process and that states may not terminate coverage for formerly incarcerated individuals during the exemption window pending verification.

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Sec. II, Part H: Assessing Impact

The IFR requires states to report data on community engagement compliance and exemption determinations, but does not require disaggregation by condition type, mandate public disclosure of outcomes or establish any requirement to track downstream health impacts. This includes coverage disruptions, treatment gaps or overdose events.

Without granular, publicly available data, it will be impossible to determine whether community engagement requirements are producing disparate impacts on people with SUD or whether exemptions are being applied consistently. The IFR creates compliance accountability without meaningful outcome measures, a significant gap for a population at elevated risk of overdose and treatment disruption.[18]

Recommendation: CMS should require states to publicly report disaggregated data on exemption determinations by condition type, including SUD. Reporting should also capture coverage disruption rates, disenrollment and re-enrollment patterns and, where data are available, downstream health outcomes, including treatment gaps and overdose events.

Conclusion

The community engagement requirements established by this IFR will not affect all Medicaid enrollees equally. People with SUDs face a distinct and compounding set of barriers: vague exemption standards, a narrow verification framework, an implementation timeline that outpaces state capacity and a data reporting structure that cannot detect harm. Taken together, these features create serious risk that people who are actively managing a chronic, life-threatening condition will lose coverage – not because they fail to qualify for an exemption, but because the rule as written cannot reliably identify that they do.

The overdose crisis has claimed more than a million American lives over the past two decades.[19] The progress made in recent years, including a nearly 27% decline in overdose deaths in 2024, reflects sustained investment in treatment access, coverage continuity and evidence-based care.[6] Community engagement requirements that interrupt that coverage, without adequate protections for people with SUD, risk reversing those gains. CMS has the authority and the responsibility to ensure that does not happen. We urge the agency to adopt the recommendations outlined above before this rule takes effect.

[1] https://www.commonwealthfund.org/publications/explainer/2025/may/medicaids-role-mental-health-and-substance-use-care

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