ASAM American Society of Addiction Medicine

July 27, 2026

The Honorable Robert Kennedy, Jr.
Secretary Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Kennedy and Administrator Oz:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 8,000 physicians, clinicians, and associated professionals specializing in the prevention and treatment of addiction, I write to offer additional clinical context to assist with the implementation of the "medically frail or otherwise has special medical needs" exclusion at 42 C.F.R. § 435.554(c)(5), as it applies to individuals with substance use disorder (SUD) (the "**SUD Exclusion**"). To be clear, this letter does not address whether the agency's interim final rule (IFR)'s interpretation of the statutory SUD Exclusion, including the agency's "significantly impairs" standard or its five-year limitation, is consistent with the statute. Indeed, ASAM remains deeply concerned that aspects of the IFR are not fully consistent with the statute and may improperly narrow the SUD Exclusion. With that said, this letter focuses on how states could implement the IFR in a manner that (1) reflects the clinical reality of SUD; (2) aligns with the agency's adoption of a five-year benchmark and a "significantly impairs" standard, and (3) helps ensure that individuals with SUD are appropriately protected under § 435.554(c)(5), including by assuring states that they will not be penalized through payment error

rate measurement (PERM) or other federal program-integrity reviews for relying on the agency's SUD-specific implementation guidance (as described below), if the agency proceeds with the IFR as written. Nothing in this letter should be construed as ASAM's agreement with the IFR's interpretation of the statute or the IFR's legality.

ASAM also recognizes that participating in community engagement activities, such as employment, can help individuals with SUD maintain recovery by escaping isolation and dependency, building confidence, achieving greater stability, and improving health. However, an ongoing administrative requirement to document and report those activities is not the same thing. If the SUD Exclusion is implemented without accounting for how SUD presents clinically, then the community engagement requirement could work against those very objectives.

ASAM's Practical Framework for Applying the IFR to the SUD Exclusion

The following are ASAM's recommended clarifications for applying the IFR to the SUD Exclusion; the recommendations below assume that the IFR remains in place as written:

- **Clarify that states may treat active SUD, or SUD remission of less than 5 years, as a clinical indicator constituting sufficient evidence that the IFR's "significantly impairs" standard is met.** Under the IFR, individuals with SUD who are in "stable recovery" are *categorically* outside the SUD Exclusion. Applying that underlying logic consistently, states should be permitted to treat individuals who are either experiencing active SUD or not in stable recovery (i.e., in remission for less than 5 years) as presenting a clinical indicator sufficient to satisfy the IFR's "significantly impairs" standard without requiring a second individualized functional assessment. The agency's research supports the conclusion that earlier periods of recovery carry persistently higher, fluctuating, and clinically meaningful risk of recurrence and related functional impairment distinct from stable recovery.

- **Clarify that individuals in SUD remission for 5 or more years are not outside the SUD Exclusion when their recovery continues to be supported by ongoing treatment, monitoring, or other medically necessary clinical or recovery support services.**[1] As more fully described below, research indicates that these individuals remain at elevated risk beyond five years, and a disruption in those services can quickly reintroduce functional impairment directly relevant to their ability to comply with the community engagement requirement.

To effect these recommended clarifications, **the agency should issue additional guidance clarifying that states may treat individuals with SUD who are either (1) experiencing active SUD, (2) in remission from SUD for less than 5 years, or (3) in remission for 5 or more years but continue to have their SUD recovery supported by ongoing treatment, monitoring, or other medically necessary clinical or recovery support services, as having clinical indicators constituting sufficient evidence that the individual's condition significantly impairs the individual's ability to comply with the community engagement requirement, without requiring a second individualized functional assessment. The agency should also clarify that these identifications should be made possible through diagnosis, claims, encounters, beneficiary attestations made under penalty of perjury (when other reliable evidence is unavailable), or other auditable data sources. Finally, the guidance should further confirm that state determinations made pursuant to said guidance, including state determinations based on diagnosis, claims, encounters, beneficiary attestations made under penalty of perjury (when other reliable evidence is unavailable), or other auditable data sources, will not be treated in PERM or other federal program-integrity reviews as payment or eligibility errors solely because states rely on that additional guidance rather than on additional individualized functional assessments.**

Individuals experiencing active SUD easily fall within the SUD Exclusion under ASAM's framework. The discussion below therefore focuses on individuals in remission and explains why these clarifications represent the minimum clinically sound framework for applying the IFR if the agency proceeds with it as written.

How the Agency Defines "Medically Frail" Under the IFR

The IFR frames the relevant inquiry for "medically frail" in functional terms: whether a condition, including SUD, "significantly impairs" an individual's ability to comply with the community engagement requirement. As the agency notes, "[t]he best reading of the statutory phrase 'medically frail or otherwise has special medical needs' is one that considers . . . the extent to which the condition impairs an individual's ability to engage in community engagement activities (including but not limited to work) *or otherwise comply with the statutory requirements in section 1902(xx) of the Act*" (emphasis added). In practice, that should mean considering not only whether an individual with SUD can perform qualifying activities in the abstract, but whether they are likely to meet the ongoing reporting and verification requirements over time.

Recovery Prior to 5 Years of SUD Remission: Why a Meaningfully Higher Likelihood of SUD Recurrence Matters for Compliance

The IFR states that an individual in "stable recovery (which means, an individual who is in recovery for 5 or more years)" is outside the SUD Exclusion. ASAM appreciates the agency's reliance on research [2] showing that reaching stable recovery takes time. At the same time, the

agency's use of a five-year recovery benchmark raises an important implementation question: how to account for functional limitation during the earlier years of recovery?

As noted above, the agency's cited research shows that the risk of SUD recurrence can decrease over time, and recovery becomes more stable at five years of sustained remission from SUD. But that same research relies on research showing that risk remains elevated, unpredictable, and clinically meaningful before said five years. [3] That period of instability matters under the agency's own "significantly impairs" standard, because it directly affects the ability of such individuals to meet ongoing, deadline-driven, reporting and verification requirements consistently.

The IFR recognizes that the first several years of remission differ materially from stable recovery. The agency explains that it is "excluding individuals in stable recovery . . . since their SUDs are unlikely to significantly impair their ability to comply with the community engagement requirement," and defines early recovery as less than 12 months, sustained recovery as 1 to less than 5 years, and stable recovery as 5 years or longer. **To apply that logic consistently, states should be able to treat individuals who are <u>not</u> in stable recovery (i.e., in remission for less than 5 years) as presenting a clinical indicator sufficient to satisfy the IFR's "significantly impairs" standard without requiring a second individualized functional assessment.** Since the agency's research supports recognizing that a higher and unpredictable risk of recurrence is inherent to earlier periods of recovery, requiring additional individualized assessments would only add administrative burden without producing clinically meaningful distinctions among similarly situated individuals, making it difficult for states to administer the SUD Exclusion, much less administer it consistently. Public statements made by Members of Congress on the record reflect an intention to protect individuals with SUD [4] through the SUD Exclusion, and requiring individualized functional assessments for those in earlier stages of recovery would only serve to significantly increase the likelihood of inconsistent state determinations and erroneous denials or terminations of Medicaid expansion coverage for those individuals. The IFR itself was unable to identify any clinically validated criteria by which states could reliably and consistently distinguish among individuals within earlier stages of recovery in a way that is directly relevant to their ability to comply with the community engagement requirement. **Individuals within SUD remission for less than 5 years should <u>not</u> be required to provide additional evidence of impairment when their clinical indicators are inherently and uniquely marked by an elevated and unpredictable risk of SUD recurrence, which, by definition, involves directly relevant significant impairment or distress according to the American Psychiatric Association's DSM-5.**[5]

<u>Clarifying the Five-Year Benchmark for Stable Recovery</u>

The standard of care for SUD is based on a chronic care model, which treats SUD as a chronic health condition and anticipates that individuals with SUD will experience periods of remission and recurrence requiring ongoing engagement and reengagement. Consistent with that

standard, *The ASAM Criteria* (4th edition) includes a "Level 1.0," which includes a set of services for ongoing check-ins and early reintervention for patients in sustained remission from SUD. This is because many individuals in SUD remission continue to require ongoing clinical or recovery support services to support their recovery. For example, while patients taking addiction medications often do well (e.g., reduced illicit use, less unemployment, and greater stability), [6, 7, 8, 9] when their clinical/recovery support services are interrupted, their risk of SUD recurrence and death rises again. [10, 11, 12] And since Medicaid expansion coverage is often how such individuals receive those services, any disruption in that coverage can destabilize their remission, creating the very functional impairment that the SUD Exclusion is intended to prevent. **As a result, the IFR's categorical exclusion for "stable recovery" should be clarified by the agency to more precisely mean individuals in remission for 5 or more years and who do not continue to have their SUD recovery supported by ongoing treatment, monitoring, or other medically necessary clinical or recovery support services.**

Why ASAM's Implementation Clarifications Matter for Protecting Individuals with SUD and Strengthening Program Integrity Efforts

The SUD Exclusion is one of the statute's key safeguards for individuals with SUD. Unlike other conditions, Congress did not include any limiting modifiers to the SUD Exclusion in statute. Thus, applying the IFR in a way that aligns with both the clinical realities of SUD and the statute will help ensure that the SUD Exclusion functions appropriately. Taken together, the IFR's five-year benchmark, its "significantly impairs" standard, and the agency's concerns about unnecessary administrative burden support ASAM's above-referenced clarifications, which would allow states to use clear clinical and auditable SUD indicators as sufficient evidence of an individual's significant impairment, without imposing a second individualized functional assessment. Additionally, as you are aware, the agency continues to prioritize Medicaid program integrity efforts. ASAM's recommendations would serve those efforts by promoting objective, auditable criteria that will make the agency's oversight activities stronger and reduce unnecessary state variations. In turn, this would allow both federal and state program integrity resources to focus on truly improper coverage determinations and claims, rather than inconsistent application of the SUD Exclusion.

ASAM remains available to provide technical assistance as needed. If you have any questions or need further clarification, please do not hesitate to contact Corey Barton, Director, Practice Management and Regulatory Affairs at ASAM at cbarton@asam.org.

Sincerely,

Stephen M. Taylor, MD

Stephen M. Taylor, MD
President, American Society of Addiction Medicine

[1] *The ASAM Criteria* (4th ed.) defines "clinical services" as "services that are delivered by medical or clinical staff." *The ASAM Criteria* defines "medical staff" as "healthcare professionals with the scope of practice to deliver medical services and prescribe or administer medications, including but not limited to physicians, psychiatrists, nurses, and advanced practice providers." "Clinical staff" are defined as "nonmedical clinical professionals with the scopes of practice to deliver clinical and psychosocial services, including but not limited to psychologists, clinical social workers, and SUD and mental health counselors." "Recovery support services" are defined as the "collection of services that provide emotional and practical support for continuing recovery, as well as daily structure and rewarding alternatives to substance use."

[2] Frone M.R., Chosewood L.C., Osborne J.C. *et al.* Workplace Supported Recovery from Substance Use Disorders: Defining the Construct, Developing a Model, and Proposing an Agenda for Future Research. *Occup Health Sci* **6**, 475–511 (2022). https://doi.org/10.1007/s41542-022-00123-x (citing Kelly J. F., Greene M. C., & Bergman B. G. (2018). Beyond abstinence: Changes in indices of quality of life with time in recovery in a nationally representative sample of U.S. adults. Alcoholism: Clinical and Experimental Research, 42(4), 770–780. doi:https://doi.org/10.1111/acer.13604, citing White WL. *Recovery/remission from substance use disorders: an analysis of reported outcomes in 415 scientific reports, 1868–2011*. Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual Disability Services; 2012.)

[3] White WL. *Recovery/remission from substance use disorders: an analysis of reported outcomes in 415 scientific reports, 1868–2011*. Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual Disability Services; 2012.) (showing risk of SUD recurrence is high and volatile through years 1-4). https://www.naadac.org/assets/2416/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf

[4] BGR Group. (2025, May 13). House Energy and Commerce markup transcript full: FY 2025 budget reconciliation recommendations under H. Con. Res. 14 [Transcript]. https://bgrdc.com/wp-content/uploads/2025/05/House-EC-Markup-Transcript-Full.pdf

[5] American Psychiatric Association . Diagnostic and statistical manual of mental disorders, 5th ed. Arlington: American Psychiatric Association, 2013.

[6] Bart G. Maintenance medication for opiate addiction: the foundation of recovery. *J Addict Dis.* 2012;31(3):207-225. https://psycnet.apa.org/record/2012-21757-003

[7] Judson BA, Ortiz S, Crouse L, Carney TM, Goldstein A. A follow-up study of heroin addicts five years after first admission to a methadone treatment program. Drug Alcohol Depend. 1980;6(5):295-313. https://pubmed.ncbi.nlm.nih.gov/7460762/

[8] Russolillo A, Moniruzzaman A, McCandless LC, Patterson M, Somers JM. Associations between methadone maintenance treatment and crime: a 17-year longitudinal cohort study of Canadian provincial offenders. Addiction. 2018 Apr;113(4):656-667 (showing significant reductions in crime rates during methadone treatment). https://psycnet.apa.org/record/2017-52218-001

[9] Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357:j1550. https://www.bmj.com/content/357/BMJ.j1550

[10] Id.; Sees KL, Delucchi KL, Masson C, et al. Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: a randomized controlled trial. *JAMA*. 2000;283(10):1303-1310. https://jamanetwork.com/journals/jama/fullarticle/192476

[11] Sordo, supra note viii.

[12] Sees, supra note ix; Sordo, supra note viii.