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September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

**Re: CY 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P)**

Dear Administrator Oz –

On behalf of the American Society of Addiction Medicine (ASAM), thank you for the opportunity to comment on the proposed 2027 Medicare Physician Fee Schedule (MPFS). ASAM appreciates the work that CMS has done to date to increase access to services for the treatment of addiction, a chronic disease that continues to exact an enormous health, societal, and economic cost on families and communities in the United States. Building on CMS' prior efforts, ASAM encourages CMS to use the following feedback and recommendations to further strengthen the continuum of addiction care and save more lives:

- **CMS should not move forward with changes to the practice expense methodology while its impact on specialties remains relatively unknown;**
- **CMS should finalize its proposals to increase the valuations of smoking and tobacco use cessation services, as well as for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services;**
- **CMS should increase the valuation for the initiation of medication for opioid use disorder (MOUD) in emergency department settings, and consider additional payment pathways for other hospital addiction treatment services;**
- **CMS should address the limitations on the telehealth provision of services for the intensive outpatient (IOP) benefit to increase access to these services;**
- **CMS should not finalize the proposal to reduce payment for separately identifiable outpatient E/M services furnished on the same day as a procedure with a 0-, 10-, or 90-day global period to preserve access to treatment for pain and addiction;**

- **CMS should ensure its opioid treatment programs (OTP) and Part B drug payment policies for extended-release buprenorphine for the treatment of opioid use disorder appropriately support the recent Food and Drug Administration (FDA) -approved update to the prescribing information for that medication; and**
- **CMS should use the 2028 MPFS rule to propose updates that would pay for medically managed outpatient addiction treatment at parity with the same service currently provided in OTPs.**

Please see the detailed comments below for additional information and context as the agency moves toward finalizing payment and policies for the 2027 payment year. Please email Corey Barton, Director, Practice Management and Regulatory Affairs at cbarton@asam.org with any questions, concerns, or clarifications.

Sincerely,

Stephen M. Taylor
President, American Society of Addiction Medicine

**Practice Expense Methodology Changes**

ASAM is concerned about CMS' proposed changes to the practice expense methodology for calculating the relative values of services under the MPFS. Although CMS outlines several significant and interrelated changes, it has not provided sufficiently granular specialty and code-level information for stakeholders to assess their combined redistributive effects. This limitation is particularly consequential for addiction medicine, where clinicians are distributed across multiple Medicare specialties and taxonomies and therefore may not be fully represented in traditional specialty impact analyses. ASAM's preliminary analysis suggests that the proposed changes could place additional downward pressure on several high-volume outpatient evaluation and management (E/M) services commonly furnished by addiction treatment clinicians, including CPT code 99214. **ASAM recommends that CMS not finalize these changes, absent additional analysis demonstrating their impacts and providing stakeholders with a meaningful opportunity to assess their potential effects on access to care.**

**Valuation of Specific Services**

CMS proposes to increase the valuations of smoking and tobacco use cessation services (CPT codes 99406, 99407), as well as Screening, Brief Intervention, and Referral to Treatment (SBIRT) services (HCPCS Codes G2011, G0396, G0397), in line with CMS' approach to adjusting the valuations of psychotherapy services. **These are integral services for preventing and managing the chronic disease of addiction that ASAM supports and encourages CMS to finalize the changes.**

Relatedly, CMS developed HCPCS code *G2213 (Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services)* using a direct valuation crosswalk to HCPCS code G0397. **Given the low utilization of this service according to CMS data, ASAM recommends that CMS also apply the same upward adjustment to support increased access for beneficiaries that may benefit from this service.**

Relatedly, ASAM encourages CMS to evaluate the need for additional coding to support the provision of addiction treatment beyond the emergency department setting. ASAM's *Implementation Guide for Hospital and Emergency Department SUD Care (the Guide)*[1] references several models of care, including three prominent ones: bridge clinics, practice-based care, and addiction consult services. **ASAM recommends that CMS review whether additional coding or modifications thereof in the PFS could support the provision of these services.**

**Intensive Outpatient (IOP) Services Benefit and Telehealth**

ASAM supports the use of telehealth where clinically appropriate to improve access to behavioral health and SUD treatment, and CMS has also identified telehealth as a major pathway to broader access for Medicare beneficiaries. **Though CMS has previously explained that it lacked the statutory authority to permit the IOP benefit to be provided fully through telehealth, ASAM encourages CMS to clarify the services that may be rendered via telehealth under existing authority to supplement IOP care, and work with Congress to remove any barriers that limit access to this important benefit.** Importantly, research[2] has identified barriers to these services that limit access to them, especially for dually enrolled beneficiaries. ASAM encourages CMS to review any policy actions it could take to permit greater access to these services, including via telehealth.

**Impact of Modifier 22 on Addiction Treatment**

**ASAM strongly recommends that CMS not finalize its proposal for a 50 percent payment reduction for separately identifiable outpatient E/M services furnished on the same day as a procedure with a 0-, 10-, or 90-day global period.** In addiction medicine, the separately identifiable E/M work may include services integral to the provision of high-quality care, including assessment and management of SUD, medication management and counseling, withdrawal management, overdose risk reduction, management of psychiatric and medical comorbidities, and coordination of care. For clinicians who integrate addiction treatment with pain management, primary care, or psychiatric care, the proposed reduction could create significant financial disincentives to furnishing these services during the same encounter and, over time, adversely affect beneficiary access to integrated care.

ASAM's analysis of an identified cohort of addiction treatment clinicians found 55 services with 0- or 10-day global periods that accounted for nearly $3 million in Medicare payments in 2024. A substantial share of this utilization appeared to involve procedures for the treatment of pain. Although available public claims data does not permit ASAM to determine how frequently these procedures were furnished on the same day as a separately identifiable E/M service, ASAM's modeling raises significant concerns about the potential financial effects of the proposal on affected practices. More fundamentally, the proposal could create incentives for clinicians to separate otherwise appropriate services across different visits simply to avoid triggering the payment reduction. Given CMS' broader efforts to promote coordinated, integrated care and reduce fragmentation, such an incentive would move Medicare policy in the opposite direction. **CMS should therefore not finalize this proposal.**

**CMS Should Ensure Payment Policies Accommodate the Recent FDA-Approved Update to the Prescribing Information for Extended-Release Buprenorphine for the Treatment of Opioid Use Disorder**

ASAM recommends that CMS review current coding for OTPs to ensure that the codes do not improperly create barriers to the use of the new treatment protocol described in the recent FDA-approved update to the prescribing information for extended-release buprenorphine for the treatment of opioid use disorder. Specifically, existing coding is structured around weekly and monthly dosing patterns that may not support a rapid-induction protocol[3] for extended-release buprenorphine, as recently described in an FDA-approved update to that formulation's prescribing information. Under the new FDA-approved prescribing information, that protocol includes a second injection that may be administered as early as one week after the initial dose, though the current coding seems not to support the second injection. **CMS should review whether the current OTP codes require an update to reflect this new protocol and should take similar action under the PFS for the payment methodology for extended-release medications to treat SUD under the Part B program.**

**Bundled Payments for Substance Use Disorder**

*ASAM and CMS Share a Commitment to Coordinated Addiction Treatment*

Fragmented care delivery can interrupt continuity, create gaps in patient engagement, and make it harder to sustain the mix of medical, behavioral, and social support services that many patients need over time. These challenges underscore a basic principle of effective addiction treatment, that services often need to be coordinated and delivered together, rather than paid for and furnished as isolated encounters. That principle informed ASAM's adoption of the Patient-Centered Opioid Addiction Treatment (P-COAT)

payment model,[4] which was designed to support comprehensive and coordinated outpatient addiction treatment.

CMS incorporated this bundled-payment concept into Medicare via the Value in Opioid Use Disorder Treatment demonstration as a pathway to expand access to comprehensive outpatient treatment. CMS' subsequent evaluation of the demonstration further supports the promise of this approach. Participating beneficiaries experienced fewer inpatient admissions and emergency department visits, including substantially fewer SUD-related emergency department visits, along with lower Medicare expenditures.[5] These findings reinforce the potential value of payment models that support coordinated outpatient addiction treatment rather than relying exclusively on payment for isolated services.

ASAM appreciates CMS' continued efforts to refine this payment structure and welcomes the current RFI as an opportunity to ensure that Medicare payment supports coordinated models of care. The RFI builds on CMS' previous efforts to strengthen these codes and signals CMS' continued willingness to engage with stakeholders. It also provides an appropriate vehicle for highlighting that the current office-based SUD bundles do not adequately recognize medically managed outpatient treatment intensity.

*Medicare's Current Office-Based SUD Payment Structure Does Not Fully Recognize Medically Managed Outpatient Intensity*

As ASAM highlighted in a letter [6] to CMS earlier this year, just over 5% of Medicare beneficiaries with OUD received any outpatient treatment. Utilization of the bundled codes CMS established to support comprehensive office-based SUD treatment tells a similar story. Medicare fee-for-service claims data show approximately 1,800 claims for bundled payments for initial office-based treatment in 2023, falling to just over 1,100 claims in 2024, a roughly 37% decrease. While several factors may contribute to low utilization, these trends warranted concern from ASAM that the current coding and payment structure exposed a gap for patients needing comprehensive outpatient addiction treatment.

ASAM continues to believe that this gap exists for beneficiaries who require a greater degree of medically managed outpatient care than is expressly recognized under the current bundled payment structure, last updated before the most recent edition of The ASAM Criteria. When CMS last updated these codes, the Third Edition of The ASAM Criteria noted ambulatory withdrawal management on a separate track from the broader treatment continuum. The Fourth Edition integrates medically managed services into the main continuum, giving CMS a newer framework for evaluating whether payment structures developed before that change adequately recognize medically managed outpatient intensity.

In essence, the central issue is not *whether* Medicare pays for individual clinical components of Level 1.7 care, but that the PFS does not have a payment that recognizes the additional clinical-staff resources, monitoring, reassessment, and coordination needed to furnish those components *together* as medically managed outpatient addiction treatment.

As ASAM noted in its last letter, in the revised continuum, ASAM Level 1.0 (Long-Term Remission Monitoring) supports ongoing monitoring for patients in stable remission, including medication management as appropriate, and much of this care can be paid for through existing outpatient E/M codes. The new ASAM Level 1.5 (Outpatient Therapy) more closely reflects the counseling and psychotherapeutic services already recognized within Medicare's existing office-based SUD treatment codes, including G2086 and G2087. By contrast, ASAM Level 1.7 (Medically Managed Outpatient)

reflects a level of care in which patients may require more frequent medical management and/or nurse monitoring, including for intoxication or withdrawal, initiation or titration of addiction medications, or significant biomedical/psychiatric concerns. **The PFS does not include a bundled payment that expressly recognizes this level of outpatient intensity.**

*Medicare Pays for Many ASAM Level 1.7 Services, but Not as a Model*

To be clear, Medicare covers and pays for many discrete clinical services associated with ASAM Level 1.7 that may be reasonable and necessary for the treatment of SUD. That coverage matters, but it does not resolve the issue that Medicare payment does not recognize the integrated medically managed outpatient model in which those services must be coordinated, monitored, and reassessed together. Table 1 highlights these services, associated codes, and their intended uses.

**Table 1: Existing Medicare-covered Services for ASAM Level 1.7**

| **Level 1.7 service** | **Existing Medicare code** | **What Medicare already pays for** | **Level 1.7 gap** |
|---|---|---|---|
| Medical evaluation and medication management | Office/outpatient E/M codes (99202-99205/99211-99215) | Practitioner evaluation, reassessment, and medication management | Whether repeated encounters alone adequately support the broader medically managed model |
| Withdrawal management/monitoring | E/M services (99202-99205/99211-99215); separately payable medications and laboratory testing; OTP periodic assessment (G2077) as a functional analogue | Practitioner assessment and treatment of withdrawal-related needs, medication management, and relevant testing may be separately payable; OTP policy also recognizes reassessment of treatment response and changing medical/psychiatric needs | Medicare does not appear to have an office-based PFS code that expressly recognizes withdrawal management as part of an integrated medically managed outpatient SUD model with ongoing monitoring and rapid reassessment |
| Comprehensive office-based SUD treatment | G2086, G2087 | Monthly management, care coordination, individual/group psychotherapy, and counseling | These bundles do not expressly distinguish Level 1.7 medically managed intensity |
| Additional treatment/counseling time | G2088 | Additional 30-minute increments after the applicable treatment-time threshold | More treatment time is not necessarily the same as greater medical/nursing intensity |

| Level 1.7 service | Existing Medicare code | What Medicare already pays for | Level 1.7 gap |
|---|---|---|---|
| Ongoing behavioral-health clinical-staff management | 99484; 99492–99494 | Monthly BHI/CoCM services, including clinical-staff follow-up, treatment monitoring, care coordination, and medication-related treatment changes | These services have their own requirements and do not constitute a medically managed SUD level of care |
| More intensive chronic clinical-staff management | 99487–99489 | Clinical-staff management for complex chronic care | May apply to qualifying beneficiaries, but is not designed around Level 1.7 SUD treatment |
| Medication-response and changing-needs reassessment | G2077 (OTP) | Periodic reassessment of MOUD dosing, treatment response, SUD needs, and relevant physical/psychiatric needs | OTP-only code; useful functional analogue but not payable to ordinary office-based practices |
| Additional coordination/navigation/recovery support | G0534–G0536 (OTP) | Additional coordinated care/referrals, navigation, and peer-recovery services beyond the base OTP payment | OTP-only; demonstrates recognition of incremental functions above a base addiction-treatment payment |
| Medications and laboratory testing | Separate Part B/Part D and laboratory payment pathways, as applicable | Drugs and medically necessary testing can remain separately payable | Payment for the drug/test does not necessarily recognize the surrounding monitoring and integrated clinical response |

ASAM is not recommending changes to these individual codes. They should remain covered and separately payable where appropriate, including in cases where a clinician may be unable to offer the Level 1.7 integrated model. The point of the table is instead to show that existing payment pathways recognize pieces of Level 1.7 care without necessarily recognizing the coordinated, medically managed outpatient model those pieces support.

ASAM's concern is that payment for individual services may not be sufficient to sustain comprehensive addiction treatment when those services must be coordinated and delivered together as a model. Although existing codes may recognize portions of Level 1.7 care in particular circumstances, it remains unclear whether the current combination of payment pathways adequately recognizes the clinical-staff resources and practice capacity needed to furnish those services together as a coherent medically

managed outpatient model, without creating conflicting billing requirements, duplicative payment concerns, or substantial administrative complexity.

*CMS Should Use Lessons Learned to Propose Updates to the SUD Bundles for CY 2028*

Understanding how Level 1.7 is currently fragmented among several different codes, CMS should use this opportunity to pursue a similar path it has taken before to strengthen payment for addiction treatment when evidence has demonstrated differences in clinical intensity or resource use. For example, CMS revised the psychotherapy resources incorporated into the office-based SUD bundles, created additional OTP payments when services exceeded those reflected in the base payment, and has previously considered whether the SUD bundles should be stratified to reflect variation in service intensity.

CMS now has substantially more information than it had when these bundles were first established, including nearly six years of claims experience, findings from the Value in Opioid Use Disorder Treatment demonstration, experience from state Medicaid section 1115 demonstrations, and recent findings from the US Department of Health and Human Services (HHS) Office of Inspector General (OIG).[7] CMS previously used state examples when establishing the OTP benefit and could do the same here to understand how higher-intensity outpatient services are defined, staffed, and paid, even though there is no statutory mandate. This record gives CMS a precedent through this timely opportunity to improve access, strengthen continuity and integration of care, and promote responsible stewardship of Medicare resources by ensuring that the bundled payment structure appropriately reflects the services and resources required to furnish care. **ASAM urges CMS to use this opportunity to develop and propose, for the CY 2028 payment year, updates to the SUD bundles that appropriately recognize medically managed outpatient treatment intensity. While ASAM believes that CMS has sufficient information for such a proposal, the Society stands ready to provide targeted clinical input as necessary.**

| **Evidence available to CMS** | **What CMS has learned** |
|---|---|
| Nearly six years of G2086–G2088 claims experience | How the bundled codes are being used in practice, including persistently limited utilization |
| Value in Opioid Use Disorder Treatment demonstration | Coordinated outpatient OUD treatment was associated with fewer inpatient admissions and ED visits and lower Medicare spending |
| State Medicaid §1115 demonstrations | Higher-intensity ambulatory SUD services, such as withdrawal management can be operationalized within public payment systems and across an ASAM-aligned continuum |
| HHS OIG findings | Payment policy must address both access to treatment and payment accuracy by ensuring bundled payments reflect the services and resources actually furnished |

*CMS Should Consider Multiple Approaches to Address the Level 1.7 Gap*

There are several coding and payment approaches for CMS to consider in response to this RFI, and ASAM encourages CMS to weigh the benefits and limitations of each. **First, CMS could propose a standalone monthly code for ASAM Level 1.7 that consolidates payment for the services and resources associated with this medically managed level of care, rather than requiring practices to rely on multiple separate**

**coding pathways and billing rules. ASAM continues to support this preferred approach, as recommended in its previous letter to CMS,[8] because it would most directly recognize Level 1.7 as a coherent model of medically managed outpatient care.** CMS has also recently used a similar consolidation strategy through Advanced Primary Care Management (APCM), which combines multiple care management functions into a single monthly payment. ASAM highlighted an illustrative code descriptor [9] for a standalone Level 1.7 approach in its letter to CMS earlier this year.

Under this approach, CMS would establish a new G-code as a distinct monthly service with its own descriptor and valuation. The code could recognize the additional clinical-staff involvement, withdrawal management services, monitoring, reassessment, and coordination associated with Level 1.7 care, while preserving separate payment for medications and laboratory testing, where appropriate. Like existing codes for OTPs, CMS could consider whether CMS has statutory authority to include costs of long-acting injectable medications in any revised bundles to limit bureaucratic red tape for practices using these medications. In developing valuations, CMS should consider existing Medicare resource and payment analogues, including relevant OTP payment inputs where comparable clinical functions are already recognized. Those analogues should inform, rather than dictate, the final valuation for office-based Level 1.7 care.

**Alternatively, CMS could establish a medically managed intensity add-on to G2086 or G2087 for beneficiaries requiring Level 1.7 care.** CMS has used similar base plus add-on structures elsewhere in Medicare to pay for addiction treatment. Within the OTP benefit, CMS maintains an underlying bundled payment while separately recognizing higher-intensity IOP services through G0137 when applicable statutory requirements are met. CMS also permits G2077 to be billed when a beneficiary requires a medically reasonable and necessary periodic assessment of medication dosing, treatment response, and changing physical or psychiatric needs, while G0534–G0536 recognize additional coordination, navigation, and peer-recovery services beyond the base episode of care. CMS has likewise used base plus add-on approaches outside addiction treatment, including within APCM. Collectively, these policies demonstrate CMS' ability to preserve an existing base payment while separately recognizing an identifiable increase in clinical intensity or additional resource needs. This approach may be administratively easier than creating a wholly new bundled service, but CMS would need to define the add-on carefully to avoid overlap with services already reflected in G2086, G2087, or other separately payable codes. These payment structures are not directly transferable to ASAM Level 1.7, but they provide useful design precedents as CMS considers how medically managed outpatient intensity could be recognized under the PFS.

**A third approach ASAM encourages CMS to explore is restructuring the entire G2086–G2088 code family.** This approach may be appropriate if CMS determines that adding either a standalone Level 1.7 code or an intensity add-on would create confusing overlap, distort the relative valuation of existing services, or otherwise make the coding structure more difficult to administer. In that circumstance, CMS could consider revising the entire code family so that the descriptors more clearly distinguish the types and intensity of outpatient SUD services reflected across ASAM Levels 1.0, 1.5, and 1.7, while preserving appropriate relativity across the family.

Should CMS move ahead with this option, it should ensure coding separately recognizes: (1) lower-intensity outpatient monitoring and management; (2) comprehensive outpatient therapy and counseling; (3) medically managed outpatient treatment requiring greater clinical staff involvement and monitoring; and (4) additional treatment time beyond the applicable base service. This approach would allow CMS to

resolve overlaps created by incremental additions to the current code family through a more comprehensive redesign.

Ultimately, CMS should prioritize an approach that clearly defines the medically managed outpatient intensity being recognized, avoid duplicative payment for separately payable services, minimize administrative burden for office-based practices, and preserve beneficiary access to coordinated care by ensuring that the valuation for this new service is at parity with how this service is valued in OTPs.

**ASAM urges CMS to use the information received through this RFI and the evidence already available to CMS to develop and propose, for CY 2028, a payment pathway that expressly recognizes medically managed outpatient addiction treatment intensity under the PFS. ASAM would also welcome the opportunity to assist in any future stakeholder engagement process regarding the development of related payment policy.**

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[1] American Society of Addiction Medicine, Implementation Guide for Hospital and Emergency Department Substance Use Disorder Care (2026), available here.

[2] Gretchen Bell, Andrew Spicer & Deborah Steinberg, "Expanded Medicare Coverage of Intensive Outpatient Services: Considerations for States," Center for Health Care Strategies (Mar. 2025), https://www.chcs.org/media/Expanded-Medicare-Coverage-of-Intensive-Outpatient-Services-Considerations-for-States.pdf.

[3] U.S. Food and Drug Administration, *SUBLOCADE (buprenorphine extended-release) injection, for subcutaneous use: Prescribing Information* (2025), FDA prescribing information.

[4] American Society of Addiction Medicine & American Medical Association, Patient-Centered Opioid Addiction Treatment (P-COAT): An Alternative Payment Model Concept for Office-Based Treatment of Opioid Use Disorder (2018), available here.

[5] Centers for Medicare & Medicaid Services. (2026). Value in opioid use disorder treatment (VIT-OUD) demonstration evaluation: Final report to Congress. U.S. Department of Health and Human Services. CMS report.

[6] American Society of Addiction Medicine, Proposal for Mitigating Outpatient Substance Use Disorder Payment Disparities (Feb. 27, 2026), available here.

[7] U.S. Department of Health and Human Services, Office of Inspector General, Medicare Could Have Saved $301.5 Million if Bundled Payment Rates for Opioid Use Disorder Treatment Services Had Reflected Services Provided to Enrollees (Oct. 2025), A-09-23-03002, available here.

[8] American Society of Addiction Medicine, Proposal for Mitigating Outpatient Substance Use Disorder Payment Disparities (Feb. 27, 2026), available here.

[9] *GXXXX (Office-based treatment for a substance use disorder, monthly bundle not including medication and dispensing costs, including medical management services, withdrawal management, toxicology testing, development/revision of the treatment plan, care coordination, individual therapy and group therapy and counseling)*