

How Medicaid Requirements Could Fail Patients in Recovery

By [Ashleigh Hollowell](#) | August 11, 2026

The addiction treatment field often looks at recovery as an ongoing journey, rather than a final destination. But [changes to Medicaid](#) brought on by the [One Big Beautiful Bill](#) could threaten to turn recovery milestones into an insurance cliff for patients who rely on coverage to maintain stability.

[Guidance](#) released by the Centers for Medicare & Medicaid Services (CMS) in June for the [interim final rule](#) clarified that beneficiaries must meet an 80-hour-per-month [work requirement](#) through employment, education work programs, community service or a combination of these options. However, individuals who are exempt from this requirement must fit CMS' definition of "medically frail."

For the most part, individuals who are actively in drug or alcohol treatment and rehabilitation are exempt from the work requirements. Patients who have received treatment for a substance use disorder (SUD) and are actively in recovery are exempt up to five years. After five years, individuals are considered by the definition to have entered "stable recovery" and no longer eligible for the work requirement exemption.

"We believe that it is inappropriate to include individuals with an SUD who are in stable recovery (which means individuals who are in recovery for 5 or more years) in the medically frail exclusion," CMS' interim final rule states in the [Federal Register](#). "The risk of SUD recurrence for an individual in stable recovery is approximately the same as the general population. ... We believe it is consistent with our statutory authority to exclude individuals who are in stable recovery from the definition of an individual with an SUD as we are defining the term."

CMS defines early recovery as 12 months or less, sustained recovery as between 1 year and 5 years and beyond that, individuals fall under the "stable recovery" label. But at issue both with payer organizations and providers is the arbitrary decision to cut off care after year five.

"The way that the rule is written right now, I think it's going to be very challenging for a provider," Debbie Witchey, president and CEO of the Association for Behavioral Health and Wellness (ABHW), told Behavioral Health Business. "Unless they've had a long relationship with the patient that has been five years plus, and oftentimes they haven't. It's going to be really hard for them to figure out how to document that. Besides the patient telling them, which is basically self-attestation, which is not permitted after the first year. It's not clear how they're even going to be able to decide that."

ABHW is a membership organization for payers that manage behavioral health insurance benefits across the U.S.

As it stands, the interim final rule from CMS puts the burden of figuring out how to document and verify that status on states and providers.

“States must ensure that they have reasonable processes and criteria in place for individuals to identify themselves as meeting the SUD medically frail exclusion, including for individuals who have a relapse,” the interim final rule reads.

Since most provisions of the interim final rule take effect beginning in January 2027, it leaves states and providers without much time or clarity on how tackle this to help ensure eligible patients don’t fall through the gaps and lose Medicaid coverage. Particularly as Medicaid is the [largest payer](#) of both mental health and substance use disorder care in the U.S.

Typically, after SUD treatment ends, the reality is that as many as [60% of patients relapse](#). This is the impetus behind many treatment organizations’ decision to [invest in recovery](#) services, programming, alumni connection events and more to keep them engaged in their sobriety.

After five years of sobriety from an SUD of any kind, relapse risk is reduced, but not zero. A [widely cited study](#) that was published earlier this year found that while five years of continued remission or sobriety is seen as “stable,” long-term relapses can still happen between 1 to 23 years in recovery. On average, people in remission or recovery who do relapse, do so around 3.6 years.

Additionally, a [2017 study](#) by Massachusetts General Hospital and Harvard Medical School found that for individuals with opioid use disorder, relapse risk remains elevated beyond five years of recovery.

“Recovery really doesn’t work on a clock, and that means that someone can be doing incredibly well five or even ten years into their recovery journey, but then have something happen,” Corey Gamberg, the executive director at the Massachusetts Center for Addiction, told BHB. “They might lose a job or someone close to them dies, their housing could fall apart, and that may suddenly put them in a very different place. ... If coverage disappears because they crossed an arbitrary date on the calendar, that can create risk where there wasn’t risk before.”

The Massachusetts Center for Addiction offers partial hospitalization programs, intensive outpatient programs and mental health treatment for patients with co-occurring behavioral health and SUD needs.

The risk of patients possibly losing coverage after reaching such a milestone in recovery could be particularly damaging for overall health and other mental health conditions too, Phil Smyth, the executive director at Milestone Treatment Center, explained. It’s also why organizations need to be proactive about investing in post-recovery resources.

“Treatment organizations should be investing in recovery services even if reimbursement hasn’t caught up,” Smyth told BHB. “Consistency and community are key when it comes to healing from substance abuse, and things like alumni programs, peer support, case management and other services can make all the difference for a potential relapse. The goal should be to help people stay stable over time. The issue is that this looks different for everyone, and each person needs different resources at different points in their recovery.”

Milestone Treatment Center provides SUD treatment for patients in New Jersey, Virginia and Texas.

Because of the complexity of CMS' definition around who qualifies as "medically frail" and for how long, coupled with a foggy understanding about how states and providers can verify patients' eligibility, Witchey said the worst-case scenario by 2027 is seeing even more individuals fall between the gaps in care.

"Best case would be that people will naturally fall into the category that they fit in. So, people who really don't need the exemption because they are truly in active recovery will be working and they won't be trying to seek the exemption. That would be ideal," Witchey said. "I think worst case is people probably are not going to be able to comply because of the complexity of the definition and they will fall off."

Either way, what federal healthcare leaders should focus on to help streamline the processes in the meantime is creating better interoperability in behavioral health with electronic health records (EHRs), Witchey said.

"They need to speed up the process of figuring out how to create interoperability and use of EHRs in behavioral health because that's really going to be the best way to be able to track and comply over time," she said.

Additionally, Witchey said the ABHW believes not only that CMS should get rid of the arbitrary five-year limit for patients in recovery, but also continue to clarify guidance around the [42 CFR Part Two](#) requirements, as that is also an area of ongoing confusion for providers.

In the meantime, as SUD providers draw closer to January 2027, being overly active in record-keeping, updating and organization is primarily the best way to limit anyone who could fall through the coverage gaps.

"Even if we thought it made sense from a policy perspective, from an operational perspective, having those kinds of records and that kind of information and being able to document that is really difficult," Witchey said. "That kind of information is not readily available to make that work."