April 16, 2025

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

Re: Recommended HHS Actions to Address the Chronic Disease of Addiction

Dear Secretary Kennedy,

On behalf of the American Society of Addiction Medicine (ASAM), the nation's leading specialty medical society representing more than 8,000 physicians and other health professionals who specialize in the prevention and treatment of addiction, I commend your decision to share your story of long-term recovery. Like millions of Americans who have faced addiction, your story is a powerful reminder that addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

As your recent renewal of the public health emergency declaration of the opioid crisis demonstrates, our nation continues to face a deadly addiction and overdose crisis. We are interested in learning more about your perspectives on addiction prevention and treatment and welcome the opportunity to work with you and your team to ensure our nation addresses addiction in a way that is grounded in sound scientific and medical knowledge. By increasing access to preventive services, expanding affordable access to the full continuum of addiction care,[1] integrating the whole self – including the spiritual self - as part of health and wellness, and making recovery support services more available, we can instill hope that remission and long-term recovery are not only possible but probable.

To that end, we have identified below ASAM's top three priorities for your consideration, along with additional medium-to-long-term

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actions - each of which would have a demonstrable, positive impact on the lives of Americans impacted by addiction.

1. **Update SMD #17-003[2] (Strategies to Address the Opioid Epidemic) section 1115 demonstration guidance to eliminate the restrictive 30-day statewide average lengths of stay (LOS) for residential treatment, and add an implementation milestone requiring residential treatment provider qualifications to fully align with the ASAM Levels 3.1, 3.5, and/or 3.7 program standards identified in HR 9232/S 4860 - the Residential Recovery for Seniors Act[3] (118th Congress), in licensure requirements, policy manuals, managed care contracts, or other guidance.**

2. **Work with the Drug Enforcement Administration (DEA) to update DEA and HHS regulations to allow qualified practitioners to prescribe methadone for OUD for pharmacy administration/dispensing so that this lifesaving treatment can be accessed through more medical settings, and support individuals on their pathway toward recovery and wellness. These settings include primary care, as well as Federally Qualified Health Centers and Certified Community Behavioral Health Clinics.** At a minimum, qualified practitioners should include board certified addiction psychiatrists and addiction medicine physicians; uniquely, addiction medicine is a *multispecialty subspeciality*, meaning these physicians may be certified by *any* primary board recognized by the American Board of Medical Specialties, including family medicine or internal medicine.[4] A recent ASAM-led coalition letter,[5] describes how this can be achieved through regulation and how such action is consistent with President Trump's executive order, *"Ensuring Lawful Governance and Implementing the President's 'Department of Government Efficiency' (DOGE) Deregulatory Initiative,"*[6] which directs the rescission or modification of regulations that are not based on the best reading of the underlying statute.

3. **Increase the valuations of Medicare codes G2086, G2087, and G2088 (office-based substance use disorder treatment) and add a performance-based incentive to ensure parity with opioid treatment program (OTP) bundled billing rates in Medicare to encourage patient choice of treatment.** A recent survey [7] revealed that nearly a third of OTPs did not offer all medication options for OUD, despite their capacity to do so.[8] ASAM recommends that HHS align codes G2086, G2087, and G2088 with the Patient-centered Opioid Addiction Treatment (P-COAT) alternative payment model, which is designed to improve outcomes and reduce spending for opioid addiction. An April 2024 interim report[9] on the Medicare Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration (which used the P-COAT framework), authorized during the first Trump Administration showed a reduction in spending on inpatient services, emergency room services, and hospitalizations.

These are immediate actions that HHS can take. In the medium-to-long-term, ASAM encourages the agency to consider the additional actions set forth below.

Prevention

1. Incentivize primary care clinicians to screen for unhealthy drug and alcohol use by increasing the valuation of Medicare codes G2011 *(Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 5-14 minutes)*, *G0396 (Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15-30 minutes)*, and *G0397 (Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention greater than 30 minutes)*.

Access to Quality Care

2. Update hospital conditions of participation in Medicare and/or work with Joint Commission on updating its standards to require hospitals to offer addiction treatment in alignment with ASAM Level 4 program standards (e.g., direct withdrawal management and biomedical services, psychiatric services, and psychosocial services (directly or through formal affiliation)).

3. Reject any Medicare Advantage plan that imposes prior authorization or other burdensome utilization management techniques on any addiction medications to ensure individuals with addiction have ready access to treatment without overly restrictive health insurance protocols.

Fraud, Waste, and Abuse

4. Require Medicare (traditional and Advantage) to use policies and procedures that are fully consistent with evidence-based, substance use disorder (SUD)-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment *(e.g. The ASAM Criteria)* for medical necessity determinations, utilization management, and appeals decisions concerning service type, service intensity, level of care, continued service, and transitions for SUD.

Data and Innovation

5. Promote innovative treatment options by issuing a notice of proposed rulemaking to create a regulatory safe harbor to protect certain evidence-based contingency management programs for the treatment of SUD, as previously planned by HHS.[10]

6. Accelerate the adoption and interoperability of information technology in addiction care by introducing standards for adoption that specify and recognize definitions and terminology that aligns with those developed by a nonprofit medical association generally recognized for

its expertise in addiction treatment *(e.g. The ASAM Criteria)*, including all levels of care levels, risk ratings, and dimensions.

7. Create a distinct metric for physicians who are board-certified in addiction medicine and are in specialties other than psychiatry for purposes of determining mental Health Professional Shortage Areas (HPSAs).

Thank you for considering these recommended actions. We stand ready to assist you in addressing addiction and saving lives. Please contact Corey Barton, Director of Advocacy at cbarton@ASAM.org for further engagement on these or other areas of interest.

Sincerely,

Brian Hurley

Brian Hurley, MD, MBA, FAPA, DFASAM
President, American Society of Addiction Medicine

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[1] American Society of Addiction Medicine. The ASAM Criteria. www.asam.org. Published 2024. https://www.asam.org/asam-criteria

[2] CMS. SMD # 17-003 RE: Strategies to Address the Opioid Epidemic. November 1, 2017. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[3] Legal Action Center. The Residential Recovery for Seniors Act: Expanding Medicare's Coverage of Addiction Treatment Services. Published 2024. https://www.lac.org/resource/closing-medicares-coverage-gap-for-residential-substance-use-disorder-services

[4] ABMS Officially Recognizes Addiction Medicine as a Subspecialty. American Board of Medical Specialties. Published March 14, 2016. https://www.abms.org/newsroom/abms-officially-recognizes-addiction-medicine-as-a-subspecialty/

[5] Trump Executive Order Opens Door to Fix Methadone for OUD Regulation. Default. Published March 31, 2025. Accessed April 5, 2025. https://www.asam.org/news/detail/2025/03/31/cut-recovery-red-tape

[6] Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Regulatory Initiative. The White House. Published February 20, 2025. https://www.whitehouse.gov/presidential-actions/2025/02/ensuring-lawful-governance-and-implementing-the-presidents-department-of-government-efficiency-regulatory-initiative/

[7] *NATIONAL SUBSTANCE USE and MENTAL HEALTH SERVICES SURVEY (N-SUMHSS), 2023: Annual Detailed Tables National Substance Use and Mental Health Services Survey (N-SUMHSS) 2023: Annual Detailed Tables Acknowledgments*. https://www.samhsa.gov/data/sites/default/files/reports/rpt53013/NSUMHSS-Annual-Detailed-Tables-23.pdf

[8] While OTPs may dispense or administer all three FDA-approved medications to treat OUD, clinicians treating OUD in non-OTP outpatient settings are limited to prescribing buprenorphine and naltrexone, as they are legally prohibited from prescribing/dispensing methadone for OUD outside of the "three-day rule" emergency exception.

[9] U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services. Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration Evaluation. April 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/vit-intermediate-rtc

[10] Reginfo.gov. Published 2024. Accessed April 5, 2025. https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202410&RIN=0936-AA13